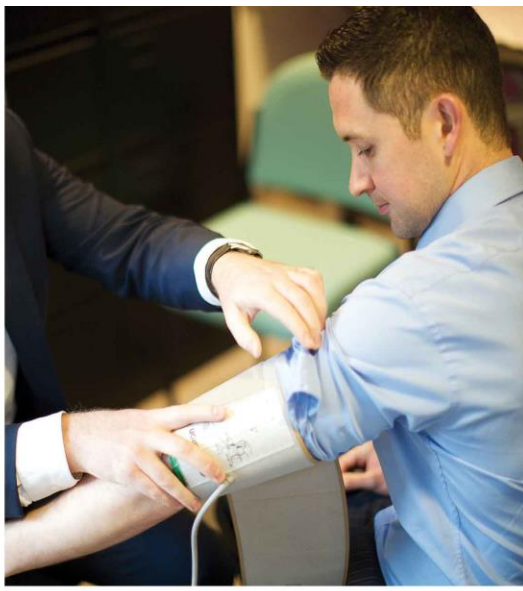
2017/18 General Medical Services (GMS) contract

Guidance for GMS contract 2017/18

August 2017



www.bma.org.uk/gpc
www.nhsemployers.org
www.england.nhs.uk
Gateway Reference 07304

Contents

Section 1: Introduction

In February 2017, NHS Employers (on behalf of NHS England) and the British Medical Association's (BMA) General Practitioners Committee England (GPC) agreed changes to the General Medical Services (GMS) contract for 2017/18.

This guidance provides information about the new contractual requirements.

Participating commissioners and practices should ensure they have read and understood the requirements in the Regulations, Directed Enhanced Services (DES) Directions and NHS England service specifications, the guidance in this document as well as the 'Technical requirements for 2017/18 GMS contract changes'[1]. This supersedes all previous guidance on these areas.

Wherever possible, NHS England seeks to minimise the reporting requirements for the services delivered by practices where these can be supported by new systems and this guidance outlines the audit requirements for the services detailed. Separate technical requirements document detailing the Read codes which practices are required to use are detailed in the 'Technical requirements document'.

This guidance is applicable in England only.

The amendments to the GMS Contract 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 (DH)[2] and NHS Employers website[3]. The detailed requirements for taking part in the enhanced services (ESs) are set out in the DES Directions or service specifications.

[1] NHS Employers. Technical requirements for 2017/18 GMS contract changes. www.nhsemployers.org/gms201718
[2] Legal documents underpinning GMS contract changes. https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013
[3] NHS Employers. Technical requirements document for 2017/18 GMS contract changes. www.nhsemployers.org/GMS201718

Section 2: New contractual arrangements for 2017/18

Data collection for indicators no longer in QOF and enhanced services

In relation to those indicators no longer in QOF (INLIQ) and retired enhanced services (ES), GPs will continue to use their professional judgement and continue to treat patients in accordance with best clinical practice guidelines.

From 1 October 2017, it will be a contractual requirement for practices to facilitate data collection on a selection of INLIQ indicators and ES's. Practices will continue to undertake relevant clinical work and code activity as clinically appropriate in relation to these indicators and ESs. A list of the data to be collected for 2017/18 is in Annex A.

Periodically, NHS England will collect anonymised data from practices' clinical systems (in relation to ES and INLIQ) which will provide statistical information, be processed for audit and publication and will help inform commissioners and practices. It is not intended for performance management purposes.

National Diabetes Audit (NDA)

The NDA is one of the largest and most comprehensive clinical audits in the world. It integrates data from both primary and secondary care sources. Using this data it aims to help improve diabetes care by enabling NHS services and organisations to:

- identify and share best practice
- identify gaps or shortfalls that are priorities for improvement
- assess local practice against NICE guidelines
- compare their care and care outcomes with similar services and organisations
- provide comprehensive national pictures of diabetes care and outcomes in England and Wales.

The NDA is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit Programme (NCA) and delivered by the NHS Digital in partnership with Diabetes UK and the National Cardiovascular Intelligence Network (part of Public Health England (PHE)). The NDA receives expert input from clinicians and people with diabetes across England and Wales.

Practice involvement in the audit is important to ensure that local services are able to benchmark their activity and review the quality of treatment and care across an area. The audit is designed to answer four questions:

- Is everyone with diabetes diagnosed and recorded on a practice diabetes register?
- What percentage of people registered with diabetes received the nine NICE key processes of diabetes care?
- What percentage of people registered with diabetes achieved NICE defined treatment targets for glucose control, blood pressure and blood cholesterol?
- For people with registered diabetes what are the rates of acute and long-term complications (disease outcomes)?

From October 2017, practices will be contractually required to allow collection of data relating to the NDA. Practices should be aware of their duties and responsibilities under the fair processing guidelines[4] and a patient's right to opt-out of data collections containing confidential personal information.

Practices will be required to code activity relating to the NDA as appropriate and allow data to be collected from their clinical systems. This data will then be fed automatically in to the wider NDA reporting process. Facilitating these automated collections will reduce practice workload associated with this clinical audit. Further detail on the Read codes, management information counts and frequency collection will be available in the 'Technical requirements document'[5] as soon as this information is available.

Further information about the audit is available on the NHS Digital website[6].

Workforce data collection

The NHS Digital General Practice Workforce Minimum Data Set is the successor to the General Practice Workforce Census. It is a practice level collection provided through the Primary Care Web Tool and Health Education England data tools, to give the detailed view of the General Practice workforce. It includes data on doctors (data published quarterly by NHS Digital) plus other practice staff (published bi-annually).

The outputs of the data collection are important to help shape policy and investment around the workforce. More recently, this data is vital to support monitoring the delivery of the commitment to an additional 5,000 doctors plus 5,000 other staff commitments made in the GP Forward View by 2020/21. Approximately 93 per cent of practices submit data through these collection tools. In order to ensure a robust data set can be collected, it is necessary to increase the returns to 100 per cent.

[4] NHS England. Fair Processing Guidelines for GPs (https://www.england.nhs.uk/ourwork/tsd/ig/ig-fair-process/fair-process-gps/)
[5] NHS Employers. Technical requirements for 2017/18 GMS contract changes. www.nhsemployers.org/gms201718
[6] NHS Digital. http://content.digital.nhs.uk/nda

To support this, practices will as from October 2017 be contractually required to submit data for the NHS Digital general practice Workforce Minimum Data Set. The contract value has been uplifted to account for the relevant staff costs to complete this.

More information is available on the NHS Digital website.

Identification and management of patients with frailty

NHS Employers and GPC have agreed a new contractual requirement to be introduced from October 2017, in relation to patients with frailty.

Practices will be required to routinely identify moderate and severe frailty in patients aged 65 years and over. Similar requirements will be made of PMS (Personal Medical Services) and APMS (Alternitive Provider Medical Services) contract holders.

The Five Year Forward View[7] notes that support for older people living with frailty, along with mental health and cancer, is one of the three areas where the NHS faces 'particular challenges'. Frailty has been described as the most problematic expression of population ageing, in part because it can be difficult to distinguish those living with frailty from those without frailty. The introduction of routine identification of frailty will help general practice address this and provide an opportunity to target and tailor appropriate care and support for older people with the greatest need. Moving from opportunistic to systematic population based identification of frailty can help reduce inequalities, improve access to care and enable the needs of individuals to be met though early, proactive targeted and appropriate interventions.

Not all older people are frail and not all people living with frailty are old. However it is important to identify older people who are living with frailty to help stratify populations by risk of future health and care use. This will ensure that health and other preventative or supportive interventions are appropriately organised and targeted.

Requirements

Practices will be required to use an appropriate frailty identification tool, for example the Electronic Frailty Index (eFI), to identify patients aged 65 and over who may be living with moderate or severe frailty.

It should be noted that the frailty tool should only be used to provide an indication of diagnosis and that clinical judgment should be used when making a final

[7] NHS England. Five year forward view. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

assessment. Clincians may want to use additional factors such as direct assessment, clinical knowledge of the patient or information available in the patient's medical record to validate the diagnosis.

For patients, identified as living with severe frailty, the diagnosis of severe frailty must be recorded in the patient's record. For those patients identified by the tool as living with moderate frailty, clinical judgement will be required to determine whether that diagnosis is appropriate. If the clinician determines that the patient has moderate frailty, the diagnosis of moderate frailty should be recorded in the patient record where clinically appropriate.

For those patients identified as living with severe frailty, practices will be required to:

- deliver a clinical review, including providing an annual medication review and where clinically appropriate discuss whether the patient has fallen in the last 12 months, and
- provide any other clinically relevant interventions, and
- explain the benefits of the enriched Summary Care Record (SCR), seeking informed patient consent to activate it. Where a patient lacks capacity to give informed consent and has not previously appointed an attorney, the clinician can make a decision in the patient's best interest to create an SCR with additional information.

Practices will code clinical interventions for this group appropriately. Data will be collected on:

- the number of patients recorded with a diagnosis of moderate frailty
- the number of patients recorded with a diagnosis of severe frailty
- the number of patients with severe frailty with a record of an annual medication review
- the number of patients with severe frailty who are recorded as having had a fall in the preceding 12 months
- the number of patients with severe frailty who provided explicit consent to activate their enriched SCR.

If the patient has reported a fall, there are a number of clinical interventions practices may wish to consider as clinically appropriate. Practices would routinely record clinical interventions, for example this could be for referrals to a falls[8] clinic. NHS England will use this information to understand the nature of the interventions made and the prevalence of frailty by degree among practice populations and nationally. This information will be used to identify patient and commissioning need to support practices in the management of frailty.

[8] Data will be collected on the number of referrals to falls clinics. This is not a contractual requirement. The data will be used by NHS England to inform need for falls clinics and improve commissioning of these services where necessary.

The data will not be used for performance management or benchmarking purposes.

NHS Employers and the BMA have produced some frequently asked questions (FAQ) signposting some further information[9].

Further information on the data collections is available in the 'Technical requirements document'[10].

Access to healthcare – change to registration process for overseas visitors accessing healthcare

The UK has a reciprocal arrangement with other European Economic Area (EEA) countries so that, when certain groups of patients from the EEA or Switzerland receive health care in the UK, their home country will reimburse the costs.

In order to support this, there is a contractual change to help to identify overseas patients with a non-UK issued European Health Insurance Card (EHIC), Provisional Replacement Certificate (PRC) or S1 form.

Overseas visitors cannot be personally charged for NHS primary medical services but patients will now be able to self-declare on registration with a GP practice if they hold a non-UK issued EHIC, PRC or S1 at the point of registration which will enable costs to be recovered in secondary care.

Requirements

From October 2017, practices are required to provide all new patients registering with them with a revised GMS1 form[11]. This revised form includes supplementary questions to help determine an overseas patient's eligibility to free NHS secondary healthcare. For those overseas patients who self-declare that they hold either a non-UK issued EHIC, PRC or a S1 form, the practice is required to manually record this information in the patient's medical record and then send a copy of the GMS form and supplementary questions to NHS Digital (for non-UK issued EHIC/PRC details) or the Department of Work and Pensions (DWP) (for S1 forms).

Patients who are 'ordinarily resident'[12] in the UK, are not expected to complete the supplementary questions. Overseas patients are not required to complete the new

[9] NHS Employers http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/GMS/Summary%20of%20requirements%20for%20frailty.pdf

[10] NHS Employers. Technical requirements for 2017/18 GMS contract changes. www.nhsemployers.org/gms201718

[11] www.nhs.uk/servicedirectories/Documents/GMS1.pdf

[12] A person will be Ordinarily Resident in the UK when their residence is lawful, adopted voluntarily and for settled purposes as part of the regular order of his or her life for the time being, whether of short or long duration.

supplementary questions of the GMS1 in order to register with the practice.

A process map to help illustrate what practices are required to do, if a patient holds a non-UK issued EHIC, PRC or S1 form, is included in Annex B, along with an example of an S1, a PRC and non-UK EHIC. Guidance for GP practice staff on EHIC, PRC and S1s can be found on the government website[13].

Practices will be sent hard copy leaflets which they can provide overseas patients with to help explain NHS Cost Recovery, including an overview of the exemption from charge categories that apply to overseas patients in secondary care, and what they should be aware of if they are referred to secondary care. Further copies of the GMS1 and the patient leaflet can be ordered from via the PCSE Portal (administered by Capita on behalf of NHS England)[14].

There have been no changes made to the GMS3 form, and practices should continue to use this form for all temporary registrations.

Sending details to NHS Digital or DWP

Where the EHIC, PRC or S1 details have been completed by the patient, the GMS1 form and supplementary questions should be scanned and sent by email to NHS Digital. The S1 form can be sent without the GMS1 to DWP. By exception, they may be sent via hard copy[15].

It is recommended that forms are scanned by the practice and sent as a scanned attachment in an e-mail, as follows:

- GMS1 forms with EHIC and PRC details to NHSDigital-EHIC@nhs.net
- The S1 details to overseas.healthcare@dwp.gsi.gov.uk

To ensure smoother processing the recommended format is:

- one email is sent for each patient
- each email should include the patient's completed GMS1 form with supplementary questions for EHIC/PRC details.
- S1 forms can be batched up and sent to DWP without the GMS1 forms.
- the patient's name should be included in the subject of the email; and
- the practice details should be included in the body of the email or as an electronic signature.

It is recommended that practices send this information to NHS Digital and DWP on a

[13] GOV: https://www.gov.uk/government/publications/help-for-nhs-to-recover-costs-of-care-from-visitors-and-migrants/information-for-nhs-staff-providing-healthcare-for-overseas-visitors-from-the-european-economic-area
[14] PCSE. https://pcse.england.nhs.uk/
[15] EHIC and PRC:By post to EHIC, PDS NBO, NHS Digital, Smedley Hydro, Trafalgar Road, Southport, Merseyside, PR8 2HH
S1: By post to Overseas Healthcare Team, Durham House, Washington, Tyne & Wear NE38 7SF

weekly basis.

Registration of people released from prisons, immigration centres or children's secure facilities

Under the GMS Regulations[16], patients must be removed from a contractors list of patients where they serve a term of imprisonment of more than two years or more than one term of imprisonment totalling, in aggregate, more than two years. Under paragraph 22 of Schedule 6 in the GMS regulations, it is also likely that people on shorter sentences, and those on remand, will register with the healthcare service in the detained estate (which is classed as an "essential service" under Regulation 15). This circumstance would also give rise to the patient being removed from the contractor's list. Following the term of imprisonment, the person being released will then need to register with a GP practice in order to receive primary medical care services.

In the past, some people being released from the detained estate (adult prisons, immigration centres, youth offending institutions, secure children's homes and secure training colleges) have had difficulty registering with a GP practice.

To help address this matter and ensure these vulnerable patients have access to timely primary care services, a contractual change has been agreed to allow people to register with a practice prior to leaving the detained estate. This change helps to ensure continuity of care and social inclusion.

Requirements

The contractural change places new duties on practices in relation to the pre-registration of people about to be released from the detained estate. It also places new duties on the detained healthcare service in support of this change.

From October 2017 contractural changes mean the process is:

- the healthcare service in the detained estate will identify with the patient a suitable practice in the community where the patient could be registered on release. The availability of registration at this practice should be checked by telephone prior to other steps being carried out
- if the preferred receiving practice's list is closed, or there are other legitimate reasons for refusing to accept the application, the practice would immediately notify the detained estate healthcare service (and confirm in writing)[17], who

[16] DH. https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013
[17] Department of Health https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013
The practice must confirm its refusal to register the patient in writing, and keep a written record of the refusal and its reason.

would either find another receiving practice, or take up the matter with the relevant commissioner. The commissioner will help with allocation of a patient when the preferred receiving practice does not accept the registration

- the detained estate healthcare service will send a pre-registration notification to the preferred receiving practice in the community (using a signed GMS1 registration form) up to one month prior to the date of release. Practices should note that release can sometimes be arranged at short notice, so the notice period may be less
- the preferred receiving practice in the community should confirm that the patient has been accepted for registration, to take effect from the date notified by the detained estate healthcare service
- on accepting a patient for pre-registration, the receiving practice would be accepting responsibility for full GMS registration of the patient from the date of release. There would be no need for the patient to attend the practice for the purposes of registration
- the detained estate healthcare service will then make arrangements for the timely transfer of clinical information to the practice, with an emphasis on medication history and substance misuse management plans, to enable better care when the patient first presents at the practice.

All healthcare services in the detained estate are directly commissioned by NHS England, for the provision of primary care (including pharmacy), mental health, substance misuse, public health and dental services. Healthcare providers also make referrals to mainstream secondary and tertiary care. It is expected that healthcare providers in the detained estate will be able to transfer a patient's clinical records on their release, using the GP2GP spine enabled service from 2018.

Section 3: 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[18]
3. those where scenarios have arisen which were not anticipated in developing guidance.

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

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

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

1. Queries relating to Business Rules 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 Employers for commissioners via:

   - GMScontract@nhsemployers.org
   - QOF@nhsemployers.org
   - VandI@nhsemployers.org

   GPC for general practice via:

   - info.gpc@bma.org.uk

   NHS England via:

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

[18] NHS Digital. http://content.digital.nhs.uk/qofesextractspecs


Query
Have you checked if the following documents address your query:
1. Guidance and/or FAQs
2. Business Rules
3. Statement of financial entitlement and/or Regulations?
Payment queries
Practices to commissioners in the first instance
Guidance and clinical queries to
gms@nhsemployers.org
Business Rules and Read code queries to
enquiries@NHSDigital.gov.uk
Practices queries to GPC via
info.gpc@bma.org.uk
CQRS
https://digital.nhs.uk/article/196/Systems-and-services
GPES
https://digital.nhs.uk/article/196/Systems-and-services
NHS DIGITAL liaise with NHS England, NHS Employers and GPC to agree responses where appropriate

Section 4: Annexes

Annex A – Data collection for INLIQ and retired enhanced services

INLIQ

The table below summarises the retired indicators which will be collected in 2017/18.

Indicator ID	Indicator Description
Clinical domain	
CHD003	The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
CKD002	The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less
CKD004	The percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 12 months
NM84	The percentage of patients on the CKD register with hypertension and proteinuria who are currently treated with renin-angiotensin system antagonists
DEP001	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a bio-psychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded
DM005	The percentage of patients with diabetes, on the register, who have a record of an albumin:creatinine ratio test in the preceding 12 months.
DM011	The percentage of patients with diabetes, on the register, who have a record of retinal screening in the preceding 12 months
DM016	The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months
EP002	The percentage of patients aged 18 or over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 12 months
EP003	The percentage of women aged 18 or over and who have not attained the age of 55 who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 12 months
HYP003	The percentage of patients aged 79 or under with hypertension in whom the last blood pressure reading (measured in the preceding 9 months) is 140/90 mmHg or less
HYP004	The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 in whom there is an assessment of physical activity, using GPPAQ, in the preceding 12 months
HYP005	The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 who score ‘less than active’ on GPPAQ in the preceding 12 months, who also have a record of a brief intervention in the preceding 12

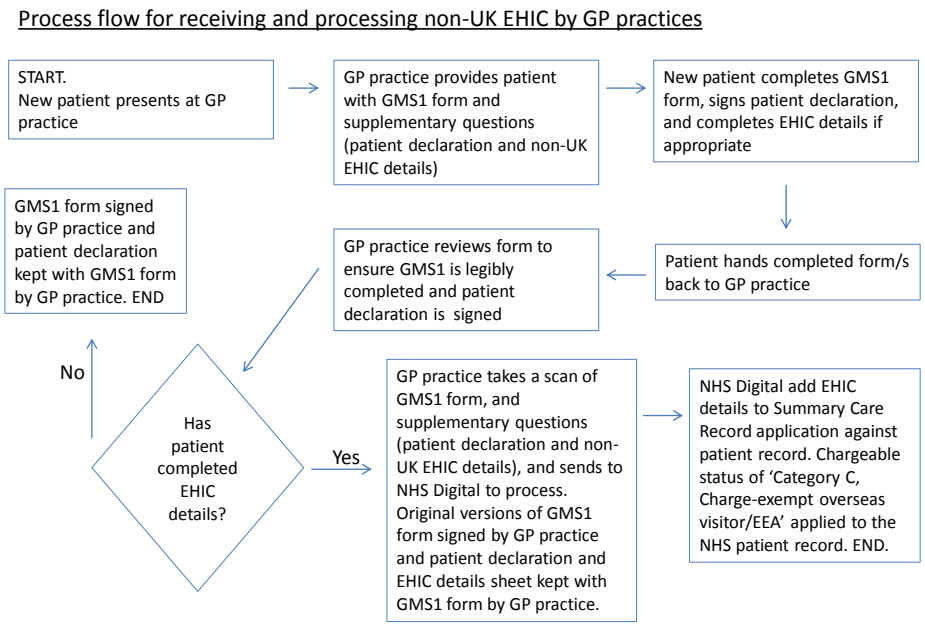
	months
LD002	The percentage of patients on the learning disability register with Down's Syndrome aged 18 or over who have a record of blood TSH in the preceding 12 months (excluding those who are on the thyroid disease register)
MH004	The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 12 months
MH005	The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months
MH006	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months
PAD003	The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
RA003	The percentage of patients with rheumatoid arthritis aged 30 or over and who have not attained the age of 85 who have had a cardiovascular risk assessment using a CVD risk assessment tool adjusted for RA in the preceding 12 months
RA004	The percentage of patients aged 50 or over and who have not attained the age of 91 with rheumatoid arthritis who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the preceding 24 months
STIA004	The percentage of patients with stroke or TIA who have a record of total cholesterol in the preceding 12 months
STIA005	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less
THY001	The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine
THY002	The percentage of patients with hypothyroidism, on the register, with thyroid function tests recorded in the preceding 12 months
Public health domain	
CVD-PP002	The percentage of patients diagnosed with hypertension (diagnosed after on or after 1 April 2009) who are given lifestyle advice in the preceding 12 months for: smoking cessation, safe alcohol consumption and healthy diet
CON002	The percentage of women, on the register, prescribed an oral or patch contraceptive method in the preceding 12 months who have also received information from the contractor about long acting reversible methods of contraception in the preceding 12 months
SMOK001	The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months

Retired enhanced services

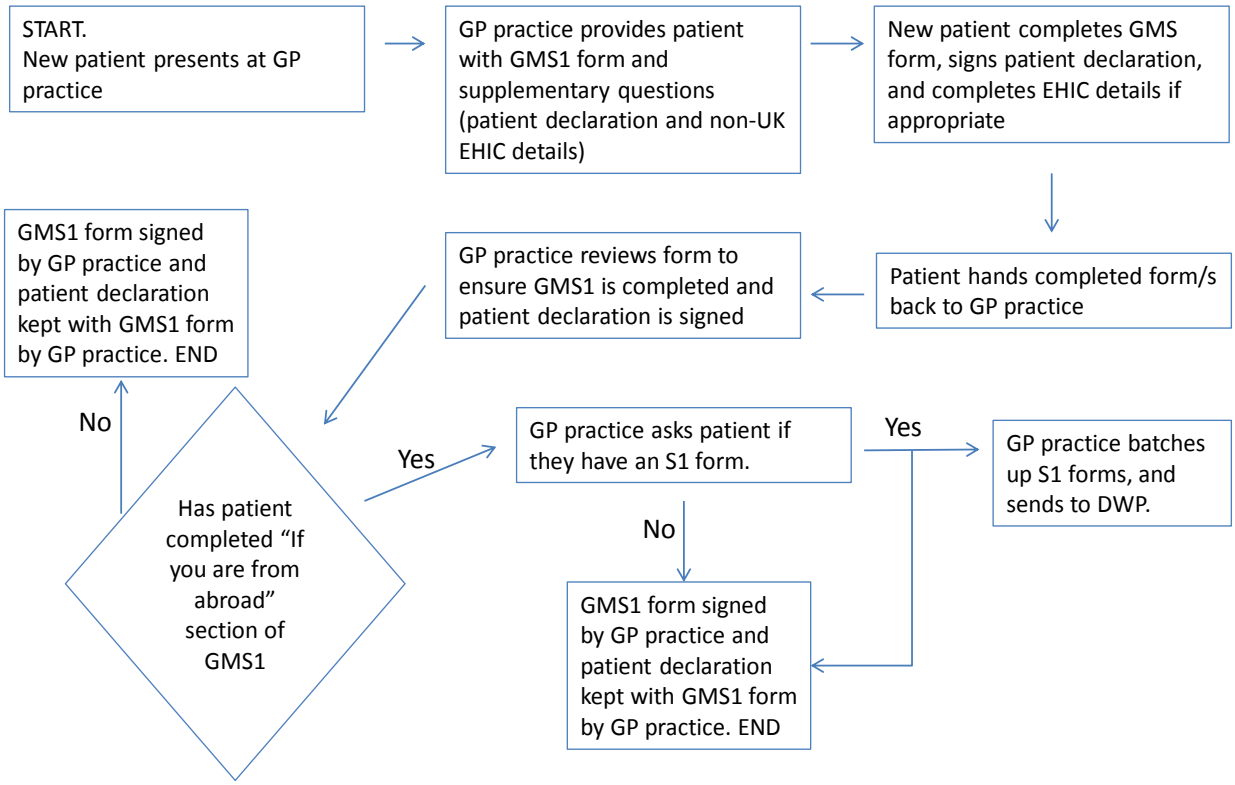
Data on the following retired enhanced services will be collected in 2017/18:

Alcohol related risk-reduction scheme
Dementia.

Annex B – Process maps for registration of overseas visitors with non-UK issued EHIC, PRC or S1 forms



Process flow for receiving and processing an S1 by GP practices



How to recognise a European Health Insurance Card (EHIC)

The cards can be easily recognised. The front of the card looks the same and carries the same information, although in different languages, in each country. The back of the card can vary from country to country.

Sample provisional replacement certificate

CERTIFICATE
PROVISIONALLY REPLACING THE
EUROPEAN HEALTH INSURANCE CARD

as defined in Annex 2 to Decision n° 190 of 18 June 2003
concerning the technical specifications of the European Health Insurance Card

Form identifier

1. E-□□□□

Issuing Member State

2. □□

Card holder related information

3. Name: □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□
4. Given Names: □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□
5. Date of birth: □□/□□/□□□□
6. Personal identification number: □□□□□□□□□□□□□□□□□□□□

Competent institution related information

7. Identification number of the institution: □□□□□□□□□□□□□□□□□□□□□□□□□□□□

Card related information

8. Identification number of the card: □□□□□□□□□□□□□□□□□□□□
9. Expiry date: □□/□□/□□□□

Certificate validity period

a) From: □□/□□/□□□□
b) To: □□/□□/□□□□

Certificate delivery date

c) □□/□□/□□□□

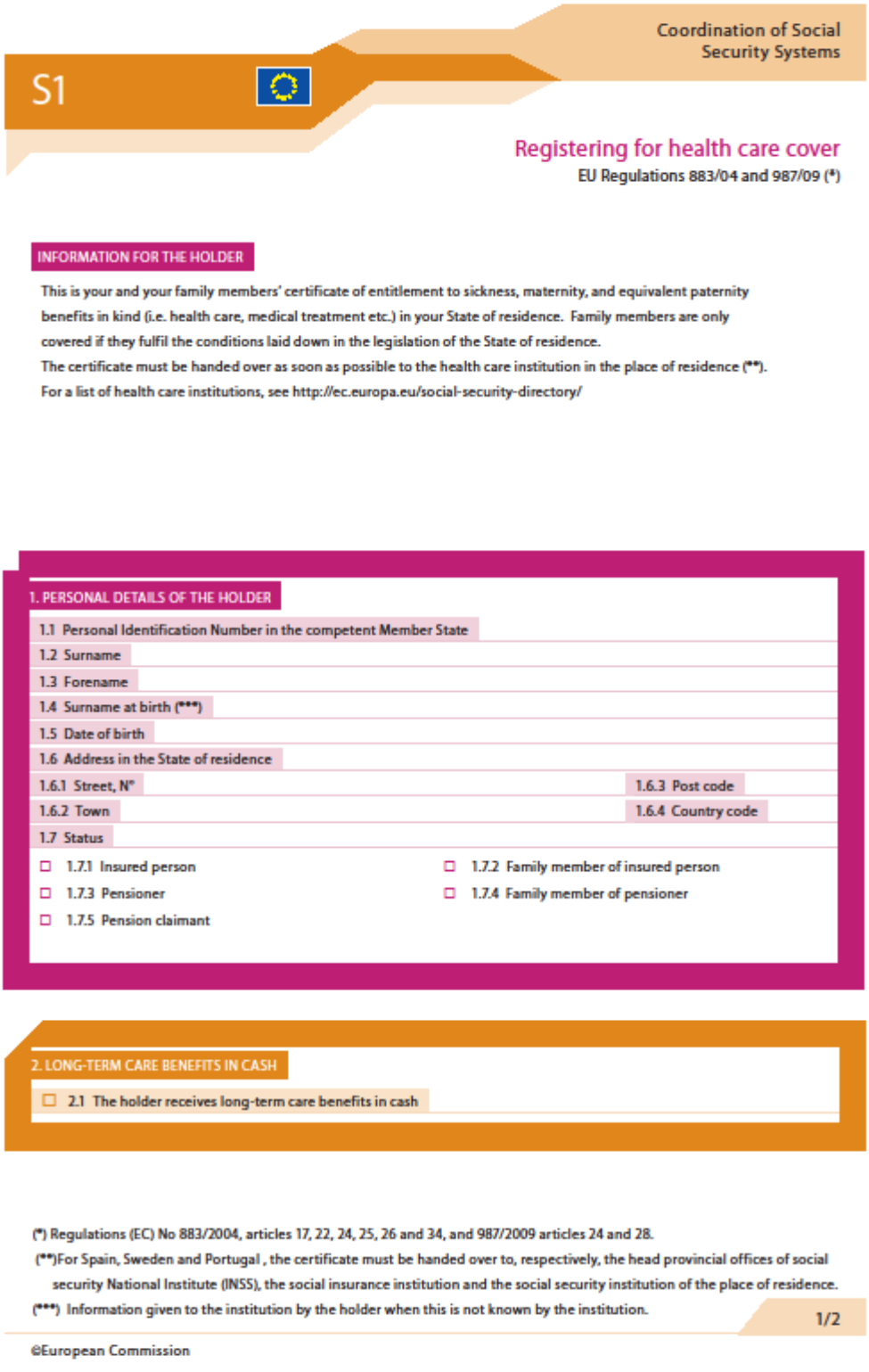
Signature and stamp of the institution

d)

Notes and information

All norms applicable to the eye-readable data included in the European card and related to the description, values, length and remarks of the data fields, are applicable to the certificate.

Sample S1 form



S1

Coordination of Social Security Systems

Registering for health care cover

EU Regulations 883/04 and 987/09 (*)

INFORMATION FOR THE HOLDER

This is your and your family members' certificate of entitlement to sickness, maternity, and equivalent paternity benefits in kind (i.e. health care, medical treatment etc.) in your State of residence. Family members are only covered if they fulfil the conditions laid down in the legislation of the State of residence.

The certificate must be handed over as soon as possible to the health care institution in the place of residence (**).

For a list of health care institutions, see http://ec.europa.eu/social-security-directory/

1. PERSONAL DETAILS OF THE HOLDER

1.1 Personal Identification Number in the competent Member State

1.2 Surname

1.3 Forename

1.4 Surname at birth (***)

1.5 Date of birth

1.6 Address in the State of residence

1.6.1 Street, N°

1.6.3 Post code

1.6.2 Town

1.6.4 Country code

1.7 Status

☐ 1.7.1 Insured person

☐ 1.7.2 Family member of insured person

☐ 1.7.3 Pensioner

☐ 1.7.4 Family member of pensioner

☐ 1.7.5 Pension claimant

2. LONG-TERM CARE BENEFITS IN CASH

☐ 2.1 The holder receives long-term care benefits in cash

(*) Regulations (EC) No 883/2004, articles 17, 22, 24, 25, 26 and 34, and 987/2009 articles 24 and 28.

(**)For Spain, Sweden and Portugal , the certificate must be handed over to, respectively, the head provincial offices of social security National Institute (INSS), the social insurance institution and the social security institution of the place of residence.

(***) Information given to the institution by the holder when this is not known by the institution.

1/2

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

NHS Employers
www.nhsemployers.org

NHS England
www.england.nhs.uk