2013/14 general medical services (GMS) contract

Guidance and audit requirements for new and amended services

Version 1 – April 2013

NHS England

NHS Employers

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Section 1. Introduction

Introduction

From 1 April 2013 NHS England is responsible for commissioning primary medical care services.

Changes have also been made to the GP contract for 2013/14.Practices[1]will continue to be offered the opportunity to deliver a number of enhanced services nationally, including the continuation of the existing clinical directed enhanced services (DES) first established in 2008/09. Those clinical DESs continue with some modifications made for 2013/14 to minimise reporting requirements for practices.

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

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

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

This guidance is applicable in England only.

About this guidance

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

- Alcohol-related risk reduction scheme
- Learning disabilities health checks scheme
- Rotavirus (childhood immunisation)
- Shingles (routine aged 70 immunisation)
- Risk profiling and care management scheme
- Facilitating timely diagnosis and support for people with dementia scheme
- Remote care monitoring (preparation) scheme
- Improving patient online access scheme

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

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

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

Calculating Quality Reporting Service and the General Practice Extraction Service

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

CQRS is being developed to support the services detailed in this document in two phases.

Phase 1 supports those services for which there is already the necessary level of specificity available and there is an operational requirement to have this function in place early in 2013/14 (i.e. because payment is due for activity in the first financial quarter).

Phase 1 support will go live from June 2013 although CQRS will not be provided with any data from GPES for the first quarter. Therefore, practices will need to enter achievement data manually for any payments due for the first financial quarter. Automated data extracts from GPES will commence in the subsequent quarter.

Phase 2 will support remaining services from 1 October 2013 for which the necessary level of specificity was not available in time for Phase 1 or there is no requirement to have this function in place for 1 April. Automated data extracts from GPES will commence for those services to be supported (including activity recorded from 1 April 2013).

Phase 1

The following services are supported by CQRS from June 2013:

1. Alcohol-related risk reduction scheme
2. Learning disabilities health checks scheme (now quarterly payment)

[2] DH. SFE. Insert link when published
[3] NHS England enhanced service specifications.www.england.nhs.uk/resources/resource-primary/

3. Rotavirus (childhood immunisation)

Phase 2
The following services are intended to be supported by CQRS from 1 October 2013:

4. Shingles (routine aged 70 immunisation)
5. Facilitating timely diagnosis and support for people with dementia
6. Improving patient online access scheme

Common to all services being supported by CQRS, if practices intend to participate in services then their achievement should be recorded in the clinical systems. This should be recorded using the relevant Read codes in this guidance from the date those services commence (i.e. from 1 April 2013 for those relevant enhanced services, from 1 July 2013 for rotavirus immunisation and 1 September 2013 for shingles immunisation).

NHS England is also exploring if CQRS can support the calculation of payments for influenza and pneumococcal services from 1 October 2013.

Further guidance on CQRS can be found on the Health and Social Care Information Centre (HSCIC) website[4].

Practices should use the 'participation record' in CQRS to accept/decline their participation in the services listed above in lieu of CQRS support being available. This is the agreement for the use of CQRS rather than the contractual agreement which should be agreed between the practice and NHS England or CCG as appropriate. It is important that practices record the services covered by this guidance using the appropriate Read codes listed in this document regardless of the availability of CQRS and GPES.

Where this guidance refers to payment being calculated based on the GPES extraction, the GPES extraction is based on the relevant service specification for that enhanced service.

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

Section 2. Clinical DES

Introduction

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

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

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

In 2012/13 the alcohol and learning disabilities DESs were extended until 31 March 2013. New indicators for osteoporosis (secondary prevention of fragility fractures) were introduced in QOF and therefore the osteoporosis DES was not extended. Although the ethnicity DES came to an end, it is expected that practices continue to record their patients' first language and ethnicity in order to assess the needs of their population. The codes for first language and ethnicity are published separately and are available on the BMA website[5].

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

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

Alcohol-related risk reduction scheme

Background and purpose

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

Introduction

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

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

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

The DES is for one year from 1 April 2013.

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

Initial screening

For this DES, screening applies to all patients registered between 1 April 2013 and 31 March 2014, who are aged 16 or over at the time the short case finding test is applied. For the purposes of this DES, the test must be applied within the financial year in which the patient registered.

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

Table 1: Alcohol Read codes – initial screening

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

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

Full screening

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

The following codes will need to be used:

Table 2: Alcohol Read codes – Full screening

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

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

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

Brief intervention

Those patients identified as drinking at increasing or higher risk levels (scores 8–19) should be offered brief advice. The recommended brief advice is the basic five minutes of advice used in the WHO clinical trial of brief intervention in primary care, using a programme modified for the UK context by the University of Newcastle, *How much is too much?* The tools[6] from this programme have been further refined.

[6] Alcohol learning centre. www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/

The following codes will need to be used for recording the intervention offered:

Table 3: Alcohol Read codes – brief intervention

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

Brief lifestyle counselling

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

Practices will need to use the following codes:

Table 4: Alcohol Read codes – brief lifestyle counselling

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

Referral for specialist advice

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

The following codes should be used for recording specialist referral:

Table 5: Alcohol Read codes – referral for specialist advice

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

GPES extraction

GPES will extract data on a quarterly basis relating to the number of patients (aged 16 or over within the financial year) who are recorded as having received the short standard case finding test (FAST or AUDIT-C). The codes to be used are those outlined under 'Initial screening'.

In addition, the GPES extraction will also identify:

- The number of newly-registered patients aged 16 or over who have screened positive using a short case-finding test (initial screening) during the financial year who then undergo a fuller assessment using AUDIT to determine increasing, higher risk or likely dependent drinking. Further information and details of the codes recommended for use are available under full screening.
- The number of patients identified as drinking at increasing or higher risk (scores 8-19) who should be offered brief advice. Further information and details of the codes recommended for use are available under brief intervention.
- The number of higher-risk drinkers (scores 16-19) who may have received extended intervention in the form of brief lifestyle counselling. Further information and details of the codes recommended for use are available under brief lifestyle counselling.
- The number of likely dependent drinkers (score 20 or over) who have been referred for specialist advice. Further information and details of the codes recommended for use are available under referral for specialist advice.

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

The data on the number of patients extracted by GPES is known as the quarterly count.

The GPES extraction for this service will normally be run within 28 days following each quarter period. It will provide a cumulative count from the start of the financial year each quarter i.e. Q1, Q2, Q3 and Q4 will all count from 1 April 2013. This will allow practices to build a picture of achievement (and therefore the scope to increase achievement) during the financial year before year-end payments are calculated. However, the first GPES extraction will run in October 2013, capturing Q1 and Q2.

Payment and validation

Payment under this DES will be on an annual basis.

CQRS will calculate the annual payment based on the data extracted from GPES (i.e. the number of newly registered patients, aged 16 or over in the financial year, who have been screened using either the FAST or AUDIT-C tool).

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

annual payment	=	number eligible patients having received screening in the financial year (Q4 extraction)	x	£2.38

Payment will be made by the last day of the month following the month in which the GPES extraction is run i.e. by 31 May 2014. Where CQRS has not been provided with data (i.e. the practice has not enabled the extraction or the extraction is not supported

by their system supplier) the data will need to be entered on to CQRS manually.

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

Learning disabilities health check scheme

Background and purpose

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

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

Introduction

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

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

The minimum expectation of staff attending will include the lead general practitioner (GP), lead practice nurse and practice manager/senior receptionist. Practices may also wish to involve specialist LD staff from the community learning disability team to provide support and advice.

The DES is for one year from 1 April 2013.

Payment under this DES will be on a quarterly basis calculated using the number of completed learning disability health checks undertaken in the quarter. CQRS will normally calculate the quarterly payments based on the data extracted from GPES. Payment will be made based on the quarterly count multiplied by £102.16.

Learning disability (LD) register

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

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

Table 6: Learning disabilities Read codes – diagnostic codes

	Read v2	Read CTV3	SNOMED CT3[7]
Mental retardation[8]	E3...%	E3...%	91138005 86765009% 61152003% 31216003% 40700009% 401201000000109 410331000000103% 192157003 192154005%
[X]Mental retardation	Eu7..%	Included in E3...%	Included in the cluster definition above
[X]Developmental disorder of scholastic skills, unspecified	Eu81z	Eu81z	192577001
[X]Mild learning disability	Eu816	XaREt	526331000000104
[X]Moderate learning disability	Eu814	XaQZ3	508191000000109
[X]Severe learning disability	Eu815	XaQZ4	508171000000105
[X]Profound learning disability	Eu817	XaREu	526341000000108
On learning disability register	918e.	XaKYb	416075005

The DES requires the data to be in reasonable order to proceed with offering and delivering checks but recognises that the lists are subject to ongoing improvement.

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

Practices will be required to confirm the count of patients on their learning disability health check register for the calculation of payments on CQRS.

Training

Multi-professional education sessions for primary healthcare staff should be established by NHS England (or CCG where NHS England requests) and offered to primary healthcare staff. The training should be provided by the strategic primary health care facilitator for people with learning disabilities (where NHS England or CCG has invested in this support) and/or members of the local community LD team (this may need to be commissioned via the local specialist NHS trust) in partnership with self advocates and family carers (as paid co-trainers).

NHS England or the CCG should use their internal procedures to approve the content of the training for their locality using this suggested framework:

- an understanding of learning disabilities
- identification of patients with learning disabilities and clinical coding
- understanding of the range and increased health needs associated with learning disabilities
- understanding of what an annual health check should cover (see health checks section)
- information that should be requested prior to an annual health check
- understanding of health action plans
- understanding and awareness of 1:1 health facilitation and strategic health facilitation
- ways to increase the effectiveness of health checks
- overcoming barriers including:
    - communication needs
    - using accessible information and aids
    - physical access
    - social and cognitive attitudes
- collaborative working including:
    - working in partnership with family carers
    - the role of the community learning disability team
    - the role of social care supporters
    - the role of other health care professionals and services
- experiences and expectations
- consent
- the Equality Act 2010

- resources – local contacts, networks, practitioners with special interest and information.

The training should be completed by healthcare professionals before health checks are conducted. NHS England and practices may find the Improving Health and Lives Learning Disabilities Observatory website[9,10] provides helpful, easy to understand information on the health and wellbeing of people with learning disabilities, which can support the commissioning and provision of annual health checks.

Health checks

As a minimum, the health check should include:

- a review of physical and mental health with referral through the usual practice routes if health problems are identified, including:
    - health promotion
    - chronic illness and systems enquiry
    - physical examination
    - epilepsy
    - dysphagia
    - behaviour and mental health
    - specific syndrome check
- a check on the accuracy of prescribed medications
- a review of coordination arrangements with secondary care
- a review of transition arrangements where appropriate.

Practices taking part in the DES should base their health checks on the Cardiff health check[11] or a similar protocol agreed with NHS England. Health checks should integrate with the patient's personal health record or health action plan. Where possible and with the consent of the patient, this should involve carers and support workers. Practices should liaise with relevant local support services such as social services and educational support services, in addition to learning disability health professionals.

Practices also participating in the new enhanced service '*facilitating timely diagnosis and support for people with dementia*' may find that the annual learning disability health check also provides an ideal opportunity to check for possible memory concerns and assessment for dementia for attending patients aged 50 and over.

[9] Improving Health and Lives Learning Disabilities Observatory. Health checks report. www.improvinghealthandlives.org.uk/news.php?nid=979
[10] Improving Health and Lives Learning Disabilities Observatory. The effectiveness of health checks. www.improvinghealthandlives.org.uk/news.php?nid=998
[11] Cardiff health check protocol. Royal College of General Practitioners (RCGP) website. www.rcgp.org.uk/docs/CIRC_Cardiff%20Healthcheck%20Template.doc

GPES extraction

GPES will normally extract data on a quarterly basis to establish the number of patients, aged 18 or over within the financial year, who are recorded as receiving a LD health check.

The following codes will need to be used to record a learning disability health check and to enable CQRS to calculate payment based on the GPES extraction:

Table 7: Learning disabilities Read codes – health checks

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

CQRS will not be provided with data in the first quarter, therefore practices will need to run a local search of their clinical system and enter the data manually (number of completed health checks in the first quarter) in to CQRS by the end of July so that calculation of the first quarter payment can be made. Automated data extracts will be in place for the second quarter.

The GPES automated extraction will also identify whether each patient having received a health check in the quarter, has an associated LD diagnostic code recorded in the patient record (see table six for the diagnostic codes currently included in QOF). The information extracted on diagnostic codes will not be used for payment purposes and does not constitute the practices learning disability health check register. But it will be used to support practices and NHS England to validate performance under the DES (and may support future review to move to an automated register count).

The GPES extraction will normally be run within 28 days following each quarter period. The first GPES extraction will run in October, capturing Q2. It will provide a non-cumulative count restarting at the beginning of each quarter i.e. Q2 will be all counts from 1 July 2013 to 30 September 2013.CQRS will report the count as a proportion of the learning disability health check register so practice achievement (and the scope for improvement in-year) can be assessed.

Payment and validation

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

CQRS will normally calculate the quarterly payments based on the data extracted from GPES (number of patients, aged 18 or over in the financial year, who are recorded as having received a learning disability health check in the relevant quarter, known as the LD health check on CQRS).

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

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

quarterly payment	=	number of eligible patients in quarter with a LD health check (if less than or equal to number of patients on the LD register)	x	£102.16

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

Payment will be made on the last day of the month following the month in which the GPES extraction is run. However, the first payment will be made by the 31 August 2013 i.e. for the Q1based on manual data entry. Automated data extraction will commence for Q2.

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

Section 3. New immunisations

Introduction

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

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

- introducing, from July 2013, a new vaccination programme for rotavirus for infants
- introducing, from September 2013, a new routine shingles vaccination programme for patients aged 70.

Rotavirus (routine childhood immunisation) – commencing July 2013

Background and purpose

From July 2013, changes to the national immunisation programme will see the introduction into the childhood immunisation schedule of a vaccine to protect infants against Rotavirus.

This has been recommended by the Joint Committee on Vaccination and Immunisation (JCVI) to improve the overall level of protection against this preventable disease.

An estimated 130,000 episodes of rotavirus induced gastroenteritis occur each year in children of less than five years in England and Wales and approximately 12,700 of these children are hospitalised. Although deaths from rotavirus in the UK are rare and are difficult to quantify accurately, there are likely to be approximately three to four each year.

Introduction

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

Further details on the arrangements for this new national programme will be available shortly and this guidance will be updated to reflect the details of the national programme.

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

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

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

GPES extraction

GPES will extract data on a monthly basis relating to the number of patients on the practices registered list, who are recorded as having received a completed course of rotavirus vaccination in the relevant month.

The GPES extraction will also identify patients whose patient record indicates either no rotavirus vaccination or an incomplete rotavirus vaccination, before six months of age in the relevant financial year. An 'incomplete rotavirus vaccination count' would be considered where only one dose of the vaccine has been recorded. This may be either where only the first or second (completing) dose is recorded. A 'no rotavirus vaccination count' would be considered where either there is no record of a first or second (completing) dose recorded or where a contra-indication or declined code is recorded. This additional information will not be used for payment purposes but will support practice assessment of achievement and the scope for improvement in-year. It will also support NHS England assessments of the effectiveness of its incentives for immunisations.

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

Table 8: Rotavirus Read codes

	Read v2	Read CTV3	SNOMED CT
First rotavirus vaccination	65d0.	Xaa9n	868631000000102
Second rotavirus vaccination	65d1.	Xaa9o	868651000000109
Rotavirus vaccination contraindicated	8I2s.	Xaa9q	868691000000101
Rotavirus vaccination declined	8IEm.	Xaa9r	868711000000104
No consent to Rotavirus vaccination	68Nw.	Xaa9s	868731000000107

The GPES extraction will normally be run within 28 days following each quarter period. The first GPES extraction will run in October, capturing Q2. It will provide a non-cumulative count restarting at the beginning of each quarter i.e. Q2 will be all counts from 1 July 2013 to 30 September 2013.

Payment and validation

Payment will be on a monthly basis.

CQRS will calculate the monthly payments based on the number of patients who are recorded as having received a completed course of rotavirus vaccination. The codes being used to identify payment will be those relating to first rotavirus vaccination and

second rotavirus vaccination subject to the qualifying criteria of age and time being met.

Payment will be made based on the monthly count multiplied by £7.63:

monthly payment	=	number of patients, in the monthly count, who have been recorded as having received both the 1st and 2nd rotavirus vaccination within the qualifying age and time criteria	x	£7.63

The first GPES extraction will be run in August 2013 (providing the monthly counts for completed vaccination for July 2013) and on a monthly basis thereafter. Payments will be made by the end of the following month.

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

Shingles (routine aged 70 immunisation) – commencing September 2013

Background and purpose

Data from a number of general practice-based studies[12, 13, 14, 15] suggest that more than 50,000 cases of shingles (herpes zoster) occur in patients aged 70 or over. The severity of shingles generally increases with age and can lead to post herpetic neuraligia (PHN) and hospitalisation. Around one in 1,000 shingles cases is estimated to result in death in people aged 70 or over.

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

Introduction

The new shingles immunisation programme is being introduced from 1 September 2013 comprising a single injection to last a lifetime, offered routinely to patients who are aged 70 and the initial stages of catch-up programme for patients aged 71–79 (as at 1 September 2013) likely to commence with patients aged 79 (and any remaining vaccines supplies used to catch up patients aged 78). Vaccine for this programme will be centrally supplied through IMMSFORM.

Further details on the arrangements for this new national programme will be available shortly and this guidance will be updated to reflect the details of the national programme.

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

NHS England is responsible for commissioning the catch-up programme for patients aged 71–79 and is expected to announce plans following engagement with key

[12]Gauthier A, Breuer J, Carrington D et al 2009. Epidemiology and cost of herpes zoster and post-herpetic neuralgia in the UK. Epidemiol Infect 137(1): 38-47.
http://www.ncbi.nlm.nih.gov/sites/entrez/18466661
[13]van Hoek AJ, Gay N, Melegaro A et al 2009. Estimating the cost-effectiveness of vaccination against herpes zoster in England and Wales. Vaccine 27(9): 1454-67.
http://www.ncbi.nlm.nih.gov/sites/entrez/19135492
[14]Fleming DM. Weekly returns service of the RCGP 1999. Commun Dis Public Health 2(2): 96-100.
http://www.ncbi.nlm.nih.gov/sites/entrez/10402742
[15]McCormick A, Charlton J and Fleming D. Assessing health needs in primary care 1995. Morbidity study from general practice provides another source of information. BMJ 310(6993): 1534.
http://www.ncbi.nlm.nih.gov/sites/entrez/7787617

stakeholders shortly. This guidance will be updated as appropriate to reflect payment provisions for catch-up.

The shingles vaccination may be given at the same time as the seasonal flu jab but it must not be given at the same time as any pneumococcal vaccination. (The two vaccinations should be given at least a month apart.)

GPES extraction

GPES will extract data on a monthly basis from October 2013 relating to the number of patients on the practices registered list, who are aged 70 on 1 September 2013 and who are recorded as being vaccinated against shingles during the financial year.

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

Table 9: Shingles Read codes

	Read v2	Read CTV3	SNOMED CT
Herpes zoster vaccination	65FY.	XaZsM	859641000000109
Herpes zoster vaccination contraindicated	8I2r.	Xaa9i	868531000000103
Herpes zoster vaccination declined	8IEl.	Xaa9j	868551000000105
No consent for herpes zoster vaccination	68Nv.	Xaa9l	868601000000108

The data on number of patients extracted by GPES is known as the monthly count.

The GPES extraction will be run monthly and provide a non-cumulative count restarting at the beginning of each month i.e. the extraction for September 2013 will include all counts of rotavirus vaccination from 1 September to 30 September 2013. The first GPES extraction will be run in October 2013.

Payment and validation

Payment for shingles (routine age 70) immunisation will be calculated through CQRS on a monthly basis.

CQRS will calculate the monthly payments based on the number of patients on the practices registered list, who attain the age of 70 on 1 September 2013 and who are recorded as being vaccinated against shingles (herpes zoster) during the financial year. The code being used to identify payment will be the 'herpes zoster vaccination given' code providing the qualifying criteria of age and time are met.

Payment will be made based on the monthly count multiplied by £7.63:

monthly payment	=	number of patients, in the monthly count, who have been recording as having received the shingles vaccination within the qualifying criteria	x	£7.63

The first GPES extraction will be run in October 2013 (providing the monthly counts for completed vaccination for September 2013) and on a monthly basis thereafter. Payments will be made within the month following.

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

Section 4. New enhanced services

Introduction

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

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

The enhanced services are for:

- the identification and management of patients identified as seriously ill or at risk of emergency hospital admission
- a proactive approach to the timely assessment of patients who may be at risk of dementia
- preparatory work to support the subsequent introduction of remote care monitoring for patients
- enabling patients to utilise electronic communications for appointment booking and obtaining repeat prescriptions.

Risk profiling and care management scheme

Background and purpose

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

Introduction

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

NHS England has asked CCGs to lead responsibility for designing and managing this ES, so that such schemes are locally and clinically driven. The specification[16] sets out the minimum requirements that all local schemes will need to meet and the funding that will be available. CCGs will be required to invite and agree arrangements with practices under this enhanced service by 30 June 3013.

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

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

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

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

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

D. The practice works with the multi-disciplinary professionals, meeting at least quarterly, to achieve a shared and integrated approach to the case management of each patient to improve the quality of care and reduce their individual risk of emergency hospital admission.

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

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

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

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

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

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

Payment and validation

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

Payment will be made based on £0.74 per registered patient, which represents a payment of £5,175 for an average-sized practice (registered population of 6, 911).

CCGs will be asked to provide assurance to NHS England that either the minimum requirements of this enhanced service (or additional requirements agreed with the CCG) have been satisfied before payments under this enhanced service will be made. This assurance must be given within 28 days of the end of the financial year (i.e. April 2013).

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

Other provisions relating to this enhanced service

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

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

Facilitating timely diagnosis and support for people with dementia

Background and purpose

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

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

Introduction

The aims of this enhanced service[17] are to encourage practices to identify patients at clinical risk of dementia, offer an assessment to detect for possible signs of dementia in those at risk, offer a referral for diagnosis where dementia is suspected and support the health and wellbeing of carers of patients diagnosed with dementia.

A system-wide integrated approach is needed to enable patients with dementia and their families to receive timely diagnosis and to access appropriate treatment, care and support. National tools and levers need to be aligned to support local system-wide improvements:

- A national dementia calculator is available to support practices to understand prevalence of dementia in their registered population.
- A national Commissioning for Quality and Innovation (CQUIN) scheme for all healthcare services commissioned through the NHS Standard Contract to incentivise case finding, prompt referral on to specialist services for diagnosis and support, as well as improved dementia care in hospitals.
- Commissioning guidance for memory assessment services currently being produced by the Royal College of Physicians.

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

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

Service requirements

The requirements for this enhanced service are:

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

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

- patients aged 60 or over with cardiovascular disease, stroke, peripheral vascular disease or diabetes
- patients aged 40 or over with Down's syndrome
- other patients aged 50 or over with learning disabilities
- patients with long-term neurological conditions which have a known neurodegenerative element, for example Parkinson's disease.

These assessments will be in addition to other opportunistic investigations carried out by practices (i.e. anyone presenting raising a memory concern).

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

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

E. The assessment for dementia offered to consenting at-risk patients for whom there is concern about memory (as prompted from initial questioning) shall comprise administering a more specific test (where clinically appropriate[18]) to detect if the patient's cognitive and mental state is symptomatic of any signs of dementia, for example the General Practitioner assessment of Cognition (GPCoG) or other standardised instrument validate in primary care

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

[18] It is recognised that in some cases (i.e. for people with severe learning disabilities) such a test may not always be appropriate. Further guidance on the assessment of dementia in people with learning disabilities has been produced by the Royal College of Psychiatrists and the British Psychological Society. Dementia and People with Learning Disabilities at http://www.rcpsych.ac.uk/files/pdfversion/cr155.pdf

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

- offer a referral, where this is agreed with the patient or their carer, to specialist services such as a Memory Assessment Service or Memory Clinic for a further assessment and diagnosis of dementia
- respond to any other identified needs arising from the assessment that relate to the patient's symptoms
- provide any treatment that relates to the patient's symptoms of memory loss

H. Patients diagnosed as having dementia will be offered a care planning discussion focussing on their physical, mental health and social needs and including referral/signposting to local support services.

I. The practice will seek to identify any carer (but not including professional carers) of a person diagnosed with dementia and where that carer is registered with the practice offer a health check to address any physical and mental impacts, including signposting to any other relevant services to support their health and well-being

J. The practice should record in the patient record relevant entries including the Read Codes in table 13 to identify where an assessment for dementia was undertaken, where applicable, that a referral was made, patients diagnosed and where health check was offered or provided to a carer.

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

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

Monitoring/GPES extraction

Details on how GPES will be used will be included in an updated version of this document which will be available shortly. The intention is GPES will be set up to support this enhanced service from 1 October 2013 providing extract of the relevant information recorded by practices from 1 April 2013.

Practices will be required to provide this information either by opting in to the relevant GPES extracts or, where GPES is not supported, provide a quarterly return based on a manual report of the required patient counts within 28 days following the end of the financial year.

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

Table 10: Dementia Read codes

	Read v2	Read CTV3	SNOMED CT
To assist in identifying any patient in an at risk group			
At risk of dementia	14Od.	XaQyJ	516651000000105
To record initial questioning for memory concern (or offer)			
Initial questioning for memory concern (new codes requested for October 2013)	tbc	tbc	tbc
Initial questioning for memory concern – declined (new codes requested for October 2013)	tbc	tbc	tbc
To record an assessment (or offer) for dementia in patients with a memory concern			
Assessment for dementia	38C10	XaaBD	869561000000101
Assessment for dementia declined	tbc	tbc	tbc
To record any referral (or offer) for a diagnosis of dementia			
Referral to memory clinic	8HTY.	XaJua	415276009
Referral to memory clinic declined	8IEn.	Xaa9t	868751000000100
To record, for diagnosed patients, any identified carer and offer of a health check where the carer is registered with the practice			
Carer of person with dementia	918y.	XaZ4h	824401000000105
Carer annual health check	69DC.	XaX4N	754731000000108
Carer annual health check declined	8IEP.	XaZKp	837271000000107

Payment and validation

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

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

Component 1
An upfront payment of £0.37 per registered patient. This represents a payment of £2,587 to an average-sized practice (where average size is based on a registered population of 6,911).

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

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

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

The number of assessments carried out be practices individually and nationally will be based on returns to CQRS (automated via GPES or manual end year entry) identifying assessments offered to consenting at-risk patients using the Read code 'assessment for dementia' (see table 10).

Example of component 2 payment calculation:

If GPES reports Practice A as completing 192 assessments for dementia during 2013/14 and nationally CQRS calculates that 1,197,408[19] assessments were carried out in 2013/14, then the end year payment is calculated as follows:

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

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

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

financial year.

CQRS will support the calculation of this payment from 1 October 2013. Details on how CQRS will calculate achievement are to follow shortly.

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

Other provisions relating to this enhanced service

Full details for provisions relating to practices that terminate or withdraw from the enhanced service prior to 31 March 2014, for provisions relating to practices that merge or split and for provisions relating to non-standard mergers or splits are available in the enhanced service specification[20].

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

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

Remote care monitoring (preparation) scheme

Background and purpose

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

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

For further information and resources on the long-term conditions programme see the DH LTC workstream[21], 3 million lives programme[22] and NHS Improvement[23].

Introduction

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

Service requirements

The requirements for this enhanced service are to:

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

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

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

[21] DH. LTC workstream. http://ahp.dh.gov.uk/2012/05/01/call-for-applications-early-implementer-sites-for-the-qipp-ltc-year-of-care-funding-model/
[22] 3millionlives programme. Improving your access to telehealth and telecare. http://3millionlives.co.uk/
[23] NHS Improvement. Long-term conditions. http://www.improvement.nhs.uk/LongTermConditions.aspx

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

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

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

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

Payment and validation

The payment available under this enhanced service will be £0.21 per registered patient, which for the average-sized practice (average registered list size of 6,911) represents a payment of £1,478.

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

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

NHS England will be responsible for post-payment verification.

Other provisions relating to this enhanced service

Full details for provisions relating to practices that terminate or withdraw from the enhanced service prior to 31 March 2014, for provisions relating to practices that merge or split and for provisions relating to non-standard mergers or splits are available in the enhanced service specification[24].

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

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

Improving patient online access

Background

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

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

Introduction

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

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

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

The arrangements should include:

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

NHS England will invite practices to sign up and participate in the enhanced service by 30 June 2013. Practices may choose to participate after this date and can do so with the agreement of NHS England providing it is no later than 31 December 2013. Practice participation in this enhanced service will be recorded via CQRS which will support the calculation of payments from 1 October 2013.

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

Payment and validation

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

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

Component 1
A single annual payment of £0.14 per registered patient, which represents a payment of £985 per average-sized practice (with an average registered list of 6,911) based on satisfactory evidence of enabling and utilisation of online booking.

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

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

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

Table 11: Evidence to validate payments

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

Payment will be made by NHS England, to the practice, on the last day of the month following the month during which evidence of achievement has been confirmed (see table 11). Payments made under this enhanced service are to be treated for accounting and superannuation purposes as gross income of the practice in the financial year.

Payments made under this enhanced service, or any part thereof, will be made only if practices satisfy the conditions set out in paragraph three of the improving patient online access scheme annex[25].

CQRS will support the calculation of all payments due under this enhanced service from 1 October 2013.

Details on how CQRS will support this enhanced service will follow.

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

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

Other provisions relating to this enhanced service

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

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

Section 5. Queries process

Queries can be divided into three main categories:

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

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

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

Queries should be directed as follows:

1. Queries relating to Business Rules/coding queries should be sent to the HSCIC via enquiries@ic.nhs.uk. Where required, the HSCIC will work with other key stakeholders to respond.
2. Policy, clinical and miscellaneous queries should be sent to:
    - Primary Care Commissioning only via the helpdesk http://helpdesk.pcc-cic.nhs.uk/
    - NHS Employers for NHS England Area Teams via QOF@nhsemployers.org
    - GPC for general practice via info.gpc@bma.org.uk

NHS Employers
www.nhsemployers.org
gmscontract@nhsemployers.org

NHS England
www.england.nhs.uk

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