

# 2016/17 General Medical Services (GMS) contract

Guidance for GMS contract 2016/17

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April 2016



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# Section 1: Introduction

In February 2016, NHS Employers (on behalf of NHS England) and the British Medical Association's General Practitioners Committee (GPC) agreed changes to the General Medical Services (GMS) contract for 2016/17.

This document sets out those changes. For any requirements that remain unchanged from 2015/16, the content has been removed and replaced by a link to the [2015/16 General Medical Services \(GMS\) guidance](#)<sup>1</sup>.

This information provides guidance for commissioners, local medical committees, for practices<sup>2</sup> that hold a GMS contract and for all practices subject to the new contractual requirements or that are offering Enhanced Services (ES) commissioned by NHS England.

Commissioners and practices 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 2016/17 GMS contract changes. This supersedes all previous guidance on these areas.

Wherever possible, NHS England seeks to minimise the reporting requirements for the services delivered by practices where these can be supported by new systems and this guidance outlines the audit requirements for the services detailed. Separate technical guidance detailing the Read codes which practices are required to use are detailed in the document *Technical requirements for 2016/17 GMS contract changes*<sup>3</sup>.

This guidance is applicable in England only.

The amendments to the GMS Contract Regulations, Directions and to the Statement of Financial Entitlements (SFE), which underpin the changes to the contract, are available on Department of Health (DH) and NHS Employers websites<sup>4,5</sup>. The detailed requirements for taking part in the enhanced services (ESs) are set out in the Directions, except for the unplanned admissions ES where the detailed requirements are set out in the service specifications which are available on the NHS England website<sup>6</sup>.

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<sup>1</sup> NHS Employers

<http://www.nhsemployers.org/~media/Employers/Documents/Primary%20care%20contracts/GMS/GMS%20guidance%202010-present/2015-16/201516%20GMS%20Guidance.pdf>

<sup>2</sup> 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.

<sup>3</sup> NHS Employers. Technical requirements for 2016/17 GMS contract changes. <http://www.nhsemployers.org/GMS201617>

<sup>4</sup> NHS Employers. <http://www.nhsemployers.org/GMS201617>

<sup>5</sup> <http://www.legislation.gov.uk/ukxi/2014/465/contents/made>

<sup>6</sup> NHS England. <https://www.england.nhs.uk/commissioning/gp-contract/>

# Section 2: Technical requirements

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

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

CQRS<sup>7</sup> is the automated system used to calculate achievement and payments on quality services. These include the Quality and Outcomes Framework (QOF), ESs and vaccination programmes.

GPES<sup>8</sup> anonymises patient identifiable data which it then collects from general practice IT clinical systems for a wide range of purposes including payments to practices and the provision of relevant data for management information purposes. This enables commissioners to monitor and verify the delivery of various contract and service requirements.

The CQRS team works with NHS England to ensure CQRS supports the contract and any changes. Practices must be offered and agree to provide each service with their commissioner.

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

Practices authorise data collections made by GPES when they accept a service on the CQRS system.

This guidance provides information on how CQRS and GPES are used in relation to enhanced services. Detailed guidance for vaccinations and immunisations and QOF are available on NHS Employers' website.<sup>9 10</sup> In order to support practices, CQRS also publishes guidance and issue communications as services become live on CQRS or GPES, which detail how to manually declare and enter relevant data into CQRS and enable data collections. Further information on when each service will be

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<sup>7</sup> HSCIC. CQRS. <http://systems.hscic.gov.uk/gpcollections>

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

<sup>9</sup> NHS Employers. <http://www.nhsemployers.org/vandi201617>

<sup>10</sup> NHS Employers. <http://www.nhsemployers.org/QOF201617>

available on CQRS and how to input data will be available on the HSCIC website<sup>11</sup>.

Where a service is supported by CQRS, practices are required to manually enter achievement on CQRS until data can be automatically collected from practice systems by GPES.

## Technical Requirements for 2016/17

The *Technical requirements for 2016/17*<sup>12</sup> document sets out additional detail on how CQRS and GPES will support services, outlines the Management Information (MI) count wording and provides the relevant Read2 and CTV3 codes that practices are required to use for each service. Read2 and CTV3 codes are used as the basis for the GPES data collection, which allows CQRS to calculate payment based on the aggregated numbers supplied and support the management information collections.

Changes which materially affect services supported by CQRS and GPES will be updated in the technical requirements document. This is available as a 'live' document on NHS Employers website and will be updated as services move from manual reporting to automated data collections. Relevant supporting Business Rules<sup>13</sup> will also be updated and available on the HSCIC website.

Although practices are required to manually enter data until 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 codes included in the technical requirements document and the supporting Business Rules will be acceptable to allow CQRS to calculate achievement and payment and enable commissioners to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes from the commencement of each service and if necessary will need to re-code patients accordingly.

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<sup>11</sup> HSCIC. CQRS. <http://systems.hscic.gov.uk/gpcollections>

<sup>12</sup> NHS Employers. <http://www.nhsemployers.org/GMS201617>

<sup>13</sup> HSCIC. <http://www.hscic.gov.uk/qofesextractspecs>

# Section 3: Contractual requirements

## 3.1 Funding

### Global sum funding and uplift

New investment for 2016/17 totals £220 million<sup>14</sup> and includes:

- a pay uplift of 1 percent
- an increase in the item of service fee for vaccination and immunisations to £9.80<sup>15</sup>
- an increase in the value of a Quality and Outcomes Framework (QOF) point to £165.18, owing to adjusted Contractor Population Index (CPI)
- funding to cover expenses relating to additional Care Quality Commission (CQC) costs and other increased business expenses.

NHS Employers, NHS England and GPC will work in 2016/17 to determine an agreed methodology for expenses which all parties might use in future.

The GMS global sum funding will also increase in 2016/17 as a number of funding streams are transferred:

- The implementation of phasing out of Minimum Practice Income Guarantee (MPIG) correction factor payments began in 2014/15 and will continue through to 2020/21. Correction factor payments are being reduced by one seventh of the 2013/14 values and the aggregate funds reinvested into GMS global sum with no out-of-hours (OOH) deduction applied.
- The implementation of phasing out of seniority payments<sup>16</sup> began in October 2015 and will continue through to March 2020, with a reduction in payments and simultaneous reinvestment into core funding every year with no OOH deduction applied. In April 2016 GMS seniority payments were reduced by approximately £11.5m and this was reinvested into global sum after adjusting for a small overpayment in 2015/16.
- There is a transfer of £42m from the dementia ES into core funding with no OOH deduction applied.

The net effect is

- Global sum payment per weighted patient increases from £76.51<sup>17</sup> to £80.59.

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<sup>14</sup> This guidance covers the GMS contract but the investment covers both GMS and PMS practices

<sup>15</sup> NHS Employers. <http://www.nhsemployers.org/vandi201617>

<sup>16</sup> NHS Employers. <http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/gms-finance/seniority-factor>

<sup>17</sup> In 2015/16 there were two global sum figures, to accommodate a reduction in seniority payments and simultaneous reinvestment into global sum. This was carried out mid-year in October 2015. The

- OOH deduction changes from 5.39 percent in 2015/16 to 5.15 percent in 2016/17.

These revised values take effect from 1 April 2016 as detailed in the SFE.

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

## 3.2 Continuing contractual requirements from 2015/16

The following requirements are wholly or largely unchanged from 2015/16, and guidance and audit requirements are set out in the [2015/16 GMS guidance](#).

- alcohol-related risk reduction
- assurance of out of hours provision
- named accountable GP for all patients - supporting Business Rules are available on the HSCIC website<sup>18</sup>. Commissioners and practices should refer to these for the most up-to-date information on Read and CTV3 codes
- parental leave arrangements
- publication of GP net earnings - there are some minor changes to the dataset for calculation of contractor net income. These are detailed at Annex A.

Information relating to coding is available in *Technical requirements for 2015/16*

## 3.3 New contractual arrangements for 2016/17

### Data on patient access

NHS England and GPC have agreed a new contractual requirement for practices to record data on the availability of evening and weekend opening for routine appointments. The recording of data will be automatic with the approach for collecting the data as simple and efficient as possible without the need for labour intensive processes. This data will be collected every six months until 2020/21 and further details will be made available in due course.

Further information will be made available by NHS England following agreement with GPC later in 2016.

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value of global sum for the first half of 2015/16 was £75.77 and for the second half of 2015/16 was £76.51 - giving an annual average for the year of £76.14.

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

# Section 4: Non contractual arrangements

## Access to healthcare

DH, NHS England and GPC will develop arrangements for identifying patients with a European Health Insurance Card (EHIC), S1 or S2 form. This will be done at the point of registration, through patient self-declaration and the details will be recorded. Discussions will consider how to address any additional workload for practices. The aim is for this to be implemented by December 2016.

## Data by named accountable GP<sup>19</sup>

All parties are committed to ensuring the highest quality of care for patients, supported with relevant information. During 2016/17, NHS England will discuss with GPC how appropriate and meaningful data relating to a patient's named accountable GP can be made available at practice level for use internally by practices, for peer review and quality improvement. This will be particularly relevant for patients being case managed and also those aged 75 and over. It is recognised that there are a number of system issues to overcome before this can be implemented.

Further information will be made available by NHS England later in 2016.

## Data for indicators no longer in QOF or ESs

Practices will continue to undertake work and code activity as clinically appropriate in relation to those indicators no longer in QOF and retired ESs. Practices are also asked to note the position outlined within the 2016/17 QOF guidance - that they are encouraged to facilitate data collection of these areas. The data is intended to inform commissioners and practices and provide statistical information. Periodically, NHS England will collect anonymised data from practices' clinical systems, which will provide statistical information, be processed for audit and publication and will help inform commissioners and practices.

It is not intended for this information to be used for performance management purposes.

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<sup>19</sup> Providing a named, accountable GP remains a contractual requirement but agreement to provide data relating to it is not.

## Locum rates

NHS England will set a maximum indicative rate based on a set of rates (which may have some degree of regional variation) for locum doctors' pay. NHS England will amend the electronic declaration (e-Dec) system to include recording on the number of instances where a practice pays a locum doctor more than the maximum indicative rate.

## Patient online services and information technology (IT)

Since ending the Improving Patient Online Access ES in 2014/15, NHS England and GPC have worked together to develop high quality secure electronic systems, and pro-actively encourage patients and practices to use them. These developments have been taken forward through changes to the contract and also through agreed joint working arrangements.

The GP Systems of Choice (GPSoC) is a national contract for Clinical Information Systems. Through the GPSoC contract functionality changes have been to enable online services.

### Continuing contractual requirements

Contractual requirements from 2014/15 and 2015/16 continue unchanged, covering referral management, online ordering of repeat prescriptions, interoperable records, patient access to their patient record and electronic appointment booking. The guidance and audit requirements remain unchanged and are set out in the [2015/16 GMS guidance](#). Information relating to coding for this is available in the *Technical Requirements for 2015/16*.

### Joint working

Building on changes agreed in 2014/15 and 2015/16, NHS England and GPC have agreed to further develop patient online services and the use of information technology. These changes are outside of contractual requirements except where specific changes to the GMS Regulations are set out below to support the use of Electronic Prescription Service, the Summary Care Record (SCR) and GP2GP.

The Joint General Practitioners Information Technology Committee (JGPITC) will be the main forum for this work, which will be ongoing throughout 2016/17. Separate jointly agreed guidance will be available on the NHS England and GPC websites and will be publicised through bulletins, for the following issues:

### Maintaining current arrangements

#### Electronic referrals

As in the 2015/16 agreement, practices are encouraged to make referrals electronically using the NHS e-Referral Service. It has been agreed to aim for at least 80 per cent of elective referrals to be made electronically using the NHS e-

Referral Service by 31 March 2017, unless the secondary provider has not made slots available on the system, there is a clinical need to refer to a provider who does not publish services on the system or patients have indicated their choice to be referred to a provider that does not publish services on the system.

## **GP2GP**

GP2GP compliant practices will continue to utilise the GP2GP facility for the transfer of all patient records between practices, when a patient registers or de-registers (not for temporary registration). The GMS Regulations will be amended so that practices are no longer required to seek permission from NHS England not to print out the electronic record, where patient records successfully transfer to a new practice using GP2GP v2.2 or its successors.

## **Information governance**

NHS England and GPC will continue to promote the completion of the HSCIC information governance toolkit, including adherence to the requirements outlined within it. Practices will also continue under the GMS Regulations to nominate a person with responsibility for practices and procedures relating to the confidentiality of personal data.

With the sheer volume of patient information that a GP practice handles, it is vital that practices can handle information confidentially and securely and that they can demonstrate this.

Practices should also be cognisant of the National Data Security Review recommendations that will outline a set of recommendations and data security standards including the potential subsequent iteration of the IG toolkit.

## **New joint working arrangements**

### **Electronic transmission of prescriptions**

Building on the 2015/16 agreement, practices will be encouraged to transmit prescriptions electronically using Electronic Prescription Services (EPS) Release 2, unless the patient asks for a paper prescription or the necessary legislative or technical enablers are not in place. It was agreed to aim for at least 80 per cent of repeat prescriptions to be transmitted electronically using EPS Release 2 by 31 March 2017, where appropriate. This will apply to repeat prescriptions only.

For Dispensing Doctors, this target would apply for non-dispensing patients only, until such time that a suitable EPS compliant dispensing system is available and sufficient time has been given to adopt this capability. This is suggested to be April 2017 which would allow 6-12 months preparation.

The GMS regulations will be changed to allow the electronic transfer of prescriptions for patients without a nomination.

### **Summary Care Record**

NHS England and GPC will jointly consider ways in which practices are best able to offer patients the opportunity to add additional information to their SCR. It is recognised that particular groups of patients, for example those likely to present in unplanned, urgent or emergency care, may benefit from the availability of additional information within the SCR. NHS England and GPC recognise that practices may incur an overhead in undertaking this work and have agreed to jointly consider how to progress this.

Separately, the GMS Regulations will be amended to say SCR uploads will be enabled on an 'ongoing' rather than 'daily' basis.

### **Access to online services**

NHS England and GPC have agreed to aim for at least ten per cent of registered patients to be using one or more online services by 31 March 2017. These are

- online access to patient record
- online booking of appointments
- electronic prescriptions

### **Apps for patients to access services**

Practices will be required to support patients, as they do now, with Patient Online Services and it will be for practices to determine the level of support they wish to provide to patients in operating these apps and services. Apps will be clinically and technically validated through the GPSoC programme during 2016/17 before being made available to patients. Technical support for patients in using the apps will be provided by the app suppliers. Those apps that are provided as subsidiary services through Lot 1 of GPSoC will be assured during the pairing process. This provides a number of services in line with Patient Online. A wider review is underway on the replacement for the previous NHS Choices App Store, with investigation underway of what appropriate assurances processes should be put in place.

### **Online access to clinical correspondence**

Practices will provide patients who request it with online access to clinical correspondence such as discharge summaries, outpatient appointment letters and referral letters unless it may cause harm to the patient or contains references to third parties. Practices will have the facility to make available online only those letters received from a chosen prospective date which will be no later than March 2017.

### **Information sharing agreements between practices**

During 2016/17 NHS England and GPC will jointly develop a national template data sharing agreement, to facilitate information sharing between practices locally for

direct care purposes. This will allow formal sharing agreements to be put place where practices choose to work collaboratively in providing care.

### **Shared discharge summaries and event posting**

To support the increased use of interoperable records, the NHS Standard Contract requires providers to send their discharge summaries electronically to practices from 1 October 2015. From 1 April 2016, practices will be required to receive all discharge summaries and subsequent post-event messages electronically.

Providers have been expected to share discharges electronically for inpatient and day case episodes into GP practices and post-event messages.

End to end sharing of discharges electronically will allow this information to be accessed real-time and captured accurately so enabling greater patient safety.

## Section 5: QOF

There were no changes to indicators or thresholds for 2016/17 and no indicators were added or removed.

For 2016/17 there are 559 points in QOF across two domains for clinical and public health indicators. The value of a QOF point for 2016/17 has been adjusted to recognise any changes in population and practice list size from 1 January 2015 to 1 January 2016. This figure is subject to change in future years. In addition, the planned changes to thresholds have been deferred for a further year to 1 April 2017.

The national average practice population figure for the 2016/17 QOF year is taken from CQRS on 1 January 2016 and is 7,460. The value of a QOF point for 2016/17 is £165.18.

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

Commissioners and practices should refer to the QOF guidance which sets out the full requirements for 2016/17 and is available on NHS Employers website<sup>20</sup>.

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<sup>20</sup> NHS Employers. 2016/17 QOF <http://www.nhsemployers.org/qof201617>

# Section 6: Vaccination and immunisations

As part of the 2016/17 GMS contract changes, NHS Employers (on behalf of NHS England) and the GPC have agreed a number of changes to the contractual arrangements for some vaccinations and immunisations effective from 1 April 2016.

This section lists those vaccinations and immunisations which continue without alteration and those where there have been some changes made.

The item of service fee for vaccinations has been increased to £9.80 from 1 April 2016. The updated figure applies to all vaccination programmes with the exception of those included in the targeted programme for children.

The following programmes<sup>21</sup> continue unchanged:

- childhood influenza vaccination programme
- hepatitis B (newborn babies) vaccination programme
- HPV vaccination programme
- measles mumps and rubella (aged 16 and over) vaccination programme
- meningococcal booster vaccination programme
- meningococcal ACWY freshers
- rotavirus vaccination programme
- seasonal influenza and pneumococcal polysaccharide vaccination programme
- shingles (catch-up) vaccination programme
- shingles (routine) vaccination programme

There have been minor changes to the following programmes:

- childhood immunisations (target payments) – the removal of the infant dose of menC<sup>22</sup> from 1 July 2016
- meningococcal B vaccination programme – the removal of the central provision of paracetamol
- meningococcal ACWY 18 years programme – the expansion of the cohort in allow for the vaccination of 19-25 year old non-freshers
- pertussis – the expansion of the programme to allow the vaccination of pregnant women from 20 weeks in to the pregnancy

Commissioners and practices should refer to the service specifications and *Vaccination and immunisation programmes 2016/17 guidance and audit*

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<sup>21</sup> Programmes are either additional services or enhanced services. NHS Employers. <http://www.nhsemployers.org/vandi201617>

<sup>22</sup> As the targeted programme has a two year payment lag, the funding for this dose will be withdrawn from 1 July 2018 (reflecting removal of the dose from 1 July 2016).

*requirements* which sets out the full requirements for 2016/17 and are available on NHS Employers website<sup>23</sup>.

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<sup>23</sup> NHS Employers. Vaccination and immunisations 2016/17.  
<http://www.nhsemployers.org/vandi201617>

# Section 7: Enhanced services

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

The facilitating timely diagnosis and support for people with dementia ES ceased on 31 March 2016. During 2016/17, dementia diagnosis rates will be monitored and if necessary the position will be reviewed for 2017/18 if there is a significant change.

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

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

- Extended hours access - the guidance and audit requirements for the extended hours ES remain unchanged and are set out in the [2015/16 GMS guidance](#). Information relating to coding for this is available in the [Technical requirements for 2015/16](#). Requirements relating to 2015/16 dates in the guidance should be applied to 2016/17.
- Learning disabilities health check scheme - the guidance and audit requirements for the learning disabilities ES remain unchanged and are set out in the [2015/16 GMS guidance](#). Information relating to coding for this is available in the [Technical requirements for 2015/16](#). Requirements relating to 2015/16 dates in the guidance should be applied to 2016/17.
- The minor surgery ES and violent patient ES, which are locally specified, remain unchanged.
- Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people - detailed guidance is set out below. Minor changes have been made in 2016/17 to clarify the timeframe for care plan reviews.

# Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people

## Background and purpose

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

This ES is designed to help reduce avoidable unplanned admissions by improving services and offering more personalised care planning for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission. The ES should be complemented by whole system commissioning approaches to enable outcomes of reducing avoidable unplanned admissions. The ES will roll-over on 1 April 2016 for one year.

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

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

Patients identified as being at risk of unplanned admission without proactive case management and on the case management register will be assigned a named accountable GP (and where relevant a care co-ordinator). This person will have overall responsibility for co-ordinating the patient's care and sharing information with them, their carer<sup>24</sup> (if applicable) and, if the patient consents, the multi-disciplinary team (MDT) and other relevant providers involved in their care. These patients will have a personalised care plan which will have been developed collaboratively between the patient, their carer (if applicable) and the named accountable GP and/or care co-ordinator, detailing how their ongoing health and care needs will be addressed to reduce their risk of avoidable admission to hospital. The patient's care and personalised care plan will also be reviewed at regular intervals agreed with the

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<sup>24</sup> Remember that the patient must understand, where they have the capacity, what role and information will be shared with their carers and the consent to their involvement should cover this issue. Commissioners and practices will be aware of the need to protect vulnerable patients and ensure necessary safeguards are in place.

patient and if applicable, the carer. Practices should also be aware of the needs of carers.

Participating practices will carry out monthly reviews<sup>25</sup> of all unplanned admissions and readmissions and A&E attendances of patients on the case management register.

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

This guidance should be read in conjunction with the 2016/17 NHS England ES specification<sup>26</sup>.

## Requirements

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

### Practice availability

1. The practice will provide timely telephone access via an ex-directory or bypass number to ambulance staff and A&E clinicians to support decisions about hospital transfers and admissions relating to any patient on their registered list<sup>27</sup>. This could, for example, be done by providing different extension options to callers, as long as this gets the caller straight through to the practice as a priority call. Where an ambulance staff member or A&E clinician specifically ask to speak to a clinician in the practice, then they should be enabled to do so whenever practically possible. Access should be within a suitable timeframe recognising that the query being raised relates to whether or not to transfer or admit a patient to hospital i.e. it may be immediate, within an hour or same day. The commissioner will be required to compile a list of all the by-pass or ex-directory telephone numbers for practices participating in the ES and share it with relevant ambulance staff and A&E clinicians.
2. The practice will provide timely telephone access via an ex-directory or bypass number to care and nursing homes, encouraging them to contact the patient's practice to discuss options before calling an ambulance (where appropriate – for example, this is not applicable if the patient is at high risk of severe harm or death, if treatment is delayed). For example, this could be done by providing

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<sup>25</sup> The reviews are to understand why each individual admission or attendance occurred and whether it could have been avoided.

<sup>26</sup> NHS England. Service specification. <http://www.england.nhs.uk/commissioning/gp-contract/>

<sup>27</sup> This number is only to be used when ambulance staff and A&E clinicians require support from a patient's practice in making decisions about transferring or admitting patients.

different extension options to callers to the practice, as long as this gets the caller straight through to the practice as a priority call. Where care or nursing home staff specifically ask to speak to a clinician in the practice, then they should be enabled to do so whenever practically possible. Access should be within a suitable timeframe recognising that the query being raised relates to whether or not to call an ambulance i.e. it may be immediate or within a couple of hours. The commissioner will be required to compile a list of all the by-pass or ex-directory telephone numbers for practices participating in the ES and share it with relevant care and nursing homes.

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

### **Proactive case management and personalised care planning**

1. The practice will use an appropriate risk stratification tool<sup>28</sup> or alternative method<sup>29</sup>, if a tool is not available, to identify vulnerable older people, high risk patients and patients needing end-of-life care who are at risk of unplanned admission to hospital. If a risk stratification tool is used, commissioners should ensure that a suitable tool has been procured for practice use.
2. The risk stratification tool or other alternative method used should give equal consideration to both physical and mental health conditions. In the event the risk stratification tool does not account for mental health conditions, the practice should endeavour to use knowledge of their patients with mental health conditions alongside the risk stratification tool to ensure these patients are considered.
3. The practice will establish a case management register of patients identified as being at risk of an unplanned hospital admission without proactive case

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<sup>28</sup> NHS England. Handbook. Using Case Finding and Risk Stratification.

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

<sup>29</sup> This may include using clinical judgement and knowledge of the practice's patient population with regards to those patients who would benefit from this service.

management. This register will be a minimum of two per cent of the practice's registered<sup>30</sup> adult patients (aged 18 and over). The minimum number of patients to be on the register in each six month period will be set on the 1 April 2016 and 1 October 2016 respectively. The minimum register size will be calculated as two per cent of the practice list size (patients aged 18 and over) from the Calculating Quality Reporting Service (CQRS on each of these days). In addition to this two per cent, any children (aged 17 and under) with complex physical or mental health and care needs, who require proactive case management, should also be considered for the register<sup>31</sup>.

4. In each six month period a tolerance of -0.2 per cent will be allowed to account for situations which temporarily lead to a dip in the number of patients on the register at the end of that six month period. Practices will also be able to submit manual data (see monitoring section) on any patients who died or moved practice during the six month periods<sup>32</sup> and these patients will count towards the minimum two per cent. However, practices will need to ensure that over the financial year the register covers at least an average of two per cent of the registered adult patients. Therefore, should the circumstances of any patient change during the first six months of the year (eg the patient has died or moved practice), resulting in their removal from the register, practices will need to identify additional patients as soon as reasonably possible for the second half of the financial year to ensure the two per cent is maintained.

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

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

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<sup>30</sup> Head count and not weighted list.

<sup>31</sup> Children on the case register will not be counted towards the minimum two per cent as detailed in the payment and validation section.

<sup>32</sup> This only applies to one six month period. Any patients claimed for in the first six month period would need to be replaced in the second six month period.

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

8. Patients on the register from the previous year will already have been notified of their named accountable GP and where applicable, their care co-ordinator and need not be informed again unless there have been any changes<sup>33</sup>. Any new patients coming onto the register in-year should be notified<sup>34</sup> within 21 days.
9. The practice will implement proactive case management for all patients on the register. This will include, where accepted by the patient, developing collaboratively with the patient and their carer (if applicable) a written/electronic personalised care plan, jointly owned by the patient, carer (if applicable) and named accountable GP and/or care co-ordinator. If the patient consents, the personalised care plan should be shared with the MDT and other relevant providers. Personalised care plans should be developed and agreed with any new patients coming onto the register in year within a reasonable timeframe, but no later than one month after entry onto the register. Practices are required to carry out an annual review of care plans. The care plan reviews must be carried out in consultation with the patient (and carer if applicable) and take place within 12 months of the development of the care plan or previous care plan review
10. The aim of proactive personalised care planning is to improve the quality and co-ordination of care given to patients on the register to improve their health and well-being. This should also aid in reducing individual risk of avoidable emergency hospital admissions, readmissions or A&E attendances.

A handbook on personalised care and support planning 'The principles of care planning'<sup>35</sup> has been developed by NHS England and the Coalition for Collaborative Care to help support implementation and provides useful examples for practices. Annex C provide practices with information as to what good practice care planning would take into account.

11. Patients and carers (if applicable) should be invited to contribute to the creation of the personalised care plan. Members of the MDT<sup>36</sup> (when relevant) and other relevant providers could be invited to contribute to the creation of the

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<sup>33</sup> Practices should notify patients of any changes to their named accountable GP and care co-ordinator

<sup>34</sup> This can be done via letter or verbally. Practices can also choose to use email or text. However, these routes should only be used where the patient has indicated this as their preferred method of communication

<sup>35</sup> NHS England. Handbooks on personalised care planning.

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

<sup>36</sup> NHS England. Handbook. MDT development. <http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/>

personalised care plan. These contributions should inform both the holistic care needs assessment (eg to take into account social factors as well as clinical requirements) and the actions that can be taken as a result.

12. The personalised care plan should, where possible and through encouragement from the attending practitioner, include a recording of the patient's wishes for the future<sup>37</sup>. 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.
13. Clinicians, working with the patient and their carer (if applicable), to develop the personalised care plan should use their clinical judgement as to what information would be helpful for proactive management of the patient's condition(s) in combination with what the patient and carer would find helpful for managing their condition(s). The following list provides an example of what information a personalised care plan could include:
  - patient's name, address, date of birth, contact details and NHS number
  - notification if the patient is a nursing or care home resident
  - details of the patient's named accountable GP and care co-ordinator (if this is different to the named accountable GP)
  - details of any other clinician(s) who play(s) a significant role in the patient's care relating to their specific condition(s) eg diabetic lead clinician, respiratory nurse, Macmillan nurse etc.
  - confirmation/details of consent given for information sharing, including if a patient has given permission for a practice to speak directly to their carer(s)
  - names and contact details of the patient's next of kin/main carer/responsible adult, if applicable
  - details of the patient's condition(s) and significant past medical history
  - details of any ongoing medication the patient is prescribed (this may also include over the counter (OTC) medicines, if relevant) and plans for review
  - allergies
  - details of any individual requirements or preferences which will aid the care and support of the individual
  - details of goals and actions that are important to the individual and that they can work towards themselves eg steps they can take to self-manage and any help they may need with this
  - key action points, for example early detection of impending deterioration with an agreed plan for escalating care, including crisis management
  - where possible and as appropriate, signatories of the named GP/care co-ordinator, patient and/or carer.

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<sup>37</sup> NHS England document. Actions for End of Life Care. <http://www.england.nhs.uk/wp-content/uploads/2014/11/actions-eolc.pdf>

14. The patient's care and personalised care plan should be reviewed at agreed regular intervals with them and if applicable, their carer. Where a patient has had no contact with any member of the MDT within the last three months, it is good practice for the practice to make contact and review whether that patient's care is in line with their needs. Clinician(s) should look at the patient's personalised care plan to ensure that it is accurate and is being implemented, making any changes as appropriate and agreeing these with the patient and where appropriate, the carer.

Patients who remain on the case management register from the previous year, will need to have at least one care review, including a review of their personalised care plan, during 2016/17 which must be within 12 months of their original care plan or previous care plan review.

In some instances, the review may be as a result of a social issue, which could require the assistance of the named accountable GP or care co-ordinator (if applicable) to link with the right people in the MDT or as an area for commissioning or design improvement. Practices will be required to use the Read2 or CTV3 codes (see monitoring section) to record when a patient's care plan has been reviewed.

15. The development of personalised care plans should follow good medical practice, taking account of the information contained in this guidance and the information contained in the NHS England handbook on personalised care planning and support<sup>38</sup>. The handbook includes case studies and examples of care plans. The practice will be responsible for ensuring information governance requirements are met.
16. Where a patient has had a review undertaken by a member of the MDT (i.e. outside of their practice), then the professional having conducted the review must inform the practice and the patient's record must be updated. CCGs will need to ensure, through their commissioning relationships with the organisations that work with the practice, that they inform the practice that a review has been undertaken.
17. The named accountable GP will be responsible for ensuring the creation of the personalised care plan and the appointment of a care co-ordinator (if different to the named accountable GP). They will also maintain overall accountability for ensuring that the personalised care plan is being delivered and patient care, including the personalised care plan, is being reviewed as necessary.
18. The care co-ordinator for the patient (appointed by the named accountable GP, unless they plan to undertake this role themselves) will act as the main point of contact for the patient. They are responsible for overseeing care for the patient,

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<sup>38</sup> NHS England. Handbooks on personalised care planning.  
<http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/>

that the care plan is delivered and that the patient and/or carer is informed of and agrees any changes as required to their personalised care plan.

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

### **Reviewing and improving the hospital discharge process**

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

### **Internal practice review**

1. The practice will be required to regularly review emergency admissions and A&E attendances of their patients from care and nursing homes (ie to understand why these admissions or attendances occurred and whether they could have been avoided). The reviews should take place at a regular interval deemed appropriate by the practice, in light of the number of emergency admissions or A&E attendances by these patients. During the review, the

practice should give consideration to whether improvements can be made to processes in care and nursing homes, community services, practice availability or whether any individual care plans need to be reviewed with the patient and carer (if applicable).

2. Where a practice has a large proportion of their patients in care and nursing homes, it should focus its reviews on any emerging themes from a sample of patients and on any patients who have regular avoidable admissions or A&E attendances. Practices will be required to agree this with its commissioner at the start of the year. In some circumstances, this may require different arrangements to be made locally to support these practices in undertaking this requirement. Examples of 'local arrangements' may include, but are not limited to, support from the CCG to co-ordinate this or support through a care home community based service.
3. The practice will undertake monthly reviews of all unplanned admissions and readmissions and A&E attendances of patients on the register<sup>39</sup>. Practices should give consideration to including any other registered patients on the register for this service who frequently have unplanned admissions or A&E attendances. During the reviews, the practice will give consideration to:
  - the practice's processes
  - identifying factors, within the practice's control, that could have avoided the admission(s), readmissions and A&E attendances
  - rectifying any deficiencies in the patient(s) personalised care plan(s)
  - amending or improving the hospital admission and discharge processes; and
  - identifying factors outside the practice's control, including any system gaps in community and social care provision and either resolving them (if within the practice's control) or raising them with the commissioner as appropriate.
4. The practice will ensure that any serious incidents are reported to the commissioner and CCG (if the CCG is not the commissioner of the ES) both as and when they occur.

## Data

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

Commissioners and practices should ensure that they have read and understood the requirements as outlined throughout this document. They should also review the

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<sup>39</sup> This applies to all patients on the practice's registered list.

coding requirements as set out in the technical requirements document<sup>40</sup> which provides the detail on Read codes, patient and management information counts.

## Monitoring

The practice will complete a reporting template on a biannual basis, no later than the 31 October 2016 and 30 April 2017 respectively. The reporting template will be for submission to the commissioner and CCG (if not the commissioner of the ES). The final end year report (i.e. the second report) should take account of the entire year and is due for submission to the commissioner on or before 30 April 2017. A national reporting template has been developed and sets out the minimum reporting requirements (Annex D). The reporting template is designed to assess the practice's performance against the five key requirements of the scheme:

- practice availability
- proactive case management and personalised care planning
- reviewing and improving the hospital discharge process
- internal practice review, taking account of both internal and external practice processes

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

Practices will be required to manually input numerical data into CQRS, until GPES<sup>41</sup> is available to conduct electronic data collections. The data input will be in relation to the payment count only. For information on how to manually enter data into CQRS, see the Health and Social Care information Centre (HSCIC) website<sup>42</sup>.

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

- the number of patients on the case management register
- the number of patients on the register who have/have not been informed of their named accountable GP
- the number of new patients on the register who have had a personalised care plan agreed with the practice
- the number of patients on the register who have declined a personalised care plan with informed dissent<sup>43</sup>

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<sup>40</sup> NHS Employers. 2016/17 technical requirements document. [www.nhsemployers.org/GMS201617](http://www.nhsemployers.org/GMS201617)

<sup>41</sup> Details as to when GPES becomes available to support this service will be communicated via the HSCIC.

<sup>42</sup> HSCIC. <http://systems.hscic.gov.uk/cqrs/participation>

<sup>43</sup> These would be patients who agree to be on the case management register to receive benefits from the service but have, post a discussion, declined to have a care plan.

- the number of patients on the register who have no record of a personalised care plan or declining a personalised care plan
- the number of patients on the register who have had/have not had care review(s)<sup>44</sup> (including a review of their personalised care plan); and
- the number of patients on the register who have a record of an emergency hospital admission.

Where necessary, practices will be required to submit manual data relating to any patient who may have been on the case management register but who died or moved practice prior to 30 September 2016 and 31 March 2017 respectively. This would be required where a practice has failed the minimum 1.8 per cent in each six month period and because the practice has not had reasonable time to replace the patient on the case management register or where the whole year register size falls below the minimum two per cent without taking account of these changes. Those patients claimed for in the first six month period under these circumstances cannot be counted in the second six month period and practices will need to find new patients for the register. Practices will be required to provide the commissioner with the following information, within two weeks of the deadline dates above, relating to each patient being claimed for:

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

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

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

The data collected on the number of patients on the register, number of patients informed of their named accountable GP and number of patients with developed, reviewed or declined personalised care plans will be used as key performance indicators. If all three of these are achieved then payments will be triggered. Where

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<sup>44</sup> Where a patient declines a care review, their initial care plan will become invalid and a declined code will need to be added to the patient record.

required, manually submitted data will also be taken into account in determining if these three key performance indicators have been met. Commissioners will also need to ensure the other requirements of the service have also been met (see payment and validation).

Practices will be required to use the relevant Read2 and CTV3 codes as published in the supporting Business Rules on the HSCIC website. The 'Technical requirements'<sup>45</sup> document lists the Read2 and CTV3 codes relevant for this service. The Read2 and CTV3 codes will be used as the basis for the GPES collection, which will allow CQRS to calculate payment based on the aggregated numbers supplied and support the management information counts. Although practices will be required to manually enter data until GPES is available, it is required that practices use the relevant Read2 or CTV3 codes within their clinical systems. This is because only those included in this document and the supporting Business Rules will be acceptable to allow CQRS to calculate achievement and payment and for commissioners to audit payment and service delivery. Practices will therefore need to ensure that they use the relevant codes and, if necessary, re-code patients as required.

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

### **Payment and validation**

Commissioners will invite practices to participate in this ES before 30 April 2016. Practices wishing to participate will be required to sign up to this service by no later than 30 June 2016. Practices signing up to this service will be signing up to all three components.

The total funding available for this ES is £162 million<sup>46</sup>.

The payments will be based on a maximum of £2.87 per registered patient. Table 1 provides full details of what payments can be expected for fully achieving the requirements of the ES. For the purposes of payments, the contractor's registered population (CRP) will be as at 1 April 2016 or be the initial CRP if the practice's contract started after 1 April 2016. A practice with an average list size of 7087 would receive payments of £20,339.69 for delivering the ES in full.

Payment under this ES for 2016/17 will be made in three components:

- **Component One** – an upfront payment of 46 per cent
- **Component Two** – a mid-year payment of 27 per cent (subject to achieving all of the following requirements):
  - i. For maintaining the register at a minimum of two per cent for the first half of the year (i.e. 1 April 2016 to 30 September 2016). Achievement of this component will be determinant on practices having a minimum of 1.8 per

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<sup>45</sup> NHS Employers. 2016/17 technical requirements. <http://www.nhsemployers.org/GMS201617>

<sup>46</sup> This figure could be increased by £500,000 to support the patient survey if implemented.

- cent<sup>47</sup> of patients on the register on 30 September 2016 as a proportion of the list size taken on 1 April 2016.
- ii. For identifying the named accountable GP and care co-ordinator (if applicable) and informing any new patients added to case management register.
  - iii. For developing personalised care plans<sup>48</sup> for any new patients on the case management register. The development or review of care plans will be undertaken with the patient and where applicable, their carer.
  - iv. For all patients already on the register undertaking at least one care review in the last 12 months. The development or review of care plans will be undertaken with the patient and where applicable their carer.
  - v. For implementing or continuing a system for same day telephone consultations for patients on the case management register with urgent enquires.
  - vi. For specifying and using the practice's ex-directory or by-pass telephone number.
  - vii. For reviewing and improving the hospital discharge process for patients on the case management register, including attempting to contact these patients, by an appropriate member of the practice or community staff, in a timely manner to ensure co-ordination and delivery of care.
  - viii. For undertaking regular practices reviews of emergency admissions and A&E attendances of all their registered patients in care and nursing homes, as well as undertaking monthly reviews of all unplanned admissions and readmissions and A&E attendances of patients on the case management register.
- **Component Three** – year-end payment payment of 27 per cent (subject to achieving all of the requirements):
    - i. For maintaining the register at a minimum of two per cent for the second half of the year (i.e. 1 October 2016 to 31 March 2017). Achievement of this component will be determinant on practices having a minimum of 1.8 per cent of patients on the register on 31 March 2017 as a proportion of the list size taken on 1 October 2016.
    - ii. See component two ii to viii for requirements.

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

The component one payment will be payable on 31 July 2016.

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<sup>47</sup> This takes into account the -0.2 per cent tolerance.

<sup>48</sup> Including those patients who have declined a care plan with informed dissent but still wish to remain on the case management register to benefit from other aspects of this ES.

The component two payment will be payable no later than 30 November 2016 subject to the practice delivering the minimum requirements of the ES. Payment will be triggered on the basis that the practice has a minimum of 1.8 per cent of patients on the register on 30 September 2016 as a proportion of the list size taken on 1 April 2016 who have been allocated and informed of their named accountable GP and who have had in the last 12 months either a care plan developed or a care plan reviewed or a care plan declined<sup>49</sup>. This will be determined from manually submitted data and automated data collections when GPES is available. Commissioners should also check that the other requirements listed under component two payment are being delivered.

The component three payment will be payable no later than 31 May 2017 subject to the practice delivering the minimum requirements of the ES. Payment will be triggered on the basis that the practice has a minimum of 1.8 per cent of patients on the register on 31 March 2017 as a proportion of the list size taken on the 1 October 2016 who have been informed of their named accountable GP and who have had in the last 12 months either a care plan developed or a care plan reviewed or a care plan declined<sup>50</sup>. This will be determined from manually submitted data and automated data collections when GPES is available. Commissioners should also check that the other requirements listed under component three are being delivered.

While there is an accepted tolerance of -0.2 per cent in each six month period, practices will need to ensure that across the financial year, their register maintains at least an average of two per cent of the eligible cohort. This will be calculated by taking an average of the percentages in each six month period (i.e. first six months % + second six months % divided by two), calculated as described above in this section i.e. based on the list taken at 1 April 2016 and 1 October 2016 respectively. If there are exceptional circumstances which lead to the average not being maintained, commissioners and practices will need to discuss and review the situation.

Practices can submit a manual claim, relating to patients who have died or moved practices, if they have not achieved the minimum 1.8 per cent in each six month period. This would only apply if the practice was unable to replace these patients on the case management register within a reasonable timeframe and any patient claimed for in the first six month period cannot be counted again in the second six month period. Practices will be required to submit the relevant information described under the monitoring section in support of any manual claims, within two weeks of 30 September 2016 and 31 March 2017 respectively.

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

CQRS will calculate all payments.

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<sup>49</sup> Payment will only be triggered if each of these requirements are met and information is supplied in support of the other requirements attached to each component.

<sup>50</sup> Payment will only be triggered if each of these requirements are met and information is supplied in support of the other requirements attached to each component.

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

Payment	Percentage of total funding	Per registered patient (total £2.87)	Payable (no later than <sup>51</sup> )
Component 1	46%	£1.33	31 July 2016
Component 2	27%	£0.77	30 November 2016
Component 3	27%	£0.77	31 May 2017

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

**Table 2: Scenarios for action to be taken in the event a practice does not deliver all<sup>52</sup> requirements under this ES**

Scenario	Component 2	Component 3	Register	Action
A	Y	Y	Y	Pay components 2 & 3. Practice keeps component 1 payment
B	Y	Y	N	Pay components 2 & 3, commissioner claws back 40% of component 1
C	Y	N	Y	Pay component 2, don't pay component 3. Claw back 20% of component 1
D	Y	N	N	Pay component 2, don't pay component 3. Claw back 40% of component 1
E	N	Y	Y	Don't pay component 2, pay component 3. Claw back 20% of component 1

<sup>51</sup> Payment by this date is subject to all elements of the payment process being delivered in time, including the practice supplying any manually submitted data to the commissioner.

<sup>52</sup> If there are exceptional circumstances which lead to a practice not achieving one element of each component and the reason for doing so can be justified, then the commissioner and practice will need to discuss and review the situation.

Scenario	Component 2	Component 3	Register	Action
F	N	Y	N	Don't pay component 2, pay component 3. Claw back 40% of component 1
G	N	N	N	Don't pay component 2 or 3. Practice required to demonstrate they have delivered the requirements (named GP and personalised care plans) to a minimum 25% of 2% register, as well as undertaking the other requirements. If practice demonstrates this, claw back 21% of component 1. If the practice cannot, claw back entire component 1 payment (46%).

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

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

# Section 8: 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<sup>53</sup>
3. those where scenarios have arisen which were not anticipated in developing guidance.

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

NHS Employers' website has a [frequently asked questions](#) page for QOF, ES and other non-clinical aspects of the GMS contract. If there are queries which cross the above areas, the recipient will liaise with the other relevant parties in order to resolve/respond. In addition, where a query has been directed incorrectly, the query will be redirected to the appropriate organisation to be dealt with.

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

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

NHS Employers for commissioners via:

- [GMScontract@nhsemployers.org](mailto:GMScontract@nhsemployers.org)
- [QOF@nhsemployers.org](mailto:QOF@nhsemployers.org)
- [vandi@nhsemployers.org](mailto:vandi@nhsemployers.org)

GPC for general practice via:

- [info.gpc@bma.org.uk](mailto:info.gpc@bma.org.uk)

NHS England via:

- [england.gpcontracts@nhs.net](mailto:england.gpcontracts@nhs.net) for general contracting and policy queries
- [england.primarycareops@nhs.net](mailto:england.primarycareops@nhs.net) for operational issues

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<sup>53</sup> HSCIC. <http://www.hscic.gov.uk/qofesextractspecs>

# Query

Have you checked if the following documents address your query:

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

## Payment queries

Practices to commissioners in the first instance

### CQRS

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

### GPES

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

## Guidance and clinical queries to

[gms@nhsemployers.org](mailto:gms@nhsemployers.org)

## Business Rules and Read code queries to

[enquiries@hscic.gov.uk](mailto:enquiries@hscic.gov.uk)

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

## Practices queries to GPC via

[info.gpc@bma.org.uk](mailto:info.gpc@bma.org.uk)

# Section 9: Annexes

## Annex A- Publication of GP net earnings

### Dataset for calculation of contractor net income

Table 3 sets out the income and expenditure which should be included in the calculation of earnings. For 2015/16, when calculating earnings for the 2014/15 financial year, contractors were expected to include income from the alcohol-related risk reduction scheme and patient participation ES. In 2016/17, when calculating income for 2015/16, these have both become contractual requirements and so income from them would be part of the overall global sum.

Table 4 sets out the expenditure which should be excluded from the calculation of earnings. This is unchanged from 2015/16.

**Table 3: Income and expenditure which are included**

<b>Income</b>	<b>Expenditure</b>
<b>Global sum (and PMS equivalent)</b> <ul style="list-style-type: none"> <li>Global sum (after removal of OOH where a practice has opted out)</li> <li>Correction Factor</li> <li>Any support and assistance payments during the phasing out of MPIG</li> </ul>	<b>Practice expenses</b> <ul style="list-style-type: none"> <li>Staff costs</li> <li>General running of practice (stationery, telephone, heating and lighting, repairs and maintenance)</li> <li>Accountancy fees and bank charges</li> <li>Depreciation</li> </ul>
<b>Quality and outcomes Framework</b> <ul style="list-style-type: none"> <li>Quality aspiration</li> <li>Quality achievement</li> </ul>	<b>Personal expenses (business expenses)</b> <ul style="list-style-type: none"> <li>Transport for home visits</li> <li>Mobile telephone</li> <li>MDU, GMC and BMA subscriptions</li> <li>Business use of capital allowances that are claimed on their motor vehicles (based on actual partner's claims)</li> </ul>
<b>Seniority</b>	<b>Any other expenses related to items which are included</b>
<b>Item of service fees for specific vaccination and immunisations</b> <p><b>Childhood immunisations:</b></p> <ul style="list-style-type: none"> <li>Rotavirus</li> <li>Pneumococcal/Hib menC booster</li> </ul> <p><b>Adult immunisations:</b></p> <ul style="list-style-type: none"> <li>Shingles (Routine Age 70)</li> </ul>	<ul style="list-style-type: none"> <li>The costs of delivering these services, which should include the relevant proportion of fixed overheads as well as variable costs</li> </ul>
<b>Enhanced services that have been determined nationally</b>	<ul style="list-style-type: none"> <li>The costs of delivering these services, which should include the relevant</li> </ul>

<ul style="list-style-type: none"> <li>• Seasonal influenza and pneumococcal immunisation</li> <li>• Childhood seasonal influenza</li> <li>• Shingles catch-up vaccination</li> <li>• Pertussis (pregnant women) Vaccination</li> <li>• menACWYfor freshers</li> <li>• Extended hours access scheme (to the level funded under the ES)</li> <li>• Learning disabilities health check scheme</li> <li>• Timely diagnosis and support for people with dementia</li> <li>• Avoiding unplanned admissions and proactive case management scheme</li> <li>• Minor surgery scheme (commissioned from all practices)</li> <li>• Childhood immunisations (target payments) scheme</li> <li>• Smoking cessation</li> <li>• NHS Health checks</li> <li>• Dispensing (DSQS)</li> <li>• Violent patients scheme.</li> </ul>	<p>proportion of fixed overheads as well as variable costs</p>
<p><b>PA Reimbursement and fees</b></p> <ul style="list-style-type: none"> <li>• Reimbursement for PA drugs</li> <li>• PA fees</li> </ul>	
<p><b>Employee's superannuation</b> (covered in global sum but should not be deducted)</p>	

**Table 4: Items to be excluded**

<b>Income</b>	<b>Expenditure</b>
<p><b>Premises</b></p> <ul style="list-style-type: none"> <li>• Rent reimbursement</li> <li>• Rates and water</li> <li>• Refuse disposal</li> </ul>	<p><b>Premises</b></p> <ul style="list-style-type: none"> <li>• Rent paid</li> <li>• Rates and water</li> <li>• Refuse disposal</li> <li>• Mortgage interest</li> <li>• Any other premises-related costs covered by premises reimbursements</li> </ul>
<p><b>Enhanced services that have been commissioned locally and which vary from area to area: eg</b></p> <ul style="list-style-type: none"> <li>• Joint injection services</li> <li>• Near patient testing</li> <li>• Shared care drug monitoring</li> </ul>	<p><b>Any expenses related to items which are not included</b></p> <ul style="list-style-type: none"> <li>• The costs of delivering these services, which should include the relevant</li> </ul>

<ul style="list-style-type: none"> <li>• Drug and addiction services</li> <li>• Phlebotomy</li> <li>• 24-hour BP monitoring</li> <li>• Post-op suture removal</li> <li>• Sexual health services</li> </ul>	<p>proportion of fixed overheads as well as variable costs</p>
<p><b>Dispensing doctors:</b></p> <ul style="list-style-type: none"> <li>• Reimbursement of drugs (exc PA)</li> <li>• Dispensing fees (exc PA)</li> </ul>	<ul style="list-style-type: none"> <li>• The cost of drugs</li> <li>• Any other costs associated with the administration of drugs</li> </ul>
<p><b>Commissioning group activities: eg</b></p> <ul style="list-style-type: none"> <li>• CCG salaries/backfill payments</li> <li>• CCG led roles</li> <li>• CCG meetings attendance</li> <li>• CCG incentive schemes</li> <li>• CCG prescribing schemes</li> </ul>	<ul style="list-style-type: none"> <li>• Expenditure incurred in engaging with CCG activities – eg expenses incurred in attending meetings; practice costs in supporting CCG roles</li> </ul>
<p><b>Extended services: eg</b></p> <ul style="list-style-type: none"> <li>• Extended minor surgery (beyond the scope commissioned from all practices)</li> <li>• Joint injections</li> <li>• IUCD and contraceptive implant fitting</li> <li>• Community based services to which other practices can refer e.g. dermatology clinic, ENT clinic</li> <li>• Prime Ministers Challenge Fund</li> <li>• Extended hours (beyond the level of the ES)</li> <li>• OOH personal income paid to the practice</li> </ul>	<ul style="list-style-type: none"> <li>• The costs of delivering these services, which should include the relevant proportion of fixed overheads as well as variable costs</li> </ul>
<p><b>Education and training: eg</b></p> <ul style="list-style-type: none"> <li>• Training grant</li> <li>• GP trainee salary reimbursement</li> <li>• Undergraduate students</li> <li>• Foundation year 2 students</li> <li>• Educational supervision</li> <li>• GP appraiser fees</li> </ul>	<ul style="list-style-type: none"> <li>• All costs incurred associated with training GPs</li> <li>• GP trainee salaries</li> <li>• Educational supervision costs</li> <li>• GP appraiser costs</li> </ul>
<p><b>Other SFE Payments</b></p> <ul style="list-style-type: none"> <li>• Payments for locum covering maternity, paternity and adoptive leave</li> <li>• Payments for locums covering sickness leave</li> </ul>	<ul style="list-style-type: none"> <li>• The costs of delivering these services, which should include the relevant proportion of fixed overheads as well as variable costs</li> </ul>

<ul style="list-style-type: none"> <li>• Payments for locums covering suspended doctors</li> <li>• Payments in respect of prolonged study leave</li> <li>• Doctors retainer scheme</li> <li>• Returners scheme</li> <li>• Flexible careers scheme</li> </ul>	
<b>NHS collaborative fees</b>	<ul style="list-style-type: none"> <li>• NHS collaborative work expenditure and relevant proportion of fixed costs</li> </ul>
<b>Non NHS income eg</b> <ul style="list-style-type: none"> <li>• Travel vaccinations and immunisations</li> <li>• Medical report fees</li> <li>• Cremation fees</li> <li>• Meetings and expenses</li> <li>• Research income</li> <li>• LMC salary</li> </ul>	<ul style="list-style-type: none"> <li>• Variable costs associated with each item and the relevant proportion of fixed costs</li> </ul>
<b>Employers' superannuation</b>	

# Annex B- Template letters and leaflets to inform patients of enrolment into the avoiding unplanned admissions ES

Templates for practices, delete recipient details as appropriate:

1. adult letter/email text
2. letter / email text (for a parent of a child on register)
3. Template letter / email text (for a guardian of a child on register)

[Practice Address]

[DATE]

[Patient Address]

Dear [Patient Name]

## **New service for patients**

The NHS has agreed a service to help people keep well and avoid unplanned hospital visits, such as in an emergency. We would like to invite [1. *you* / 2. *your child* or 3. *patients name*] to be one of the people who receives more tailored, active support from the GP practice. We believe personal care planning could help you with your health and wellbeing.

As a member of this programme, [1. *you* / 2. *your child* or 3. *patients name*] will have Dr XX as your named GP and they will have overall responsibility for the care and support that our practice will provide. We will also make sure that you have a named care co-ordinator, who may be the named GP or another health professional involved in [1. *your* / 2. *your child* or 3. *patients name*] care and is likely to be the person seen the most. The named care co-ordinator will be responsible for sharing information with [1. *You (and your carer)* / 2. *your child* or 3. *patients name*] and – if you are happy for us to do so – with other health professionals involved in [1. *you* / 2. *your child* or 3. *patients name*] care. Information would only be shared with other care organisations (eg hospitals, emergency services and if you have one, your social care team) to help co-ordinate and give [1. *your* / 2. *your child* or 3. *patients name*] care. These new arrangements do not prevent you making an appointment or seeing any doctor, of your choosing within the practice, as you would normally do.

[1. *Your* / 2. *Your child's* or 3. *patients name*] named GP or named care co-ordinator will work with you to develop a personal care plan and review / discuss with [1. *you* / 2. *your child* or 3. *patients name*] any changes needed. We will also invite, with agreement, other health or care professionals involved in your care to help develop and keep your personal care plan up to date.

[1. *Your* / 2. *Your child's* or 3. *patients name*]care planning discussion will help us (you, [your carer], your named GP and named care co-ordinator) to think about [1. *your* / 2. *your child's* or 3. *patients name*] health and care needs. With your agreement, your personal care plan may include information like:

- details of the named GP and care co-ordinator
- details of any other health or care professionals involved in [1. *your* / 2. *your child's* or 3. *patients name*] care
- confirmation that [1. *you* / 2. *your child* or 3. *patients name*] have agreed to sharing your care plan with relevant health and care professionals
- details of [1. *your* / 2. *your child's* or 3. *patients name*]condition(s) and significant past medical history
- name and contact details of parent or guardian when relating to a child
- details of any medication(s) being taken and plans for reviewing them
- any allergies [1. *you* / 2. *your child* or 3. *patients name*] may have
- the action that [1. *you* / 2. *your child* or 3. *patients name*] are taking to help manage your health and any help you need with this
- how [1. *you* / 2. *your child* or 3. *patients name*]can detect any early signs that your health may be worsening and what you should do if this happens
- who to contact if you think you need to see a doctor urgently

The named GP and named care co-ordinator will work with [1. *you* / 2. *your child* or 3. *patients name*]to review your health needs as often as necessary. They will ensure that you receive support from us and others to help you manage [1. *your* / 2. *your child's* or 3. *patients name*]health. We may also be able to help you find local community that you may find helpful.

We will also make sure that, whenever [1. *you* / 2. *your child* or 3. *patients name*]have an urgent need to see or speak to a GP or nurse, as soon as possible on the same day one of our GPs or nurses will phone you back to help deal with your problem.

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

Kind Regards

[Name]

## Template leaflet for adult patients and children's parents

The NHS has agreed a service to help people keep well and avoid unplanned hospital visits, such as in an emergency. We would like to invite [you/your child/patient's name] to be one of the [people/children] who receives more tailored, active support from the GP practice. We believe personal care planning could help with [your/his/her] health and wellbeing.

### What does this mean for [you/your child/the child in your care], as a patient?

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

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

The care planning discussion will help us [(you, [your carer], your child/patient's name,) your named GP and named care co-ordinator] to think about [your/his/her] health and care needs. With [both of] your agreement, [your/his/her] personal care plan may include information like:

- [your/his/her] NHS number
- details of [your/his/her] named GP and care co-ordinator
- details of any other health and care professional who are involved in [your/his/her] care
- confirmation that you have [both] agreed to sharing [your/his/her] care plan with relevant health or care professionals
- details of the [your/his/her] condition(s) and significant past medical history
- details of any medication(s) that [you/he/she] [are/is] taking and plans for reviewing them
- any allergies
- the action that [you/he/she] [are/is] taking to manage [your/his/her] health and any help [you/he/she] need/s with this

- how [you/he/she] can detect any early signs that [your/his/her] health may be worsening and what [you/he/she] should do if this happens
- who to contact if you think that [you/he/she] need/s to see a doctor or nurse urgently.

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

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

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

## Annex C - Principles of personalised care planning

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

Further information

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

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

## Annex D - Reporting template

[Name] Commissioners

### 2016/17 Avoiding Unplanned Admissions Enhanced Service – Reporting Template

Practice Name:

Practice Code:

Signed on behalf of practice:

Date:

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

c. Other care providers (eg mental health and social services)	
2. Does the practice have a system in place to enable patients on the case management register to receive same day telephone consultations for their urgent enquires?	YES / NO
SECTION 2 – proactive case management	
1. Has the practice agreed personalised care plans or undertaken at least one care review during the year, with at least 1.8% per cent of eligible patients (i.e. patients aged 18 and over) by:	
a. 30 September 2016?	YES / NO
b. 31 March 2017?	YES / NO
2. Has the practice agreed personalised care plans with all patients on the case management register or undertaken at least one care review during the year? (i.e. for a minimum of 2% of the practice population aged 18 and over on the register between 1 April 2016 to 31 March 2017)	YES / NO
3. Has the practice submitted manual data relating to any patients who have died or moved in each of the six month periods?	YES / NO
4. Have all patients on the case management register been notified of their named accountable GP?	YES / NO

SECTION 3 – hospital discharge process

1. Is there a system in place for contacting patients post-discharge from hospital?	YES / NO
2. What recommendations has the practice made to the commissioner and CCG (if not the commissioner of the ES) to support improvements in the commissioning of services for patients in this group?  Please provide brief details.	

SECTION 4 – internal practice reviews

1. Has the practice carried out reviews of emergency admissions and A&E attendances for:	
a. their registered patients living in care and nursing homes?	YES / NO
b. their patients on the case management register?	YES / NO
3. What recommendations has the practice made to the commissioner and CCG (if not the commissioner of the ES) to support improvements in the commissioning of services for patients in this group?  Please provide brief details.	

SECTION 5 – patient survey

1. Has the practice undertaken the survey of patients on the case management register using the materials provided?	YES / NO
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**Reporting template - notes**

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

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

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

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

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

**General Practitioners  
Committee**  
[www.bma.org.uk/gpc](http://www.bma.org.uk/gpc)

**NHS Employers**  
[www.nhsemployers.org](http://www.nhsemployers.org)

**NHS England**  
[www.england.nhs.uk](http://www.england.nhs.uk)

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