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Dear Chaand,

Payment for Avoiding Unplanned Admissions Enhanced Service

Following your letter of 7 December 2015 and since Ros is on annual leave and not returning until 6 January, I thought you would appreciate an interim response on this issue. You may have been aware that Ros had asked me to investigate the issue on her behalf.

We have worked with colleagues at the HSCIC and NHS Employers to investigate why some practices have failed to achieve the component two payment of the Avoiding Unplanned Admissions DES specification. We have now reached a decision on this issue and I wanted to take the time to set out the rationale for that decision.

You had suggested that the specification is ambiguous about the requirement to deliver a care plan within 2015/16 and in particular within 12 months of the payment date. Following discussions with NHS Employers and review of the 2014 agreement, we can confirm that while the agreement was for at least one care plan review each year, during the negotiation process we raised concerns that some patients would go up to two years without a care plan review, which was incompatible with the aims of the programme to provide proactive care. In addition, it was identified that in order to deliver a mid-year payment (which included credit for care planning) it would have been necessary to require all patients to receive a review in the first six months of 2015/16. This would have put additional pressure on practices. To deliver against both priorities, it was suggested and agreed that, whilst only one care plan was to be delivered, it should also require that all patients had a care plan review within 12 months of the payment dates. This ensured that patients benefited from proactive care planning within a reasonable timeframe (compatible with care plan requirements in both QOF and other enhanced services) and allowed practices to deliver a single care plan for each patient within the financial year. This would enable practices to qualify for both the mid-year (component two) and year end

(component three) payments. This approach had the added benefit of allowing practices the opportunity to spread the workload across the whole financial year. To support this approach, the CQRS specifications were amended to capture activity that was undertaken in the last six months of 2014/15. This is the first time that activity in a previous year has been allowed to count for an enhanced service. NHS Employers have confirmed that this requirement was included in the routine process for amending and approving the terms of the negotiated agreement.

However, we have reviewed the concerns raised both by you and by GP practices and the additional issues relating to the data collections and payment for the mid-year achievement. The review has highlighted that while the concerns you raised relate to a misunderstanding about the timing of care plan reviews, practices failed to achieve for a number of different reasons (and sometimes for multiple reasons). Other reasons for failure to achieve include failure to achieve the minimum percentage of patients on the register (1.8%) and failure to record that an accountable GP had been identified for the patient.

We have now reviewed the information at a national level and, following consultation with our Heads of Primary Care in regional offices, have agreed that while practices may not have delivered the terms of the specification, there was a possibility of practices misinterpreting the requirements for timing of the care planning element. In addition there were a number of changes to the specification following negotiations which might have led to further confusion around the requirements to record the provision of an accountable GP. These changes may have impacted on how practices have approached the scheme, although the core requirement for a minimum number of patients on the register remained unchanged from the previous year.

We have agreed on this basis that we can be more flexible in how we approach the AUA component two payment. We agree with you that we should reward work undertaken in good faith. I am sure that you appreciate that it has not been our intention to withhold payment where the work has been completed. We are aware that local teams may have already had discussions with LMCs on this issue, but to ensure a consistent position across England we are recommending to our teams that they review each practice's circumstances and adopt the following approach. This consistency of approach should now result in more practices being paid.

- Any practice that has achieved the minimum 1.8% but has technically 'failed' due to having insufficient updated care plans, or having failed to record allocating an accountable GP, **should receive the mid-year payment.**
- Any practice that has failed the minimum target of 1.8% **should not be paid.**
- Practices should be reminded that the requirement to allocate and record every patient an accountable GP is a core contractual requirement. Practices should therefore address this issue as a matter of urgency.

However, the full requirements of the AUA enhanced service must be delivered and appropriately recorded by the year end. Any practice that fails any of the requirements at the year end will not be paid the final amount. In addition, any of those practices that had benefited from the flexibility described above (and who received the payment this time) who do not achieve all elements by the year end will

be subject to the mid-year payment being reclaimed.

I hope that this reassures you that we are taking this matter very seriously. I hope that the actions which we have set in train will enable practices to be paid for the work they have undertaken as speedily as is practically possible.

Yours sincerely,

Deborah Jaines
Head of Primary Care Policy & Contracts
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