BMA

NHS England

2019/20 General Medical Services (GMS) contract

Guidance and audit requirements for GMS contract

May 2019

2019/20 General Medical Services (GMS) contract

Guidance and audit requirements for GMS contract

Version number: 1

First published: 8 May 2019

Prepared by: Primary Care Strategy and NHS Contracts Group

Classification: OFFICIAL

Gateway reference: 000339

Contents

Section 1: Executive Summary 4
Section 2: Enhanced services 4
- 2.1: Network Contract DES 4
- 2.2: Extended hours access scheme 4
- 2.3: Learning disabilities health check scheme 5
- 2.4: Minor surgery and violent patients DES 5

Section 3: New contractual requirements 5
- 3.1: GMS digital 5
- 3.2: Direct Booking from NHS 111 into in-hours GP practices 8
- 3.3: Ban on advertising and hosting of private GP services 11
- 3.4: Pay transparency 14
- 3.5: Changes to the FP10 Form 14
- 3.6: Duty of co-operation 15
- 3.7: NHS marketing campaigns 16
- 3.8: MHRA Central Alert System (CAS) 16
- 3.9: Use of the NHS logo 17
- 3.10: General Data Protection Regulations 18
- 3.11: Locum reimbursement for shared parental leave 18
- 3.12: Additional services 18

Section 4: Guaranteeing investment 18
Section 5: Vaccinations and Immunisations 20
- 5.1 Vaccination and immunisation programmes – Statement of Financial Entitlement (SFE) 20
- 5.2 Vaccine and immunisation programmes – enhanced services 21

Section 6: Non-contractual arrangements 23
- 6.1: GMS digital 23
- 6.2: Temporary residents 24

Section 7: Queries process 26
Annex A. Vaccination and immunisation programmes - summary 28
- Table 1. Existing programmes – changes 28
- Table 2. Existing programmes – rolling over with no changes 31
- Table 3. New programmes 33
- Supporting documents 34
- Technical support for vaccination programmes 35

Section 1: Executive Summary

On 31 January 2019, NHS England and the British Medical Association's (BMA) General Practitioners Committee (GPC) England published *Investment and Evolution*: *A five-year framework for GP contract reform to implement The NHS Long Term Plan* https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf.

This guidance provides information about the new and amended contractual requirements for 2019/20 and the enhanced services (ES) commissioned by NHS England. Separate guidance is available on changes to the Quality and Outcomes Framework in 2019/20.

Commissioners and practices should ensure they have read and understood the requirements in the GMS Contracts Regulations, Directed Enhanced Services (DES) Directions and NHS England service specifications (SS), the guidance in this document as well as the 'Technical requirements for 2019/20 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. The separate document "Technical requirements for 2019/20 GMS contract changes" details the clinical codes which practices are required to use.

This guidance is applicable in England only.

The amendments to the GMS Contracts Regulations, DES Directions and to the Statement of Financial Entitlements (SFE), which underpin the changes to the contract, are available on the Department of Health and Social Care (DHSC) website. The detailed requirements for taking part in the Enhanced Services are set out in the DES Directions or SSs.

Section 2: Enhanced services

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

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

2.1: Network Contract DES

Guidance, specification and Network Agreement available at:
https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/

2.2: Extended hours access scheme

Background and purpose

The Extended Hours Access Directed Enhanced Service (DES) was introduced in 2014/15 to provide access to routine appointments outside of core contracted hours. Since then, such routine appointments have become business as usual for most practices, and an entitlement for patients – delivered through this DES or the CCG-commissioned Extended Access Scheme.

As part of the five-year contract reform framework agreed in January 2019, we have agreed to improve and consolidate the way extended hours access is provided:

- this Extended Hours DES will continue from **1 April 2019 and cease on 30 June 2019;**
- from 1 July 2019, with increased funding to allow for 100% patient coverage, the requirements will transfer in full over to the new Network Contract DES (with some funding provided via Global Sum).

The requirements for practices participating in this DES for the period 1 April 2019 – 30 June 2019 remain unchanged from the 2018/19 specification.

2.3: Learning disabilities health check scheme

The guidance and audit requirements for the learning disabilities DES remain unchanged and are set out in the 2015/16 GMS guidance. Information relating to coding for this is available in the technical requirements document for 2019/20. Requirements relating to specific dates in the 2015/16 guidance should be assumed to apply to 2019/20, for example where it states on page 69 under 'requirements' that the "ES is for one year from 1 April 2015", this should be applied as the "ES is for one year from 1 April 2019".

The fee payable for carrying out a health check under this scheme increased from £116 to £140 from 1 April 2017 and remains at £140 for 2019/20.

2.4: Minor surgery and violent patients DES

The minor surgery DES and violent patient DES directions remain unchanged from 2018/19. The detailed provisions for these enhanced services remain for local determination as in previous years.

Section 3: New contractual requirements

The GMS and PMS Regulations underpinning these contractual requirements will be formally amended in October 2019. However, NHS England and GPC England have a shared expectation that commissioners and practices will deliver the changes and the improvements they provide from April 2019 or at the earliest opportunity.

3.1: GMS digital

Going "digital-first" and improving access

For 2019/20 we have agreed with GPC England to revise payments made under the Statement of Financial Entitlements (SFE) to:

- amend the rurality index payment to apply to patients living within a practice catchment area only, rather than to all patients;
- amend the London adjustment to apply to patients resident in London, rather than those registered in London. The definition of London is being updated from Primary Care Trust (PCT) and Strategic Health Authority (SHA) definitions to now refer to Lower Layers Super Output Areas (LSOAs) within the Greater London Authority (GLA). In addition, for the first time, practices from Croydon and Sutton will receive the payment through this calculation too.

These measures give rise to a slight saving which has been reinvested into global sum.

Electronic prescriptions and electronic repeat dispensing

An electronic prescription is where a practice uses the Electronic Prescription Service (EPS) to transmit an electronic prescription to a pharmacy, so that patients can pick up their medication without the need for a paper script.

It has been a long-standing objective to increase the use of electronic prescriptions as this streamlines the prescribing process considerably, saves practice and patient time, and has wider system benefits including cost savings and contributing to our overall aspiration of a paperless NHS.

It is already a contractual requirement that, once EPS Phase 4 has been installed at a practice, practices must use electronic prescriptions if they are satisfied EPS is working properly and apart from some specific exemptions, where clinical need is identified.

After piloting, EPS Phase 4 will be rolled out across England during 2019/20 and use of electronic prescriptions will become mandatory, with paper prescriptions used only by exception.

From April 2019, **practices are expected to use Electronic Repeat Dispensing (eRD) for all patients for whom it is clinically appropriate,** and practices are encouraged to promote the use of eRD to their registered patients. eRD provides an efficient way to supply patients with repeat medication without the prescriber needing to sign repeat prescriptions each time. It allows the prescriber to authorise and issue a batch of repeat prescriptions, which will be available at the patient's nominated pharmacy, at a specified interval until the patient needs to be reviewed. This has significant benefits to practices and patients as a time saving measure. GMS Regulations will be amended to make use of eRD, where clinically appropriate, a contractual requirement.

Access to patient records

From April 2019 **practices must offer newly registered patients full online access to prospective data in their digital GP patient record** (subject to existing safeguards for vulnerable groups and third-party confidentiality, and system functionality).

Patient registration (GMS1) forms will be amended to incorporate a patient request for access to their GP record. Meanwhile practices should also follow guidance on

offering online access to patient records[1] which provides information on safeguarding and confidentiality, and also guidance providing technical advice from system suppliers[2] on how to enable registration at an individual patient level.

Non-contractual requirements

NHS England and GPC England have agreed, as in previous years, that practices continue to proactively encourage patients to register for online access – this could be both through direct invitation and opportunistically at consultation. Practices are encouraged to ensure staff are familiar with guidance on identity checking for GP online services to make patient registration as simple as possible[3] and to maximise opportunities to increase uptake.

Practices are encouraged to promote digital products that enable NHS Login, such as the NHS App.

Further information is available in the *records access* section at https://www.rcgp.org.uk/patientonline and https://www.england.nhs.uk/gp-online-services/ and https://www.nhs.uk/using-the-nhs/nhs-services/nhs-login/..

Access to online booking of appointments

From July 2019 **practices will be expected to make 25% of their appointments available for booking online**. GMS Regulations will be amended to make this a contractual requirement.

This requirement relates to the complete range of appointments practices offer, including, but not limited to:

- GP appointments;
- a variety of nurse and other health care professional led clinic appointments, for example, cervical smear tests, vaccinations and immunisations, asthma reviews, blood tests and similar; and
- appointments that have been made available for direct booking by NHS111 (see below) and in the future, subject to the introduction of the appropriate technology, appointments booked on patients' behalf by 111.

Further information is available in the S*etting up patient online services* section at https://www.rcgp.org.uk/patientonline.

Encouraging patient access to online services

Patients need to actively sign up to access their patient record, book appointments or order repeat prescriptions online. It has been a contractual requirement for some years to "promote and offer" these online services to patients and practices should continue to proactively do so.

[1] https://www.rcgp.org.uk/patientonline Section on Registering new applicants for patient online
[2] https://www.rcgp.org.uk/patientonline Section on Registering new applicants for patient online
[3] https://www.england.nhs.uk/wp-content/uploads/2018/12/gp-online-services-identity-verification-what-you-need-to-know.pdf

Below are a few possible ways of undertaking this which are not part of the contractual agreement:

- at the point when a new patient registers with the practice;
- at annual or medication reviews undertaken for patients with long term conditions or patients attending for an annual health check;
- when a patient is first prescribed a repeat medication by the GP;
- by writing to/emailing/texting all patients in 2019/20 who are not registered for online appointment booking or online ordering of repeat prescriptions to make them aware of the service;
- by displaying posters promoting the availability and benefits of online appointment booking and online ordering of repeat prescriptions;
- by including on their recorded telephone voice message, a reminder to patients that they can book appointments and order repeat prescriptions online;
- by promoting online appointment booking and online ordering of repeat prescriptions on their online presence e.g. website. The practice's website home page should link directly to the online booking system; and

Practices should support patients struggling to log in to their accounts, including providing information on how to reset passwords.

Information is available at https://www.rcgp.org.uk/patientonline and https://www.england.nhs.uk/gp-online-services/.

3.2: Direct Booking from NHS 111 into in-hours GP practices

There will be a requirement in the GMS contract for practices to make available a proportion of their appointments for direct booking via NHS 111, where the functionality exists.

Operational requirements and recommendations

Practices must make available a minimum of one appointment per whole 3,000 patients per day for direct booking from NHS 111. If a practice has a registered list of less than 3,000 patients, the practice should make one appointment available per day for direct booking from NHS 111.

Practices can locally agree to make more appointments available if they feel it is appropriate to do so.

Initial learning from early implementation suggests that for direct booking from NHS 111 in to practices, the highest utilisation rates are evident when appointments are spread over the day, with the most effective time slots usually:

- between 9:30-10:30am;
- approx.1pm
- between 3:30-4:30pm.

Where practices are offering more than one appointment slot per day, slots should be spread throughout the day.

Where appointment slots are not utilised by NHS 111 they will be returned to the practice. Appointments that have not been utilised will be released back two hours

prior to the appointment time, unless a different local agreement is in place. Regular local review and feedback mechanisms between practices, the LMC, NHS 111 and local commissioners should be in place to understand inappropriate booking of such appointments from NHS 111.

The NHS 111 assessment process

Any patient contacting NHS 111 will initially go through a NHS Pathways assessment, NHS Pathways triage works on a basis of ruling out, rather than diagnosing. Once NHS Pathways triage gets to a point where it can no longer safely rule something out it will result in an outcome, which is termed the 'disposition'. If this assessment shows a patient needing a face to face primary care booking, at this point the case can be referred to a clinician for further assessment.

Direct booking from the NHS 111 service into the practice will be enabled where a clinician has assessed the patient, and deemed them in need of an appointment within a locally agreed list of specific timeframes e.g. within 2, 6, 12 or 24 hours. In some local areas, local agreements with practices are already in place about direct booking by non-clinical call handlers. This is not a contractual requirement but the contract facilitates that those local agreements may continue.

The appointment booking process

The Directory of Services will identify the patient's GP practice.

When NHS 111 books the appointment for the patient it will be made clear that it will be at the discretion of the practice as to whether they will be seen face to face or via a call back. Although the patient can assume that they need to attend at the appointed time, they may be contacted by the practice prior to the appointment for a telephone consultation. If they do not hear from the practice they must attend at the appointed time.

If there is not the capability for patients to be booked in to an appointment then they may be advised to contact their GP practice themselves or may be referred to another appropriate service on the Directory of Services.

Service and patient responsibility

Once the NHS 111 clinical assessment is complete and the patient has been provided with the appointment details, it is then the patient or guardian's responsibility to attend the selected point of care at the appointed time.

The receiving service (GP Practice) must ensure:

- That they are alert to new appointment bookings.
- That they decide at the earliest opportunity how the patient will be managed and if this is not via a face to face appointment (e.g. via a call back) that they contact the patient in a reasonable period prior to the appointment time. It will be up to the practice to decide the channel by which appointments are conducted (face to face, telephone etc).

An appointment booking made by NHS 111 should not be considered as a transfer of responsibility for further care. Until the patient is contacted by the practice or attends for their appointment, responsibility remains with the patient for their own care.

When an episode is completed in NHS 111 a Post Event Message (PEM) will be sent to the patient's practice via ITK, as currently takes place. This will apply to all NHS 111 cases whether a booking is made or not and will contain the assessment outcome. The practice should consider what action is required (if any) following receipt of the PEM.

How does a practice know if the appointment is booked or not?

Practices set up their appointment book and allocate appointment slots to consumer organisations and organisation types, in this case NHS111. When an appointment is booked it will be visible to the practice as a booked appointment. However, how this is displayed within the GP System will be different depending upon the provider.

Technical recommendations for implementing GP connect appointment booking

Accessing appointment booking capability

NHS Digital assures any GP provider system on the GP systems framework. Systems are checked for technical configuration, connectivity and booking capability. As a result, there is no requirement for GP practices to undertake separate technical assurance.

GP practices will need to configure the appropriate number of appointment slots within their system. Once this has been completed it is recommended that practices check that the system is working correctly by using test patients.

Further technical guidance will be available to practices once they adopt the GP connect service. Information can also be found on the GP connect[4] webpages.

A GDPR-compliant data sharing contract agreement between NHS111 and practices should be put in place by the commissioner.

Specific configuration and considerations

Turning on the GP Connect appointment management capability at the GP practice requires limited action. Some systems may require an end-user to enable the appointment management capability through a simple tick box. The system's user guidance documentation will detail this if it is required. Practices may require a local system administrator to undertake the necessary action where this is required.

The practice will need to configure the appointment slots to be GP Connect bookable to allow them to be seen and booked via the GP Connect functionality.

Technical process to release and take back unused appointment slots

[4] https://digital.nhs.uk/services/gp-connect/getting-involved-with-gp-connect

GP practices are able to take back unused NHS 111 directly-bookable appointments, maintaining practice control of their appointment book. NHS 111 appointments will become available for practices to use two hours ahead of the appointment time.

In the event that the practice decides to reallocate an appointment slot reserved for NHS 111, then the practice configures the slot type as they would do for any other appointment. Steps on how to do this are provided in the GP system guidance documentation.

Escalation route in case of technical issue with GP Connect (national service desk support and support numbers etc)

If a GP practice is having technical difficulties with GP Connect, they should contact their local service desk (LSD) in the first instance. The LSD should perform the initial triage and if the issue is considered to lie outside of their local environment, they should in turn refer on to the National Service Desk.

Monitoring and reporting

It is important that CCGs and practices understand how utilisation is measured. Not all appointments released for NHS 111 are booked due to many contributing factors (patient choice, appointment times, volume of calls received for each surgery).

Utilisation can be measured by identifying the number of calls received by NHS 111 which resulted in the option to select the direct booking service following triage vs the number of those calls that resulted in an appointment booking.

Although not mandatory, it would be useful locally to understand how many appointments resulted in did not attends as well as the proportion of appointments taking place as a call back rather than a face to face appointment. Feedback on whether calls were correctly disposed to general practice would be essential feedback to improve the system.

We would expect GPs, commissioners and providers to maintain oversight of the above and work together to ensure any unwanted effects are monitored and addressed.

3.3: Ban on advertising and hosting of private GP services

NHS England has agreed with GPC England that “to safeguard the model of comprehensive NHS primary medical care, from 2019 it will no longer be possible for any GP provider either directly or via proxy to advertise or host[5] private paid-for GP services that fall within the scope of NHS funded primary medical services. NHS England will consult in 2019 on expanding this ban on private GP services to other providers of mainly NHS services.”

[5] In this context, we acknowledge that in leased premises contractors have no influence over how the landlord chooses to use any other part of the building not covered by the contractor’s lease.

The reason for this contractual change is that there are an increasing number of instances where the line between NHS and private practice is becoming blurred to the detriment of NHS patients:

- There are examples of private companies partnering with existing NHS GP practices and advertising their private services to NHS patients when the service should be delivered as an NHS service by the NHS GP practice.
- Some private companies are using NHS GPs to provide private services to patients from NHS practice premises, including during NHS core hours.

This contractual change will prevent these models from being delivered by NHS GPs in NHS surgeries. It will also prevent GP practices from advertising private GP services provided by a private company owned by them or another organisation.

NHS England remains committed to the position that the NHS is free at the point of delivery. We want clarity for patients about what are free NHS GP services and what are not, and we want to maintain patient confidence in the integrity of general practice. We will keep the advertising ban changes under review, in order to identify and close any further or future potential gaps in these provisions.

Current rules

The current rules on charging patients remain unchanged.

The provisions of Regulation 24 of the GMS Contracts Regulations 2015 and 18 of the PMS Agreement Regulations 2015 preclude GP practices from charging any of their registered patients for any treatment or prescription **whether under the contract or otherwise**, other than those services listed in Regulation 25 and Regulation 19.

This list is very limited and includes for example certain medical examinations and attendance at a road traffic accident or a police station. It also includes most travel vaccines as well as malaria prophylaxis.

The current rules mean that practices may not charge their own registered patients for a private consultation outside this very limited list of procedures. For example, practices cannot charge their own patients for services such as flu vaccinations for patients not in “at-risk” categories, other vaccinations such as chicken pox, or minor surgical procedures. This list is not exhaustive.

The rules do allow practices to charge patients for such things as signing passports or providing medical examinations for insurance purposes. Again, this list is not exhaustive.

New restrictions on advertising and hosting private GP services

Under the new contractual provisions, GP practices will not be allowed to advertise or host private GP services that patients should get on the NHS from their own practice.

What this means in practice

NHS GP practices will no longer be able to:

- advertise the services of companies which offer patients access to private GP appointments, “with an NHS GP” via an online booking system; or
- offer private GP appointments through these services from their practice premises; or
- advertise any private GP services (including their own except where allowable under regulation 25) in any way including in leaflets, using posters, on the practice website, in any web presence or digital channel etc or allow others to advertise any such private services. This list is not exhaustive;
- host (from their NHS-funded premises or through online and digital platforms such as the practice website or smartphone applications that have not been nationally, or locally commissioned) a private provider of primary medical services that the practice provides for free on the NHS;
- allow GPs to deliver (for any patients) private primary medical services other than those allowable under GMS Regulation 25 or PMS Regulation 19 from their practice premises[6].

The new provisions also mean that private companies who partner with existing NHS GP practices will not be able to advertise their private GP services whilst legitimately providing NHS services. Advertising in this context means any reference to such private services at all.

Although we do not think that this practice is currently widespread, we do not wish to see an expansion of this type of service within an NHS general practice setting. NHS England will also consult in 2019 on expanding this specific ban on the provision of paid-for GP services to other providers of mainly NHS services.

This policy will not prevent individual GPs from offering purely private GP services to non-registered patients outside of times they are contracted by an NHS provider of primary medical services and on alternative premises which are not NHS-funded. However, these services must be completely separate to the services provided to their NHS patient list. There should be no doubt as to whether a GP is providing services as a NHS-contractor or as a private GP or GP practice, but this must not occur from any NHS funded premises or be advertised from them.

We do not intend for this measure to impact patient access to travel vaccinations. Therefore, practices will be permitted to provide on a private basis to non-registered patients from their practice premises[7] those travel vaccinations for which there is no remuneration by the NHS, which they currently can provide to their registered patients under Regulation 25. But to retain the distinction between NHS and private services, these services can only be provided to non-registered patients on a private basis outside of core hours. A review of vaccination and immunisations is ongoing and this is without prejudice to its conclusions.

What the policy is not intended to do

---

[6] Practices can deliver private travel vaccinations allowable to registered patients under Regulations 25, to non-registered patients

[7] There will be no consequent change to existing arrangements for abatement of notional rent under the Premises Costs Directions.

- Prevent practices undertaking those services already allowed under Regulation 25 of the GMS Regulations and Regulation 19 of the PMS Regulations
- Prevent practices from letting space within their building for other companies such as pharmacies, dentists or opticians;
- Prevent practices from hosting non-GP private services such as physiotherapy, psychotherapy, hypnotherapy or acupuncture;
- Prevent practices from providing travel vaccines for which there is no remuneration by the NHS: for registered patients as set out under Regulation 25 or privately to non-registered patients outside of core hours.
- Prevent practices from charging their own patients legitimately, for example, for HGV medicals.

Some practical examples

- Could a practice premises house an NHS and private GP service in the same building?

  It would be considered to be hosting a private GP service, and would not be allowed at any time. In leased premises the leaseholder would have no influence over how the landlord chooses to use any other part of the building.

- Could a practice offer a digital first model of care to its registered patients, but also offer an alternative private GP service to non-registered patients?

  The practice must not advertise private GP services to registered or non-registered patients.

- Is it permitted for a practice to rent out parts of its practice premises to, for example, a pharmacist, optician or dentist, all providing some private services?

  Offering private pharmacy, optometry, or dental services, and not private GP services would be allowed. Those providers could not offer private GP services, either physically or digitally.

- Can a practice run a private travel vaccination clinic in its building for unregistered patients?

  Yes, but it can only provide vaccines for which there is no remuneration by the NHS and that must be outside of core hours.

3.4: Pay transparency

We have agreed with GPC England that "GPs with total NHS earnings above £150,000 per annum will be listed by name and earnings in a national publication, starting with 2019/20 income. The Government will look to introduce the same pay transparency across other independent contractors in the NHS at the same time."

Further details will be published in due course.

3.5: Changes to the FP10 Form

Legislation is in place to provide for free-of-charge treatment of sexually transmitted infections (STIs). Treatment provided from stock held on the premises of specialist clinics will not incur a prescription charge. However, many local authorities now commission a variety of STI services from different providers across primary and secondary healthcare based on their local needs. Some of these services are using FP10 prescriptions to supply medicines. An NHS prescription form will also be used where patients seek treatment from their GP. Where these medicines are supplied by way of an FP10 prescription form, there is currently no mechanism or operational arrangement for exempting the patient from the prescription charge, so patients may be charged for medicines that should be supplied for free.

The back of the current FP10 prescription form is being re-designed. Changes will be made to the layout to make it easier for patients to claim the exemption to which they are entitled, within the limits of the paper size and legal requirements. To coincide with this work, we are introducing a new prescriber endorsement that will enable prescribers to indicate to the dispenser that an item is for free-of-charge treatment of an STI.

Prescription endorsements exist for other products[8] i.e. the prescriber endorsement ‘CC’ applies to free-of-charge contraceptives and ‘SLS’ applies to the Selected List Scheme (Part XVIIIB of the Drug Tariff ‘the grey list’). It is therefore proposed that in future, prescribers should use the prescription endorsement “SH” for ‘Free-of-charge sexual health treatment’.

Once the necessary changes have been made to NHS systems and prescription processing procedures, prescribers will be able to hand endorse paper FP10s, or select the endorsement for each item prescribed for an STI on the Electronic Prescription Service (EPS) digital systems. Further information will be issued in due course on the changes to the FP10 form and the new prescriber endorsement (including to confirm the endorsement code, the date from which it can be used, scope for indications covered etc). Any necessary changes will also be made to legislation.

3.6: Duty of co-operation

There will be a new contractual requirement for all GP practices to engage with and support their PCN to deliver services to their collective registered population, whether or not they are signed up to the Network contract DES.

GP practices will be required to:

- Co-operate with GP-practice members of PCNs who are delivering the Network Contract DES services to the collective registered population and as required engage in wider PCN meetings with other PCN providers.

[8] See: https://psnc.org.uk/dispensing-supply/endorsement/endorsement-guidance/ or https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/prescribing-and-dispensing/endorsement-guidance

- To inform patients, as required, of changes to PCN services.
- To support wider co-operation with other non-GP provider members of the PCN.
- As clinically required to support the delivery of PCN services, be party to appropriate data sharing and data processing arrangements, that are compliant with data protection legislation.
- Share non-clinical data with members of the PCN to support delivery of PCN business and analysis, following a process that is compliant with data protection legislation.

In order to qualify for the SFE Network Participation Payment, GP practices who are signed up to the Network contract DES must be delivering these requirements in full as well as actively participating in the Network Contract DES.

3.7: NHS marketing campaigns

From 2019-20, NHS England and GPC England have agreed that GP practices will be required to support up to six national NHS marketing campaigns on an annual basis, where the GP contractor will be required to put up and display in their premises, campaign display materials six times every 12 months. NHS England and GPC England will discuss which campaigns should run.

NHS national marketing campaigns are run to change people's behaviour in the way they access NHS services or look after their own health and are developed to help the audience groups they are targeted towards. For NHS marketing campaigns to be effective it requires audiences to see or hear messages many times so that they act on the information we are providing. This means that it is important that the NHS makes best use of all the opportunities to deliver our messages to our audiences, including displaying national campaign materials in GP practices.

NHS England will provide GP practices with campaign materials for practice staff to put on display for their patients in appropriate places within the practice. These materials will be sent to practices at relevant times during the year, such as when the national campaign advertising activity is about to start so that practices can display campaign materials when the same messages are being delivered to the public via other channels.

Practice staff will be expected to:

- Identify the best places for patients to be able to view the campaign materials within their practice.
- Receive the campaign materials when they are sent out to practices.
- Display the campaign materials that are provided, for example put up posters in prominent positions in the practice or run provided files on public information screens in the practice.

3.8: MHRA Central Alert System (CAS)

The Medicine and Healthcare products Regulatory Agency (MHRA) Central Alerting System (CAS) is the national system for issuing patient safety alerts, important

public health messages and other safety critical information to all providers, including GP practices.

There are different national ‘issuing bodies’ who have the ability to issue CAS alerts to general practice and these include NHS Digital, the MHRA, the Department of Health and Social Care, NHS England and NHS Improvement.

Currently CAS alerts are cascaded to practices via local arrangements which have been put in place by NHS England commissioning teams. Once the system is updated, it will allow relevant alerts to be sent directly to practices by email, with the ability to send alerts via text message in the exceptional event of an IT outage. This change in how practices receive alerts will improve public safety by removing the need for the information to be cascaded. Practices will also receive the alerts in a timely manner.

From October 2019, there will be a contractual requirement for practices to:

- register a practice email address with the CAS team and to monitor the email account to act on CAS alerts which are received. All alerts issued to the account will have been vetted to ensure they are relevant to GP practices;
- notify the CAS team if the email address changes to ensure continued receipt of alerts; and
- register mobile phone details with the CAS team, which will only be used as an emergency back-up to email for text alerts when e-mail systems are down.

NHS England local teams (or fully delegated CCGs where appropriate) will supply the CAS team with the contact information they hold for GP practices in their area. Practices will then be invited to access the CAS website to confirm the details held are correct, including completing or updating any missing e-mail or mobile phone contact details.

Where appropriate, practices will need to login to CAS to acknowledge response to CAS alerts which have been issued.

3.9: Use of the NHS logo

Patient/public research conducted in 2015 showed that people find it helpful and reassuring when they see the NHS Identity applied to primary care services: 87% of people would expect to see the NHS Identity at GP surgeries.

There is a single NHS primary care logo for all primary care contractors to use. It includes the strapline ‘Providing NHS services’ which makes it clear that the primary care contractor is providing NHS services, but is not an NHS organisation itself. The logo can be downloaded here https://www.england.nhs.uk/nhsidentity/identity-guidelines/primary-care-logo/. The NHS logo, which forms part of the NHS primary care logo, is protected by law. It is a UK trade mark owned by the Secretary of State for Health and Social Care. It is also protected by copyright. Only original artwork files for the NHS primary care logo should be used. The NHS primary care logo must always be used in its entirety. The NHS logo must not be used on its own.

If GP practices choose to use the NHS primary care logo in relation to their NHS services, they must adhere to the NHS Identity guidelines at https://www.england.nhs.uk/nhsidentity/identity-guidelines/primary-care-logo/.

Visual examples showing how to correctly apply the NHS primary care logo are available at https://www.england.nhs.uk/nhsidentity/identity-examples-organisations/primary-care-contractors/.

If practices choose to use the NHS primary care logo, it only needs to be applied to new offline information and materials as and when they were being replaced or replenished, to avoid wastage. Existing digital channels, such as websites, are usually easier and quicker to change, so can be updated as soon as is practical.

3.10: General Data Protection Regulations

The GP Contract Five Year Framework states that CCGs will be responsible for offering a Data Protection Officer (DPO) function to practices in addition to their existing DPO support services. The new Securing Excellence in General Practice Digital Services 2019-2021 GP IT Operating Model will be updated in 2019 to reflect this as a core and mandated requirement. CCGs will be required to commission a DPO service, which will include offering a named DPO to practices for them to designate as their own. This function can be shared between practices. Practices may choose to appoint their own DPO at their own cost if they do not want to use the CCG commissioned service. General practices are public authorities and data controllers, so remain the legally responsible body for ensuring a designated DPO. This requirement is not intended to replace existing arrangements where a CCG may have provided funding for practices to appoint a DPO.

3.11: Locum reimbursement for shared parental leave

Legislation allows for parents to share parental leave on the birth or adoption of a child. To support GPs who wish to do this, commissioners will now reimburse the cost of GP performer cover for shared parental leave, in the same way that they do for maternity leave. It will be for the GP performer and practice to demonstrate eligibility and then apply for reimbursement of any incurred costs in the normal way. Commissioners will reimburse the lower of actual, invoiced costs or a weekly maximum amount, for up to 26 weeks.

Further information on this and other GP performer reimbursement policies can be found in the NHS England *Locum protocol*.

3.12: Additional services

From October 2019, contraception services will no longer be an Additional Service under the Regulations but will become part of Essential Services. There will be no opt-out or reduction of global sum payments as a result

Section 4: Guaranteeing investment

From 1 April 2019, core general practice funding will increase by £109m, rising to an extra £978m per year by 2023/24. This takes into account other agreed changes, including:

- £105m for the new Practice Network Participation financial entitlement payable each year, equating to £14k per average practice of 8,000 patients;
- the changes to GP indemnity costs for 2019/20 as a result of the introduction of the new Clinical Negligence Scheme for General Practice (CNSGP) which comes into force from 1 April 2019;
- the transfer of £66m of funding from 1 July 2019 from the practice contract to the Network Contract DES, equating to £87m recurrently per annum, for the Extended Hours Access DES. Responsibility for meeting the extended hours access criteria will transfer alongside the funding, from practices to PCNs, on 1 July 2019; £30m of additional annual recurrent funding for access and also reflecting the introduction of 111 direct booking;
- £20m additional funding per annum for GDPR Subject Access Requests for the next three years;
- reinvestment of Minimum Practice Income Guarantee (MPIG) and seniority savings into global sum, without Out of Hours deduction, as normal;
- an uplift to allow an increase to the Item of Service (IoS) fee for certain vaccination and immunisations (V&I) from £9.80 to £10.06, in line with consumer price index inflation. These are:
- childhood seasonal influenza;
- pertussis; and
- seasonal influenza and pneumococcal polysaccharide;
- other increased business expenses.

Table 1: QOF, out of hours and global sum adjustments

Key Contract Figures	2018/19	2019/20	£ increase	% increase
Value of QOF Point	£179.26	£187.74	£8.48	4.7%
Global Sum price per weighted patient[9]	£88.96	£89.88	£0.92	1.0%
OOH adjustment (%)	4.87%	4.82%		
OOH adjustment (£ amount)	£4.33	£4.33	£0.004	0.1%

The first payment of the new Practice Network Participation payment will be made to practices on or before the end of July 2019 – backdated to cover April, May and June. It equates to £1.761 per weighted patient per year – i.e. £0.147 per month – and, following the initial payment, will be paid monthly in arrears on or before the end of the following month. For example, the payment relating to July will be paid on or before the end of August.

For completeness, several items of correspondence containing specific pieces of guidance were issued prior to this document being prepared, as below:

- 31 January 2019 letter: This announced the publication of Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan jointly with the BMA's General Practitioners Committee

[9] Of the 92 pence increase, 83 pence is from existing seniority payments and Minimum Practice Income Guarantee (MPIG) payments, which are both being eroded and reinvested into global sum payments.

England. https://www.england.nhs.uk/publication/gp-contract-reform-letter-from-ed-waller/
- 19 February 2019 letter: Set out further details, including the 2019/20 values of the Global Sum price per weighted patient and Quality & Outcome Framework point. https://www.england.nhs.uk/wp-content/uploads/2019/02/EW-Letter-_-GMS-Contracts.pdf
- 7 March 2019 letter: Provided more information, including on the payments to cover indemnity inflation, NHS Pension Scheme employer superannuation changes. https://www.england.nhs.uk/wp-content/uploads/2019/03/gp-contract-reform-letter-07-03-19.pdf
- 20 March letter: Provided details of changes to allocations resulting from the GP contract settlement. https://www.england.nhs.uk/publication/gms-contract-settlement-and-allocation-changes-2019-20-to-2023-24-letter-from-ed-waller/

All enhanced SSs and guidance available at:
https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/

Section 5: Vaccinations and Immunisations

The following provides guidance for commissioners and GP practices providing immunisation programmes commissioned by NHS England for 2019/20. Commissioners and GP practices should ensure they have read and understood the requirements in the Regulations, Directions, NHS England's SSs and NHS Digital Business Rules. A summary of the 2019/20 vaccination and immunisation programmes is included at annex A.

5.1 Vaccination and immunisation programmes – Statement of Financial Entitlement (SFE)

This section outlines the immunisation programmes that are set out in the GMS Statement of Financial Entitlements (SFE) directions. The SFE sets out the administrative provisions, eligibility, claims and the conditions relating to payment under a programme.

Changes for 2019/20

NHS England and GPC England agreed the introduction of a new MMR catch-up programme for 10 and 11-year olds who have not received a completed course of vaccines via the school programme. A payment of £5 per head will be made if GP practices have completed vaccination or they have met the specified criteria. Details of all specified requirements relating to this programme are set out in the SFE.

GP practices should continue to support MMR opportunistic vaccination for those who have attained the age of 5 years but who have not yet attained the age of 25 years whose records show no, or an incomplete course of MMR vaccination.

For details of the requirements for the MMR vaccination programme, see payments already covered elsewhere within the SFE as follows:

- 2 - 5 year olds
- 5 - 16 year olds

- Over 16s receive an item of service fee.

HPV completing dose – from 1 April 2019 the eligible cohort will be extended to opportunistically vaccinate girls and women aged from 14 years to those who have not yet attained the age of 25 years with IOS fee of £10.06. The HPV for boys programme will begin as part of the HPV vaccine programme (including girls and boys going forward) from September 2019. NHS England, GPC England and PHE have agreed that the catch-up element for boys will not need to be delivered through GP practices in 2019/20. Any boys who miss the initial doses from September 2019 to 31 March 2020 will be offered another appointment via the school-based programme. We anticipate that boys will be added to the HPV catch-up scheme in general practice from April 2020.

Meningococcal completing dose – the eligible cohort has been expanded in the SFE to include patients who have attained the age of 14 years on or after 1 September 2010.

For 2019/20 the following immunisation programmes remain unchanged.

Childhood immunisations, Rotavirus, Pneumococcal (infant) (PCV) Hib/MENC booster, Shingles (routine 70-year olds), Hepatitis B at-risk (newborn babies), Meningococcal B and MMR 16 and over.

5.2 Vaccine and immunisation programmes – enhanced services

The detailed requirements for ES vaccination programmes are set out in NHS England services specifications.

The SSs outline the requirements for the programme and commissioners and GP practices should ensure they have read and understood all sections of the specification prior to implementation**.**

Changes for 2019/20

An increase in the IOS from £9.80 to £10.06 has been agreed from the 1 April 2019 for the following programmes: Childhood seasonal influenza, Pertussis, Seasonal influenza and Pneumococcal polysaccharide.

Childhood influenza – from 1 September 2019 the following vaccines are recommended for the following clinical at-risk groups:

- 6 less than 2 years – standard egg-grown quadrivalent inactivated influenza vaccine (QIVe);
- 2 less than 18 years – LAIV unless contra-indicated (or otherwise unsuitable) then a suitable quadrivalent influenza vaccine (QIVe) is recommended.

Seasonal Influenza – from 1 September 2019 the following cohorts will be added to the eligibility groups entitled to receive a flu vaccination under the Directed Enhanced Service (DES) for patients registered with the GP practice:

- health and social care staff employed by a registered residential care/nursing

home or registered domiciliary care provider and;
- health and care staff employed by a voluntary managed hospice provider

GP practices should order the following vaccines recommended by NHS England for the 2019/20 influenza season for those eligible under the DES in a clinical risk group.

- six months to under 18 years in clinical risk groups a QIVe[10]
- 18 to 64 year olds (including pregnant women) either QIVe and cell-based quadrivalent inactivated influenza vaccine (QIVc)
- For 65 years and over aTIV or QIVc

GP practices will only be eligible for payment for vaccination and reimbursement of the vaccine if the GP practice has used the specified vaccines recommended in this guidance and the DES specification.

For 2019/20 the following enhanced services remain unchanged:

Meningococcal ACWY (MenACWY) freshers and Shingles (catch-up).

For details of the clinical codes, payment and management information counts for all programmes, see the 'Technical requirements' document.

Further details on the above programmes, including dosage, timings and administration can be found in the Green Book[11]:

Technical Requirements

The Calculating Quality Reporting Service (CQRS) team works with NHS England to ensure CQRS supports the contract and any changes. GP practices must be offered and agree to provide each service as well as agreeing to participate in a service on CQRS with their commissioner.

GP practices are advised that to ensure they receive payment, particular attention should be paid to the payment and validation terms. GP practices will need to ensure they understand and use the designated clinical codes as required. The technical requirements 2019/20 document sets out additional detail on how CQRS and GPES will support these services. This document will be updated when details of services become available from NHS Digital.

Where a service is supported by CQRS, GP practices are required to manually enter achievement on CQRS using the relevant clinical codes within their clinical systems until data can be automatically collected from practice systems by GPES.

Where possible, NHS England seeks to minimise the reporting requirements for the services delivered by GP practices where these can be supported by new systems.

Commissioners and GP practices will be aware of the requirements for access to

---

[10] Healthy children aged 2 and 3 year are covered by a separate enhanced service.

[11] https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

patient identifiable data. Where patients have expressed a desire that their information is not shared, GP practices will need to advise the commissioner and make an appropriate note in the patient's record. For further information about the requirements set by GDPR, the Data Protection Act, Human Rights Act and Common Law Duty of Confidentiality as well as policy and guidance, consult your local Information Governance lead.

Key Links

The key links to referenced vaccine and immunisation programmes throughout this guidance are listed below:

NHS England:

Investment and evolution: A five-year framework for GP contract reform to implement *The NHS Long Term Plan* https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

NHS England enhanced SSs https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/

Update on vaccines 2019/20 seasonal influenza programme https://www.england.nhs.uk/wp-content/uploads/2018/11/20181120-Gateway-08529-Vaccines-for-201920-seasonal-flu-vaccination-programme.docx.pdf

Department of Health and Social Care (DHSC)

Statement of Financial Entitlements: https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013

Annual Seasonal Flu letter: https://www.england.nhs.uk/publication/vaccine-ordering-for-2019-20-influenza-season-letters/

NHS Digital

Business Rules http://content.digital.nhs.uk/qofesextractspecs

CQRS http://systems.digital.nhs.uk/gpcollections

GPES http://content.digital.nhs.uk/gpes

Manual Entry http://systems.digital.nhs.uk/gpcollections

Section 6: Non-contractual arrangements

6.1: GMS digital

Making progress towards future developments

NHS England and GPC England have agreed an ambitious programme of work to be delivered over the next five-years.

We have agreed measures that will become contractual requirements in April 2020 or April 2021 subject to available IT infrastructure, and NHS England and GPC England expect practices where feasible to make progress in 2019/20 towards meeting those requirements.

These are:

- all practices will be offering online consultations by April 2020 at the latest;
- all patients will have online access to their full digital GP record, as the default position from April 2020, subject to existing safeguards for vulnerable groups and third-party confidentiality and system functionality;
- all practices will be giving all patients password-protected online access to digital correspondence by April 2020, as the system moves to digital by default
- by April 2020, practices will no longer use facsimile machines for either NHS or patient communications;
- all practices will be offering consultations via video by April 2021 at the latest.

Patient-facing email accounts

Practices are encouraged to have a patient-facing email account. NHS England and GPC England will publish guidance on how to deal with emails from patients, including how frequently in-boxes should be monitored.

6.2: Temporary residents

Introduction

A patient does not need to be "ordinarily resident" in England to be eligible for NHS primary medical care – this only applies to secondary and community care services. There is no set length of time that a patient must reside in the country in order to become eligible to receive NHS primary medical care services.

In effect, therefore, anybody in England may register and consult with a GP practice without charge either on a permanent or temporary basis.

Therefore, all asylum seekers and refugees, overseas visitors, students, people on work visas and those who are homeless, whether lawfully in the UK or not, are eligible to register with a GP practice even if those visitors are not eligible for secondary or community care services.

Background

GP practices are obliged to provide emergency treatment to people who are not registered with their practice and to provide treatment to temporary residents.

The temporary resident arrangements in the current regulations[12] are designed so that patients can access primary medical services when they are away from home for more than 24 hours but less than 3 months.

[12] https://www.legislation.gov.uk/uksi/2015/1862/contents/made

Under current regulations, a GP practice, may, if their practice list is open to new patients, accept a person as a temporary resident provided they are satisfied that the person is:

a) temporarily resident away from their normal place of residence and is not being provided with essential medical services (or their equivalent) under any other arrangement in the area where that person is temporarily residing; or
b) moving from place to place and is not resident in any one place for the time being.

To be accepted as a temporary resident, the contractor must be satisfied that the patient intends to stay at their current address for more than 24 hours but not for more than three months.

Currently GP practices receive a payment for temporary patients as an element in their global sum allocation (the amount paid for delivering primary medical services to their patients). The amount each contractor receives in respect of such patients has been based on the average amount historically claimed by the practice in each of the five years prior to 1 April 2004.

However, changes in the average amount paid to a GP practice can be made by the commissioner if there are significant increases or decreases in numbers of temporary residents.

Commissioners should consider in any given year whether a GP practice has faced a significant increase or decrease in the numbers of unregistered patients requiring treatment from it and apply appropriate temporary patient adjustment funding accordingly (see 3.5). This would ordinarily be in response to a GP practice raising this as an issue. Examples of where this may apply are:

- Where there are travellers staying in the local area for short periods of time and need access to primary medical services;
- for university practices, where their list size increases exponentially at the beginning of a university term; or
- for practices who are based in tourist areas and their practice list size increases during the summer months.

Payment Mechanisms

All contractors are to receive a payment for unregistered patients as an element in their global sum allocation. Annex C of the Statement of Financial Entitlements[13] sets out in detail how these payments should be made and is called the ‘Temporary Patients Adjustment’.

Where a Temporary Patients Adjustment has been calculated in a financial year, that payment amount should be made in the following financial years unless there is a significant change to the numbers of temporary patients.

---

13 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213225/GMS-Statement-of-Financial-Entitlements-2013.pdf

In the event that there has been no Temporary Patients Adjustment calculated in the previous financial year, the commissioner is to determine for the contractor a reasonable annual amount which is an appropriate rate for the area where the practice is located. Before making such a decision, the commissioner must discuss the matter with the contractor and then apply this Temporary Patients Adjustment for that financial year and following years.

The amount calculated in accordance with paragraphs 3.2 to 3.3 is the annual amount of the contractor's Temporary Patients Adjustment, which is the amount to be included in its Initial Global Sum Monthly Payment (GSMP) calculation.

However, there may be exceptional cases where a calculation produces an amount that is clearly inappropriate as the basis for a payment in the financial year to which the payment relates. This may occur, for example, where the practice has faced a significant increase or decrease in the numbers of unregistered patients requiring treatment from it. Practices will be expected to provide evidence on patient registrations from their clinical system to support any claims for increased funding

In these cases, the commissioner is instead to determine for the contractor, as the basis for its Temporary Patients Adjustment, a reasonable annual amount which is an appropriate rate for the area where the practice is located. Before making such a determination, the commissioner must discuss the matter with the contractor.

Once a Temporary Patients Adjustment has been determined, it remains unchanged for the financial year to which the calculation relates, this should be made in accordance with the Statement of Financial Entitlements (SFE).

Section 7: Queries process

Where a practice or commissioner has queries relating to the 19/20 contract changes that is not addressed within this guidance, they should be directed as follows:

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

   NHS England via:
   - england.gpcontracts@nhs.net for general contracting and policy queries
   - england.primarycareops@nhs.net for operational issues

   GPC England via:
   - info.gpc@bma.org.uk

Annex A. Vaccination and immunisation programmes - summary

Table 1. Existing programmes – changes

Programme	SS or SFE	Timeframe	Change	Cohort	Vaccine/dosage	Vaccine supply	£ details
Childhood seasonal influenza	SS	1/9/19 - 31/3/20	Change to IoS fee only.	2-3 years on 31 August 2018	The nasal spray is recommended for children. Alternative inactivated vaccine only supplied for children defined as at-risk in the specification and Green Book and children medically contra-indicated to the LAIV vaccine. 1 dose for most children. Children aged 2–9 defined as at-risk require 2nd dose where no previous influenza vaccination. Where 2 doses required, they must be at least 4 weeks apart. Practices are required to operate call and recall services for all eligible patients. Vaccinations to be concentrated between 1/9-30/11 in line with the Green Book and CMO advice to ensure optimum coverage – service will run to 31/3.	Central supply[14]	£10.06 per dose CQRS and GPES

[14] PA fees are not claimable for vaccines supplied centrally.

HPV completing dose	SFE	In line with SFE	Change to cohort from 14-18 years to 14-24 (inclusive) opportunistically.	14-24 years (girls & women)	1 dose Practices are not required to proactively offer or encourage patients to be vaccinated. Vaccination only where the patient has missed schools provision.	Central supply	£10.06 per dose Manual reporting via CQRS
Meningococcal ACWY (MenACWY) completing dose	SFE	In line with SFE	Change to cohort eligibility. Previously eligibility was 1 April 2012.	14-23 years (inclusive) on 1 September 2010.	1 dose, conjugate vaccine. Practices are not required to proactively offer or encourage patients to be vaccinated. Vaccination of 14-16 years is only where the patient has missed the school provision.	Central supply	£10.06 per dose CQRS and GPES*
Pertussis	SS	In line with SFE	Change to IoS fee only.	Pregnant women (and new mothers who missed the opportunity to be vaccinated while pregnant). Vaccination required for each pregnancy.	1 dose	Central supply	£10.06 per dose CQRS and GPES

<table>
<tr>
<td rowspan="2">Seasonal influenza and pneumococcal polysaccharide</td>
<td rowspan="2">Directions and SS</td>
<td>Influenza
1/4/19 - 31/3/20</td>
<td>Influenza
Change to IoS fee.

Addition of care home and social care staff to cohort.

Change to clarify NHS England recommended vaccines <u>must</u> be used.</td>
<td>Influenza[15]
At-risk patients as defined in the service specification and Green Book.

Practices are required to operate ‘proactive call’ if not at risk, or ‘proactive call and recall’ for at risk patients.</td>
<td>Influenza
1 dose except for children aged 5–9 years (inc) defined as at-risk require 2nd dose where no previous influenza vaccination. Where 2 doses required, they must be at least 4 weeks apart.

Vaccinations should be concentrated between 1/9-30/11 in line with Green Book and CMO advice to ensure optimum coverage - service will run to 31/3.

This programme can be delivered alongside the pneumococcal and shingles programmes.</td>
<td>Influenza
Central supply for patients under 18 years. Other vaccines direct from manufacturer.

Practices are reminded ALL vaccinations should be recorded on ImmForm as per section of specification.

Practices <u>must</u> use the influenza vaccine recommended in NHS England guidance.</td>
<td rowspan="2">£10.06 per dose

CQRS and GPES

Influenza and pneumococcal are mutually dependant in the specification but separate services on CQRS and GPES.</td>
</tr>
<tr>
<td>Pneumococcal
In line with SFE</td>
<td>Pneumococcal
No changes - included for completeness as one programme with influenza.</td>
<td>Pneumococcal
At-risk patients as defined in the service specification and Green Book.</td>
<td>Pneumococcal
1 dose</td>
<td>Pneumococcal
Direct from manufacturer</td>
</tr>
</table>

[15] The DES Directions reflect the scope of influenza immunisations NHS England commission as primary medical care services. The specification reflects that NHS England commissions influenza immunisation for wider risk groups identified in the Green Book including pregnant women. These are public health functions carried out on behalf Secretary of State for Health under Section 7a.

Table 2. Existing programmes – rolling over with no changes

Programme	Specification or SFE	Timeframe	Cohort	Vaccine/dosage	Vaccine supply	Payment details	Additional information
Hepatitis B at-risk (newborn babies)	SFE	In line with SFE[16]	Newborn babies. Babies whose mother has HepB have an increased risk of contracting HepB. This programme ensures they receive vaccinations within the first month after birth and at 12 months.	3 doses: 1st dose @ newborn (hospital) 2nd dose @ 1 month 3rd dose after 12 months AND deliver or refer for a heel prick blood test Practices must update patient record with the blood test results, notify parent/guardian and make referral to paediatrics as necessary.	Central supply of Infanrix hexa® all other vaccines direct from manufacturer	£10.06 per dose Manual reporting via CQRS Payment for 3rd dose after blood test results recorded and parent/ guardian updated.	Patients will present for other vaccinations for at least 1 of the doses and there are no contra-indications to this.
Meningococcal ACWY (MenACWY) freshers	SS	In line with SFE	19-24 years attending university for the first time, who have not been previously vaccinated (19 years on 31/8/19 but not yet 25 on 31/3/20).	1 dose, conjugate vaccine Practices are not required to proactively offer or encourage patients to be vaccinated.	Central supply	£10.06 per dose CQRS and GPES*	
Meningococcal B	SFE	In line with SFE	**Routine -** 3 doses of vaccine at 2, 4 and 12 months (in line with routine	Bexsero supplied in a pre-filled 0.5 ml syringe JCVI recommend first 2 doses	Central supply	£10.06 per dose CQRS and GPES	

[16] The timings for the SFE are 1 April to 31 March unless otherwise stated.

			childhood immunisations). **Catch-up -** Usually 3, 4 and 12/13 months, or 4 and 12/13 months but children can be vaccinated up to 2 years.	provide a “primary course” and both are required to deliver protection for peak incidence at 5 months.			
MMR	SFE	In line with SFE	16 years and over - immunise patients that have no record or incomplete vaccination.	1 or 2 doses as required Practices are not required to proactively offer or encourage patients to be vaccinated.	Central supply	£10.06 per dose Manual reporting via CQRS	
Rotavirus	SFE	In line with SFE	6 weeks and 6 months (but not over 24 weeks).	2 doses Oral suspension	Central supply	£10.06 per dose Payment on completion of dose 2 CQRS and GPES	
Shingles routine	SFE	In line with SFE	Patients aged 70 years. Patients are eligible from the day they turn 70 years, they do not have to be 70 on 1 September of the relevant financial year. Patients aged 70 on or after 1	1 dose provides lifetime coverage. Practices are not required to proactively offer or encourage patients to be vaccinated.	Central supply	£10.06 per dose CQRS and GPES	This programme can be delivered alongside the seasonal influenza and pneumococcal programmes.

			September 2013 remain eligible until their 80th birthday.				
Shingles catch-up	SS	In line with SFE	1 dose provides lifetime coverage.	Practices are not required to proactively offer or encourage patients to be vaccinated.	Central supply	£10.06 per dose CQRS and GPES	This programme can be delivered alongside the seasonal influenza and pneumococcal programmes.

* The MenACWY (completing dose and freshers) vaccination programmes are one combined service on GPES.

Table 3. New programmes

Programme	Specification or SFE	Timeframe	Cohort	Vaccine/ dosage	Vaccine supply	Payment details	Additional information
MMR catch-up 10-11 year olds	SFE	In line with SFE	Children aged 10 and 11 years who have not received a completed course via the schools based MMR vaccination programme.	1 or 2 doses as required	Central supply	£5.00 Manual reporting via CQRS	Practices can claim the fee on vaccination and also, if they have met the criteria set out in the SFE ie in cases where they tried but have been unable to vaccinate a child. A patient identified as ‘eligible for vaccination’ should be contacted on no less than 3 occasions with a record of this activity shared with their commissioner. The detail of these and other requirements attached to payment are detailed in the SFE.

Other programme notes for information:

- Pneumococcal PCV – as part of the 2018/19 contract discussions it was agreed that in the event 1 of the 3 doses for this programme was recommended for removal it could be removed from the programme. The fee of £15.02 would not change when reducing to 2 doses. This change is still under review pending a recommendation.
- The HPV programme for boys will begin as part of the HPV vaccine programme (including girls and boys going forward) from September 2019. NHS England, GPC England and PHE have agreed that the catch-up element for boys will not be delivered by general practice in 2019/20. Any boys who miss the initial doses from September 2019 to 31 March 2020 will be offered another appointment via the school-based programme. We anticipate that boys will be added to the HPV catch-up scheme in general practice from April 2020.
- Practices are reminded that they should continue to support the opportunistic vaccination of 5-24 year olds (inclusive) whose records show no, or an incomplete course of MMR vaccination. Payment for these vaccinations is as follows:
    - patients aged 5-15 (inclusive are covered by existing global sum allocations)
    - patients aged 16 and over attract an IoS fee of £10.06 (see table MMR programme in table 2).

Supporting documents

- Technical requirements document – tbc, but will be published by NHS England https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/
- Statement of Financial Entitlements – https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013
- DES Directions – https://www.gov.uk/government/publications/gp-contract-directions-2019-to-2020
- NHS England service specifications – https://www.england.nhs.uk/gp/gpfv/investment/gp-contract/
- NHS Digital Business Rules - http://www.hscic.gov.uk/qofesextractspecs
- The Green Book - https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book

Queries on the vaccination programmes can be sent to england.gpcontracts@nhs.net

Technical support for vaccination programmes

The intention is for all programmes to be supported by CQRS in line with the start date of the programme. Some programmes will remain CQRS only, but other programmes will be supported by GPES when it comes on line. Payment for vaccination programmes is monthly where payment is on a per dose basis and not linked for other doses. Where not monthly, it is outlined above.

CQRS – manual reporting only	**CQRS with GPES support when available**		
• HepB (babies) • HPV completing dose • MMR • MMR 10-11 years	• Childhood seasonal influenza • Meningococcal completing dose* • MenACWY freshers*	• MenB • Pertussis • Pneumococcal polysaccharide • Rotavirus	• Seasonal influenza Shingles – routine • Shingles – catch-up

* although these are separate programmes, they are a combined service on CQRS

The speed of CQRS and GPES support will be determined by the extent of change and wider GPES commitments ie programmes that are currently supported and are unchanged should be supported as close to commencement as possible, but ahead of the first payment date ie Rotavirus 1 April whereas previously unsupported programmes may take longer to agree the technical specifications.

Further details will be provided in the technical requirements document which will be published in due course and also updated in communications from NHS Digital.

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

NHS England
www.england.nhs.uk