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To:

- All GP practices in England
- Primary Care Network Clinical Directors

Cc:

- CCG Clinical Leads and Accountable Officers
- Regional Directors of Commissioning
- Regional Directors of Primary Care and Public Health
- Regional Heads of Primary Care

21 January 2021

Supporting General Practice in 2021/22

Dear colleagues

1. Thank you for all that you and your teams have done, and are continuing to do, for your patients and communities over the last incredibly difficult year. This year is like no other and it is not yet clear when the pandemic will end, with general practice:

(i) rising to the most important task in its history – rapidly **administering the COVID vaccination programme to priority groups**;

(ii) **responding to the pandemic**, which continues to call on practices to adapt, remaining fully and safely open, in order to offer accessible healthcare to all, with a particular focus on inequalities;

(iii) facing a **backlog of care,** e.g. QOF reviews for people with chronic conditions, **with the added burden of additional population ill-health,** e.g. long COVID, the extent of which is not yet fully known; and

(iv) needing to **support the workforce** who have worked incredibly hard for many months.

2. NHS England and the BMA GPC England have agreed that too much remains unclear to confirm contractual arrangements for the whole of 2021/22. But we can offer some reassurance and certainty now.

3. The *Update to the GP contract agreement* in February 2020 guaranteed that the available funding for the PCN Additional Roles Reimbursement Scheme (ARRS)

would increase from a maximum of £430m in 2020/21 to a maximum of £746m in 2021/22.

4. This was intended to support the introduction of new PCN services from April. **We reconfirm the increase in ARRS funding from April as promised, but the additional four services will <u>not</u> be introduced at the beginning of the year from April 2021, given reprioritisation necessitated by the pandemic.**

5. The NHS needs every GP it can attract. Last year's *Update to the GP contract agreement* confirmed additional multi-year Government funding, in line with its published manifesto costings, for a programme of **GP recruitment and retention initiatives and we will promote their fullest possible uptake during 2021/22**.

6. To support the pandemic response and the COVID vaccination programme, NHS England is currently committing an additional £30m/month for capacity expansion for the last five months of 2020/21 and 100% funding support for PCN Clinical Directors for the last quarter (£10m/month) where PCNs are participating in the vaccination programme. The potential need for some continued **COVID funding** in the first months of 2021/22 will be kept under review.

7. **To provide practice stability and support recovery, QOF for 2021/22 will be based upon the indicator set already agreed for 2020/21, with very limited changes only.** The one main exception is vaccinations and immunisations, where we previously committed to improving payment arrangements for vaccinations and immunisations by **replacing the Childhood Immunisation DES with item of service payments, and a new vaccination and immunisation domain within QOF**. Four indicators have been agreed to comprise the new vaccination and immunisation domain, transferring almost £60m from the DES to QOF in 2021/22. This reform to the contract does not generate new workload but provides clearer support for the delivery of vaccinations and immunisations.

8. **The pandemic has required a rethink to the timetable for introducing new QI modules. No new modules will be introduced in 2021/22**. The Quality Improvement modules on Learning Disabilities and Supporting Early Cancer Diagnosis are subject to income protection arrangements for 2020/21. These modules are too important not to be completed in full. They will be repeated for 2021/22 in their original format, with some slight modifications to account for the impact of the pandemic upon care.

9. COVID has cast a harsh light on the inequalities in our society. The life expectancy of people with a serious mental illness (SMI) is 15-20 years lower than the general population. NHS England will **invest a further £24m into QOF from April in order to strengthen the SMI physical health check indicator set and support uptake**. Minor changes have been made to the cancer care domain, and also to specific existing indicators for asthma and heart failure diagnostics.

10. **The ARRS will continue to expand and be more flexible**. From April 2021 further ARRS roles will be added: (i) paramedics, as planned; (ii) advanced practitioners; and (iii) mental health practitioners, in a way that supports improved working with local mental health services.

11. **A joint funding model will bring together additional community mental health service funding with PCN funding**. From April 2021, every PCN will become entitled to a fully embedded FTE mental health practitioner, employed and provided by the PCN's local provider of community mental health services, as locally agreed. 50% of the funding will be provided from the mental health provider, and 50% by the PCN (reimbursable via the ARRS), with the practitioner wholly deployed to the PCN. This entitlement will increase to 2 WTE in 2022/23 and 3 WTE by 2023/24, subject to a positive review of implementation. For PCNs with more than 100,000 patients the entitlements are double. Staff funded in this way will be additional to those mental health practitioners and co-located IAPT practitioners already embedded within general practice. The new obligation on mental health providers will be confirmed in the final version of the NHS Standard Contract.

12. PCNs in London have faced an additional recruitment challenge in not being able to offer the same **inner and outer London weighting** that is available to other NHS staff in London. NHS London may now offer this on top of maximum current ARRS reimbursement amounts. For 2021/22, this will be reinforced through the Network Contract DES. This will not mean an increase to ARRS funding for London (but offers more flexibility in its use) nor a reduction in ARRS allocations outside London.

13. There will be a further opportunity, from 1 April 2021 to 30 September 2021, for clinical pharmacists that remain on the Clinical Pharmacist in General Practice scheme to transfer to PCNs and be reimbursed under the ARRS, as per previous transfer arrangements. Limits on the number of pharmacy technicians and physiotherapists which can be reimbursed will be removed.

14. **We encourage all PCNs to make full use of their ARRS entitlements as soon as possible**. PCNs are a platform for general practice investment. The extent to which they deploy that investment is a measure of their success.

15. The *Update to the GP contract* guaranteed that **at least £30m of the £150m IIF funding in 2021/22 will incentivise improvements in access for patients**. Beyond this commitment, it would be premature to decide now how exactly the IIF will expand beyond the initial indicator set. In light of the ongoing pandemic, there will be a **more phased approach to the introduction of new IIF indicators for 2021/22**, just as new PCN service requirements will also be phased. Indicators on seasonal flu vaccination (including for over 65s, patients aged 18-64 in a clinical at-risk group, and children aged 2-3 years), annual Learning Disability Health Checks and Health Action Plans, and social prescribing referrals will continue for 2021/22.

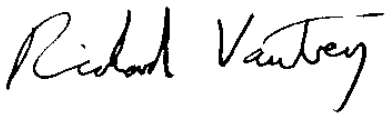
Details of the points and thresholds associated with these indicators will be communicated prior to 1 April.

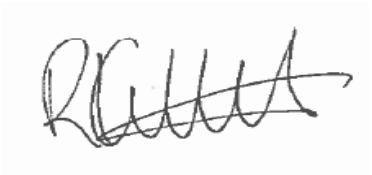
16. Extended access services have been used to support the general practice pandemic response, including the delivery of the COVID vaccination programme. The transfer of funding for the CCG commissioned Extended Access Service will now take place in April 2022. A nationally consistent enhanced access service specification will be developed by summer 2021, with the revised requirements and associated funding going live nationally from April 2022. Commissioners are strongly encouraged to make local arrangements for a transition of services and funding to PCNs before April 2022, where this has been agreed with the PCN, and the PCN can demonstrate its readiness. This has already happened in many parts of England.

17. NHS England and the BMA's GPC England have also agreed to discuss, in early 2021/22, the introduction of an enhanced service on obesity and weight management with a view to introducing this as early as circumstances allow during 2021. This will be supported by additional funding from the Government.

The additional arrangements for 2021/22 will be developed and communicated as soon as the response to pandemic allows, providing as much notice to practices as possible.

Yours sincerely





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Annex A – new QOF indicators for 2021/22

Table 1 - New vaccination and immunisation domain

Indicator ID	**Indicator wording**	**Points**	**Payment thresholds**	**Points at lower threshold**
NM197 (adapted)	The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months.	18	90-95%	3
NM198	The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months	18	90-95%	7
NM199	The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years.	18	87-95%	7
NM201	The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years.	10	50-60%	0

Table 2 – Agreed serious mental health and cancer QOF indicators, points and thresholds

Clinical area	Indicator ID	Indicator wording	Points	Thresholds
SMI	MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	4	50-90%
	NEW	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight) or preceding 24 months for all other patients	8	50-90%
	NEW	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	8	50-90%

Cancer	NEW	The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and informed of the support available from primary care, within 3 months of diagnosis.	2	70-90%
	CAN003	The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template within 12 months of diagnosis.	6	50-90%

Annex B – Expanding the Additional Roles Reimbursement Scheme – new roles requirements

Paramedic role requirements

Reimbursement level: Indicative Agenda for Change Band 7

Description of role

Paramedic practitioners work independently within their scope of practice in the community, using their enhanced clinical assessment and treatment skills, to assess and manage patients presenting with acute presentations which include minor illness or injury, abdominal pains, chest pains and headaches.

Training requirements

1. Where a PCN engages a paramedic to work in primary care under the Additional Roles Reimbursement Scheme, the PCN must ensure that the paramedic:

    a. is educated to degree/diploma level in Paramedicine or equivalent experience

    b. is registered with the Health and Care Professions Council (HCPC)

    c. has completed their two-year 'Consolidation of Learning' period as a "newly qualified paramedic"

    d. has a further three years' experience as a band 6 (or equivalent) paramedic

    e. is working towards developing Level 7 capability in paramedic areas of practice and, within six months of the commencement of reimbursement for that individual (or a longer time period as agreed with the commissioner), has completed and been signed off formally within the clinical pillar competencies of the Advanced Clinical Practice Framework.

Integrated working

2. Where a PCN employs a paramedic to work in primary care under the Additional Roles Reimbursement Scheme, if the paramedic cannot demonstrate working at Level 7 capability in paramedic areas of practice or equivalent (such as advanced assessment diagnosis and treatment) the PCN must ensure that each paramedic is working as part of a rotational model with an Ambulance Trust, in which they have access to regular supervision and support from clinicians signed off at clinical practice level 7.

Clinical responsibilities

3. The PCN must ensure that each paramedic has the following key responsibilities:

a. They will work as part of a multi-disciplinary team (MDT) within the PCN.

b. They will assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team.

c. They will advise patients on general healthcare and promote self-management where appropriate, including signposting patients to the PCN's social prescribing service, and where appropriate, other community or voluntary services.

d. They will be able to:
   - perform specialist health checks and reviews within their scope of practice and in line with local and national guidance
   - perform and interpret ECGs
   - perform investigatory procedures as required, and
   - undertake the collection of pathological specimens including intravenous blood samples, swabs, and other samples within their scope of practice, and within line of local and national guidance.

e. They will support the delivery of 'anticipatory care plans' and lead certain services (e.g. monitoring blood pressure and diabetes risk of elderly patients).

f. They will provide an alternative model to urgent and same day GP home visit for the network.

g. They will communicate at all levels across organisations ensuring that an effective, person-centred service is delivered.

h. They will communicate proactively and effectively with all colleagues across the multi-disciplinary team, attending and contributing to meetings as required.

i. They will maintain accurate and contemporaneous health records appropriate to the consultation, ensuring accurate completion of all necessary documentation associated with patient health care and registration with the practice.

j. Communicate effectively with patients, and where appropriate family members and their carers, where applicable, complex and sensitive information regarding their physical health needs, results, findings, and treatment choices.

Advanced Practitioner: additional role requirements

Reimbursement level: Indicative Agenda for Change Band 8A

Description of role

An advanced practitioner reimbursement tier may apply to the following PCN roles: Clinical Pharmacist; Physiotherapist; Occupational Therapist; Dietician; Podiatrist; and Paramedic. To be reimbursable at band 8a, this role needs to have the following additional minimum training requirements, plus these extra responsibilities.

The number of advanced practitioners will initially be limited to 1 WTE per PCN under or at 99,999 registered population; and 2 WTE for PCNs larger than that, until the HEE advanced practitioner registration process has been established and implemented (expected by October 2021).

Training requirements

1. The PCN must ensure that the practitioner both:

    a. is educated to master's degree level in relevant area of expertise; and

    b. has the capabilities of advanced clinical practice set out in section one of the *Multi-professional Framework for Advanced Clinical Practice in England*.

Clinical responsibilities

2. The PCN must ensure that each band 8a advanced practitioner has the following additional responsibilities:

    a. They will assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team.

    b. They will be able to manage undifferentiated undiagnosed condition and identify red flags and underlying serious pathology and take appropriate action.

    c. They will use complex decision making to inform the diagnosis, investigation, complete management of episodes of care within a broad scope of practice.

    d. They will actively take a personalised care approach and population centred care approach to enable shared decision making with the presenting person.

    e. They will have completed the relevant training in order to provide multi-professional clinical practice and CPD supervision to other roles within primary care, for example first contact practitioners and the personalised care roles.

Mental Health Practitioner overview and requirements

Reimbursement level: Indicative Agenda for Change Band 5 / 6 / 7 / 8a (depending on the individual registered clinician providing the service). The maximum reimbursement rates will be set at 50% of the standard levels, reflecting the 50% PCN contribution to the salary and employer NI/pension costs of the individual(s) delivering the service.

Deployment arrangements

The mental health practitioner role will be employed and provided under a local service agreement by the PCN's local provider of community mental health services, and embedded within the PCN. PCNs will be entitled to a service equivalent to one FTE practitioner for PCNs under or at 99,999 registered population; and two for PCNs larger than that. PCNs will contribute 50% of the salary and employers NI/pension costs associated with the individual(s) delivering the service. The remaining costs will be covered by the mental health provider.

The final NHS Standard Contract will include obligations on all community mental health providers to provide the mental health practitioner role on this basis. If needed, the CCG will broker agreement between the PCN and community mental health provider on the detail of deployment arrangements.

In addition to the adult and older adults' role, PCNs may also choose to embed a children and young people practitioner with the agreement of the mental health provider. This would be funded on the same joint basis.

Requirements

1. The mental health practitioner may be any registered clinical role operating at Agenda for Change Band 5 or above including, but not limited to, a Community Psychiatric Nurse, Clinical Psychologist, Mental Health Occupational Therapist or other clinical registered role, as agreed between the PCN and community mental health service provider.

2. The mental health practitioner will:

    - provide a combined consultation, advice, triage and liaison function, supported by the local community mental health provider;

    - work with patients to:
        a. support shared decision-making about self-management;
        b. facilitate onward access to treatment services;
        c. provide brief psychological interventions, where qualified to do so and where appropriate.

    - work closely with other PCN-based roles to help address the potential range of biopsychosocial needs of patients with mental health problems. This will include the PCN's MDT, including, for example, PCN clinical

pharmacists for medication reviews, and social prescribing link workers for access to community-based support.

- operate without the need for formal referral from GPs, including accepting some direct bookings where appropriate, subject to agreement on volumes and the mechanism of booking between the PCN and the provider.

- be supported through the local community mental health services provider by robust clinical governance structures to maintain quality and safety, including supervision where appropriate.

Annex C: other changes agreed for 2021/22

1. NHS England and GPC England remain committed to reviewing and agreeing changes to the terms and conditions of practice staff within existing resources, as set out in the *Update to the GP contract agreement*, during 2021/22. In the interim we will:

- undertake a data collection survey in general practice to get an accurate baseline of current terms and conditions of practice staff, in order to inform the development of good practice guidance on employment terms and conditions;

- explore how general practice gender pay gap information can be made more transparent in a way which respects individual privacy and does not result in undue additional burdens upon practices, with a view to agreement and implementation during 2021/22.

2. We confirm the definition of the core digital offer which all practices must provide to patients, including the offer and use of video and online consultations, ability to do online prescriptions, and online appointment booking. This is already the norm in the vast majority of practices. This is as follows:

- Practices offering online consultations that can be used by patients, carers and by practice staff on a patient's behalf, to gather submitted structured information and to support triage, enabling the practice to allocate patients to the right service for their needs
- The ability to hold a video consultation between patients, carers and clinicians
- Two-way secure written communication between patients, carers and practices
- An up to date accessible online presence, such as a website, that, amongst other key information, links to online consultation system and other online services prominently
- Signposting to a validated symptom checker and self-care health information (e.g. nhs.uk) via the practice's online presence and other communications
- Shared record access, including patients being able to add to their record
- Request and management of prescriptions online
- Online appointment booking

For online consultations and video consultations, practices will need to not only install online and video consultation tools but also use them ordinarily. Practices will be enabled with the tools and functionality, as part of CCG infrastructure responsibilities.

3. We will extend the arrangement from April 2021 that those practices which have implemented and operate a 'total-triage' / 'triage-first' model do not have to meet the 25% online booking contract requirement.

4. Practices will provide the functionality for patients to use an online method to inform their practice of a change of address, contact details or of their demographic information, including ethnicity.

5. The cervical screening additional service will become an essential service.

6. The removal of the requirement for patient consent in use of eRD made under the pandemic regulations will become a permanent change.

7. A contractual requirement for a more timely transfer of patient records when patients move between practices will be introduced.

8. Changes will clarify that digital services are allowed to be delivered by contractors through locations other than practice premises, in line with current practice.

9. Minor updates will be made to the existing Structured Medication Review and Early Cancer Diagnosis services within the Network Contract DES from April 2021.