

Update to the GP contract agreement 2020/21 - 2023/24

6 February 2020



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Introduction and summary

This agreement document updates and enhances the existing five-year GP contract agreement *Investment and Evolution*¹, which stands unless otherwise amended in this update document.

Jointly developed by the British Medical Association (BMA) General Practitioners Committee England (GPC) and NHS England and NHS Improvement, the revised deal has been confirmed by Government.

Enhancing the Additional Roles Reimbursement Scheme

1. More roles are now added to the Scheme from April 2020, at the request of Primary Care Network (PCN) Clinical Directors. PCNs can now choose to recruit from the following roles within the Scheme, in addition to those previously agreed, to make up the workforce they need: pharmacy technicians, care co-ordinators, health coaches, dietitians, podiatrists and occupational therapists. Mental health professionals will be added from April 2021 following current pilots. Some further flexibility is included in the operation of the 'additionality' rules.
2. 6,000 extra staff are funded by Government, through additional investment – committed in the Government's election manifesto – for NHS England and NHS Improvement of £150m/£300m/£300m/£300m between 2020/21 and 2023/24, expanding the Scheme to 26,000. Reimbursement now increases from the current 70% to 100% for all 26,000 roles. Essential for achieving the 26,000 target, the move to 100% reimbursement frees up the existing £1.50/head to contribute to management support for PCNs. Funding entitlements increase from £257m to £430m in 2020/21 and, in 2023/24, from £891m to £1,412m.
3. For the average PCN in 2020/21², that means around 7 Full Time Equivalent (FTE) staff, through an average reimbursement pot of £344,000. This rises to 20 FTE staff and an average reimbursement pot of £1.13 million in 2023/24. A ready reckoner will be published on the NHS England and NHS Improvement website. Assurances made under this deal mean PCNs can recruit fully, without worry about the theoretical risk of future employment liability and redundancy costs. PCNs are encouraged to take immediate action to recruit, with additional support from their Clinical Commissioning Group (CCG), e.g. through collective/batch recruitment exercises, supporting joint or rotational roles with

¹ NHS England and the BMA (2019) Investment and evolution: a five year framework for GP contract reform to deliver the NHS Long Term Plan. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

² For the purposes of this document, references to the 'average' or 'typical' PCN have been derived by taking national funding entitlements (and associated potential workforce roles) and dividing by 1,250 PCNs. The figures for an individual PCN will vary, depending on its size and population characteristics.

other community providers. Adding 26,000 extra staff in the PCN additional roles scheme now becomes a first order priority for the whole NHS.

More doctors working in general practice

4. The Government is conducting an urgent review of pensions to seek to solve the taper problem. Extra Government investment funds new GP training recruitment and retention measures. GP trainee numbers increase from 3,500 to 4,000 a year from 2021. 24 months of the 36 month training period will be spent in general practice, from 2022. Together with the increase in trainees, this change will contribute over half of the 6,000 extra doctors working in general practice. The Targeted Enhanced Recruitment Scheme (TERs) will be expanded: from 276 places now, to 500 in 2021, and 800 in 2022, encouraging GP trainees to work in under-doctored areas.
5. A two-year *Fellowship in General Practice* will now be offered as a guaranteed right to all GP trainees on completion of their training. It will automatically be offered as part of signing up to GP training. Our shared goal is to achieve as close to 100% participation as possible. The Fellowship programme will also be extended to newly qualified nurses. A new national *Mentors Scheme* will offer highly experienced GPs the opportunity to mentor GPs, in return for a minimum time commitment. To boost the GP partnership model, from April 2020, the *New to Partnership Payment* guarantees first-time partners a £20,000 one off payment, plus £3,000 funding for business training. The *Induction and Refresher Scheme* will be expanded and enhanced to provide more support to GPs returning to general practice, including those with childcare or other caring responsibilities. A new *Locum Support Scheme* will provide greater support to locum GPs, in return for a minimum time contribution. Enhanced shared parental leave is introduced. A core offer for staff has been developed to support good employment practices.

Releasing time to care

6. The Government is committed to reviewing Cross-Government Bureaucracy in General Practice. NHS England and NHS Improvement will develop complementary proposals to reduce administrative burdens. The digitisation of Lloyd George records starts in 2020.

Improving access for patients

7. More people working in general practice will help achieve 50 million more appointments in general practice. An improved appointments dataset will be introduced in 2020, alongside a new, as close to real-time as possible, measure of patient experience. At least £30m of the £150m PCN Investment and Impact Fund in 2021/22 will support improved access for patients, rising to at least £100m of the £300m Fund in 2023/24. A new GP Access Improvement

Programme will identify and spread proven methods of improving access including cutting waiting times for routine appointments. Every PCN and practice will be offering a core digital service offer to all its patients from April 2021.

Reforming payment arrangements for vaccinations and immunisations

8. The findings of the vaccinations and immunisations review will be implemented over the next two years³. The payment model will be overhauled to support improved vaccination coverage. Vaccinations and immunisations will become an essential service in 2020. New contractual core standards will be introduced. Item of service payments will be introduced and standardised across all routine programmes over the next two years. This will begin with Measles Mumps and Rubella (MMR) in 2020/21 and extend to other vaccines from April 2021. New incentive payments will be introduced to maximise population coverage as part of QOF, replacing the current Childhood Immunisation Directed Enhanced Service (DES).

Updating the Quality and Outcomes Framework

9. The asthma, Chronic Obstructive Pulmonary Disease (COPD) and heart failure domains have been overhauled, with 97 points recycled into 11 more clinically appropriate indicators. £10m of additional funding will support a new indicator on non-diabetic hyperglycaemia worth 18 points. This brings the total number of available QOF points to 567. In 2020/21, the quality improvement modules are Learning Disabilities and Supporting Early Cancer Diagnosis.
10. Maternity medical services become an essential service with a universal 6-8 week post-natal check for new mothers, backed by £12m of additional funding. From 2020/21, we will also introduce a new non-contractual requirement for GPs to offer to refer people with obesity into weight management services, where this is clinically appropriate and where commissioned services exist.

Delivering PCN service specifications

11. The Structured Medication Review and Medicines Optimisation, Enhanced Health in Care Homes and Supporting Early Cancer Diagnosis service specifications have now been significantly improved in the light of consultation responses. Agreed by GPC England and NHS England and included in chapter 7, they will be introduced in 2020/21. Delivery of Structured Medication Reviews is linked to available pharmacist capacity. Medical input into the care homes service is specified as needing to be appropriate and consistent. In recognition

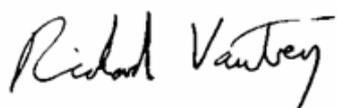
³ NHS England and NHS Improvement (2019) Interim findings of the Vaccinations and Immunisations Review – September 2019. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/10/interim-findings-of-the-vaccinations-and-immunisations-review-2019.pdf>

of the differential extra workload, a new care home premium payment worth £120 per bed per year will be introduced when the service goes live from 30 September 2020. Every care home will be supported by a single PCN with a named GP or GP team. By 31 July a delivery plan for the new service will be agreed with community provider partners. From 2021/22, at least one third of the PCN Investment and Impact Fund will support effective delivery against the service specifications. The remaining four service specifications – CVD diagnosis and prevention, tackling inequalities, personalised care and anticipatory care - will be introduced in 2021/22, following negotiation with GPC England. From April 2020 every PCN will be offering a social prescribing service. Where the Network Contract DES delivers services that were previously funded locally, that investment must be reinvested by the CCG into primary medical care.

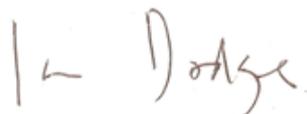
Introducing the Investment and Impact Fund (IIF)

12. The Fund rewards PCNs for delivering objectives set out in the *NHS Long Term Plan* and GP contract agreement. It will operate in a similar way to QOF. Eight indicators are included in 2020/21, relating to seasonal flu vaccination, health checks for people with a learning disability, social prescribing referrals, and prescribing. The Fund will be worth £40.5m in 2020/21, increasing to £150m in 2021/22, £225m in 2022/23 and £300m in 2023/24.

The over-riding priority in 2020/21 for both the NHS and the profession is to expand the size of the general practice workforce by making full use of the investment guaranteed under this agreement. The improvements to the additional roles scheme, with 100% reimbursement for 26,000 staff, show unequivocal backing for the PCN model. The new recruitment and retention measures are intended to increase the number of doctors working in general practice, and the partnership model will be boosted by the new incentive for first time partners. More people are needed, to alleviate workforce and workload pressures and ensure general practice is sustainable and can thrive, delivering new and better services and improved access for patients.



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1. Enhancing the Additional Roles Reimbursement Scheme

- 1.1 Expanding the workforce is the top priority for primary care, foundational to all other goals. Far more people are needed to boost capacity, for three reasons:
- to alleviate workload pressures on existing staff, and thereby ensure primary care is sustainable and can thrive;
 - to improve patient experience of access, cut waiting times and meet the Government's commitment to provide 50 million more appointments within general practice; and
 - to improve the quality of care and implement NHS Long Term Plan goals⁴, including the integration of care as set out in the January 2019 five-year GP contract deal⁵.
- 1.2 Under this agreement, **an array of significant additional measures will now be introduced, in order to secure two new national workforce targets: 26,000 extra staff under the Additional Roles Reimbursement Scheme, and 6,000 extra doctors working in General Practice.** These commitments now become first order priorities for the entire NHS. Their attainment is the main means of securing the 50 million more appointments and further sustaining general practice.

Adding more roles

- 1.3 The Additional Roles Reimbursement Scheme was established in 2019 with the advent of Primary Care Networks (PCNs). Inclusion of a role within the Scheme is subject to satisfying three criteria:
- sufficient expected available supply nationwide;
 - demand from general practice for the roles; and
 - it must be operationally feasible to guarantee the roles are additional to those that are already in place, and so avoid the risk of funding for existing primary care staff being diverted into the newly funded posts with no net increase in capacity.
- 1.4 Initially, five roles met these three criteria: clinical pharmacists and social prescribing link workers in 2019/20; physician associates and first contact

⁴ NHS England (2019) The NHS Long Term Plan. Available from:

<https://www.longtermplan.nhs.uk/online-version/>

⁵ NHS England and the BMA (2019) Investment and evolution: a five year framework for GP contract reform to deliver the NHS Long Term Plan. Available from:

<https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

physiotherapists from 2020/21; and community paramedics from 2021/22. The Government is committed to bringing forward secondary legislation to regulate physician associates as soon as parliamentary time allows. That will enable autonomous working and open up the possibility of independent prescribing in the future, and so maximise the potential to relieve workload from GPs and other staff.

1.5 PCNs want more flexibility. Consistent with the three criteria, the scope of the Additional Roles Reimbursement Scheme extends into six more roles, taking the total number for 2020/21 from four to ten:

- **Pharmacy technicians**, as envisaged in the five-year deal. Working with Health Education England (HEE), NHS England and NHS Improvement is committed to an increase in the numbers of pharmacy technician trainees. For 2020/21 and 2021/22 only, in recognition of workforce supply constraints, the default expectation is that PCNs will not recruit more than one additional individual pharmacy technician under the Scheme, or two in those PCNs with a population of over 100,000 patients. This limitation is unnecessary where CCG agreement, on behalf of the local system, confirms that local supply constraints are not an issue and will be reviewed for 2022/23;
- New roles for both **health and wellbeing coaches** and **care co-ordinators**. These can be distinct roles from the social prescribing link worker role. In some parts of the NHS, health coaching, care navigation and co-ordination, and social prescribing are combined; it is up to PCNs to determine as long as the minimum requirements for at least one of the roles are met. All three roles can support patients to lead healthier lives including achieving and maintaining a healthy weight. The health coaching roles will be set at up to an indicative *Agenda for Change* band 5 and care co-ordinator at up to band 6. The roles must be additional;
- **Occupational therapists, dietitians, and podiatrists**, permitted at an indicative *Agenda for Change* band 7. Their inclusion in the scheme is at the direct request of a number of PCN Clinical Directors. This flexibility does not constitute an expectation that PCNs must now deliver services more normally performed by community health providers and does not change the contractual requirements of GMS; and
- **Community paramedics**, due to be introduced to the Scheme from April 2021, will be reimbursed up to an indicative *Agenda for Change* band 7 rate, increased from the planned *Agenda for Change* band 6.

1.6 **In addition to these six, mental health practitioner roles** – including Improving Access to Psychological Therapy (IAPT) practitioners - **will also be included in the Scheme from April 2021**. The exact arrangements will be informed by the work of twelve sites across England piloting integrated models

of primary and community mental health care and wider engagement. The Network Contract Directed Enhanced Service (DES) will include requirements on the individual to work in collaboration with community mental health providers and/or IAPT providers.

- 1.7 **We will also explore whether or not it is feasible to include Advanced Nurse Practitioners in the scheme**, bearing in mind supply constraints and the critical need for additionality beyond the significant numbers who are already working in primary care.
- 1.8 It is important to note that medicines optimisation in care homes (MOCH) clinical pharmacists and pharmacy technicians must be transferred into the Scheme at the point at which they have completed their training. The last date at which this transfer can happen is set at 31 March 2021. Where the roles were counted in the 31 March 2019 staffing baseline, they form an exemption from the calculation of additionality. Aside from this specific exemption, together with the existing exemption for clinical pharmacists transferring to PCNs from the Clinical Pharmacists in General Practice scheme, reimbursement is only for those roles which are demonstrably additional to the 31 March 2019 baseline agreed by CCGs and PCNs. Baseline data for pharmacy technicians was collected as part of the original exercise to baseline the five original ARRS roles.

TABLE 1: 2020/21 MAXIMUM ANNUAL REIMBURSEMENT RATES

Role	AfC band	Maximum reimbursable amount over 12 months (with on costs)
Clinical pharmacist	7-8A	55,670
Social prescribing link worker	Up to 5	35,389
First contact physiotherapist	7-8A	55,670
Physician associate	7	53,724
Pharmacy technician	5	35,389
Community paramedic	7	N/A – reimbursement available from 2021/22
Occupational therapists	7	53,724
Dietitians	7	53,724
Chiropodists / podiatrists	7	53,724
Health and wellbeing coach	Up to 5	35,389
Care co-ordinator	4	29,135
Mental health practitioners	TBC (from 2021/22)	TBC (from 2021/22)

More operational flexibility

- 1.9 Whilst PCNs recognise the necessity of the additionality rules to ensure net capacity expansion, aspects of their operation have been criticised as needlessly restrictive.
- 1.10 Voluntary sector partners are often best placed to provide social prescribing services. The original rules could make this difficult and partway through 2019 they were amended. When engaging this service from a third party, PCNs can pay and reclaim a contribution of £2,400 for additional costs – beyond salary and on-costs, but within the maximum reimbursable amount – for each service equivalent of one annual whole time equivalent social prescribing link worker.
- 1.11 Until now, the additionality calculation has operated on a role-by-role basis. From 1 April 2020, PCNs may substitute between clinical pharmacists, first contact physiotherapists and physician associates within their practice-funded baseline, with the agreement of their commissioner which will not be unreasonably withheld. This will help prevent the operation of the Additional Roles Reimbursement Scheme from inadvertently ossifying the service delivery model.
- 1.12 Under the current rules, where there is an unexpected short-term vacancy in a *practice-funded role counted within the Additional Roles Reimbursement Scheme baseline*, this would automatically lead to a commensurate reduction in claims by the PCN for an additional such role. We have heard that this can create challenges in the relationships and financial flows between individual practices and the network in which they operate. A three-month ‘grace period’ will now operate for vacancies in these practice-funded baseline roles, from the point at which the role becomes vacant, before the commensurate reduction in Scheme funding is applied. It does not of course apply to vacancies in roles funded under the Scheme.
- 1.13 Other than pharmacy technicians, for whom a baseline was established in March 2019, the five further roles now added to the scheme in 2020/21 are employed in tiny numbers in primary care. A further baseline exercise would not be proportionate. When so declared by PCNs they will be deemed to be additional.

Extra Government investment in 6,000 more staff

- 1.14 For the main purpose of improving access and cutting waiting times in surgeries, through providing greater support to general practices, **extra Government investment is funding 6,000 extra staff through the Scheme at 100% reimbursement.** The Government will now increase NHS England’s revenue budget by £150m/£300m/£300m/£300m between 2020/21-2023/24. Under this agreement, that funding is now added to the Scheme, so that it funds

26,000 rather than 20,000 staff. The funding is deliberately front-loaded in order to maximise impact by the end of the five-year contract deal.

1.15 **It is up to each PCN to decide the distribution of roles required, limited only by differentially available supply of different roles in different parts of the country.** Table 2 provides what is purely an illustrative example, and is not an expectation of how a typical PCN will actually recruit. That will depend on the make-up of their existing workforce and local population needs, and will only become clear through the new bottom-up planning process (described below) and actual recruitment exercises.

TABLE 2: ILLUSTRATIVE DISTRIBUTION OF ROLES FOR AN AVERAGE PCN BY 2023/24, BASED ON EXPECTED NATIONAL SUPPLY

Role	Illustrative FTE
Clinical pharmacists	6
Pharmacy technicians	2
First contact physiotherapists	3.5
Physician associates	2.5
Social prescribing link workers/health and wellbeing coaches/care co-ordinators	5
Paramedics and other AHPs	2
Total	21

100% reimbursement

1.16 **From April 2020, all roles will be reimbursed at 100% of actual salary plus defined on-costs, up to the maximum reimbursable amounts.** For 2020/21 these are set out in Table 1. This enhancement is intended to:

- accelerate the pace of recruitment, by providing total certainty of full funding. 100% reimbursement is a necessary corollary of 26,000 extra staff becoming a first order national delivery commitment for the Government and the NHS, as opposed to an optional funding arrangement;
- respond to one of the major criticisms raised through the engagement exercise on the draft service specifications, that the 30% reimbursement contribution from practices could adversely impact on existing practice services. It also means that increases in total practice income and other streams such as the new Impact and Investment Fund can more readily be deployed to support increases in GP and practice nurse numbers;
- free up much needed management and transformational support for Clinical Directors. We have heard that the £1.50/head support for PCNs – worth £72,000 annually for an average PCN – has been deployed to contribute to the 30% funding of additional roles. Instead it can now be used as needed for development and transformation support. It equates to a full-time band

8A, and increasing the contribution to Clinical Director time by almost 50%. We encourage Clinical Directors to use the funding to ensure sufficient support as rapidly as possible; and

- demonstrate unequivocal and long-term backing for PCNs.

1.17 Taken together, the extra 6,000 staff and 100% reimbursement constitute a step-change in funding guaranteed in the Scheme:

TABLE 3: GUARANTEED INVESTMENT IN THE SCHEME

(£ millions)	20/21	21/22	22/23	23/24
Original funding	257	415	634	891
Additional funding	173	331	393	521
Revised total	430	746	1,027	1,412

1.18 As set out in the Additional Roles Reimbursement Scheme guidance⁶, from April 2020/21, each PCN will be allocated a single combined maximum sum under the Scheme. The sum will be based upon its weighted population share. The weighting takes account of the relative costs and workload associated with service delivery, including deprivation and health inequalities, age profile and deprivation. To ensure consistency and fairness in allocations, the basis for weighting is the same as for the practice global sum. A ready reckoner will be made available for PCNs.

TABLE 4: AVERAGE PCN ADDITIONAL ROLES REIMBURSEMENT SUM⁷

(£000s)	20/21	21/22	22/23	23/24
Original funding	206	332	507	713
Revised total	344	597	821	1,130

Addressing worries about accrued employment liabilities

1.19 The Network Contract DES is an extension of the existing practice contract. The Scheme gives general practice the choice to hire additional staff under its direct control, to be part of the PCN team and is a major boost to the independent contractor model. Nonetheless, some networks and practices have naturally been worried about the risk of taking on big additional employment liabilities.

⁶NHS England (2019) Network Contract Directed Enhanced Service: Additional Roles Reimbursement Scheme Guidance. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/12/network-contract-des-additional-roles-reimbursement-scheme-guidance-december2019.pdf>

⁷ Calculation based on 1250 PCNs

1.20 Three measures address this concern:

- **For those PCNs who do not wish to employ extra staff directly, we encourage them to engage their community-based partners, who can employ staff on their behalf.** CCGs can help broker these arrangements;
- **Under this agreement, we can confirm that the level of reimbursement already drawn down to support new staff employed by a PCN will now be guaranteed during this GP contract period with their ongoing participation in the Network Contract DES, and these staff will be treated as part of the core general practice cost base beyond 2023/24 when we consider future GP contract funding, like the practice global sum; and**
- **Furthermore, should all the practices which comprise a PCN ever decide in future to hand back the DES, the commissioner must arrange timely alternative provision for the same services from another provider, e.g. another PCN or an NHS community provider. In this circumstance the law regarding transfer of staff would apply as normal.** The commissioner will approach the appointment of the new provider on the basis that, unless there are exceptional circumstances not to do so, (1) relevant staff will transfer from the outgoing practice(s) to the replacement(s), (2) the TUPE Regulations will apply to that transfer and (3) transferring staff will be treated no less favourably than if the TUPE Regulations had applied.

Making full use of funding

1.21 **GPC England and NHS England and NHS Improvement are clear that the additional roles funding should be fully used each year, rather than lost to general practice.** This means taking action as soon as possible (including in the remainder of this financial year), aided by a clear and simple workforce planning process, with explicit support from CCGs and systems. We encourage all PCNs to spend time now to think through their longer-term recruitment plans, aided by the extra certainty provided by this deal document, as well as firming up their intentions for 2020/21.

1.22 **As part of the DES, all PCNs will be expected to seek to utilise 100% of their available funding. CCGs will be placed under a corresponding duty to support their PCNs in doing so.** A CCG-wide plan to use the available Additional Roles Reimbursement Scheme budget will be developed every year, jointly with Clinical Directors and LMCs. Community partners should also be fully engaged.

1.23 **NHS Digital will increase the frequency and timeliness of its workforce reporting** so that data on additional roles recruitment are available monthly with less of a time lag before publication. The monthly data will be able to be disaggregated by PCN, CCG and system. We anticipate this will be in place by spring 2020.

PCN intentions

1.24 **A simple workforce planning template will be developed and agreed with GPC England shortly, for PCNs to share their intentions.** By this means, rather than anything more onerous, PCNs will be asked to indicate the number of each additional reimbursable roles to which they realistically intend to recruit and by when, so they spend their funding every year. This should include firm initial intentions for 2020/21, with indicative intentions for the remaining years of the contract through to 2023/24. This will help understand demand as well as which PCNs want and need most assistance. PCNs will be free to change these plans at any stage and at the same time keep their CCG and local primary care training hub informed.

System support for PCNs

1.25 CCGs and systems are expected to explore different ways of supporting PCNs. These should include, but not be limited to:

- **the immediate offer of support from their own staff to help with co-ordinating and running recruitment exercises;**
- **the offer of collective/batch recruitment across PCNs.** Where groups of PCNs wish to advertise vacancies collectively, CCGs or Integrated Care Systems (ICSs) will be tasked with supporting this;
- **brokering arrangements to support full-time direct employment of staff by community partners, or to support rotational working across acute, community and (in time) mental health trusts, as well as community pharmacy.** We are seeing increasing examples of rotational working across the country and we strongly endorse this approach. It can help build more rewarding careers, support collaboration and secure extra capacity more quickly; and
- **ensuring that NHS workforce plans for the local system are as helpful as possible in meeting PCN intentions.**

Redistribution of funding as fallback

- 1.26 If a CCG judges there still remains a likelihood of significant unspent entitlement, even after inviting community partners to propose joint or rotational posts, the CCG will be expected to share funding across PCNs. **It is neither desirable nor expected that redistribution will be necessary on a widespread basis, but it is better than the alternative of funding being lost to general practice.**
- 1.27 Each CCG will need to estimate the likely level of unclaimed entitlements under the Additional Roles Reimbursement scheme and share this with their PCNs and the LMC by the end of July 2020.
- 1.28 If a PCN and a CCG agree that a PCN is unlikely to use its year's full allocation, this funding may then be made available to other PCNs within that CCG area to bid for to enable them to undertake additional recruitment. CCGs will be required to assess bids from PCNs for additional funding, in line with high-level national criteria. These criteria will include:
- evidence that a PCN has a recruitment process ready to begin and is well-placed to undertake further recruitment;
 - if yes to the above, has the PCN had a share of their allocation held by the CCG for re-allocation but then found themselves able to recruit (if yes, priority will be given to such bids);
 - in conjunction with the above, consideration of whether or not a PCN currently has staff on paid leave e.g. parental or sickness;
 - evidence that a PCN is in an area of high deprivation; and
 - CCG discretion for other factors to consider.
- 1.29 Any reallocation would be on a one-off basis for the remainder of the financial year. The increase in PCN allocations from year to year would cover the additional funding required for any PCNs who have been able to undertake additional recruitment. We envisage that this exercise will be repeated by CCGs at the end of October, based on discussions with PCNs during the first half of the year. CCGs will monitor on a year-to-year basis any redistribution which has taken place. Where there are repeated occurrences of redistribution from and/or to particular PCNs, particularly where this risks creating or worsening health inequalities, this will be reviewed on a local basis by the CCG and relevant PCNs, discussed with the LMC and, where appropriate, the ICS, and appropriate supportive actions taken.

1.30 The additional roles workforce planning timetable is no later than as set out in table 5. The June and July dates are backstops, and NHS England and the BMA warmly encourage those PCNs and CCGs that are able to go faster to do so.

TABLE 5: 2020/21 ADDITIONAL ROLES WORKFORCE PLANNING TIMETABLE

Task	Date
PCN discusses and works out its intentions	From now
Each PCN seeks to accelerate recruitment exercises that are being planned, supported by CCG staff if requested	From now
Each PCN submits its intentions to its CCG	By no later than 30 June 2020
Each CCG confirms an effective local plan. This must be agreed with PCN Clinical Directors, before being shared with Regions	By no later than 31 July 2020
Regional engagement and support	Early June 2020 onwards
CCGs declare amount for in-year redistribution to other PCNs	By end July and again in October 2020

Improving employment practices

1.31 We have agreed a new *Core NHS Offer* statement for staff delivering primary medical services. This will be published in due course.

1.32 During 2020/21 we will review and agree changes in the following areas to be delivered within existing resources:

- the minimum sickness and parental leave provisions all staff in primary care should be able to expect;
- childcare support;
- occupational health provision, aligned to wider NHS England and NHS Improvement work; and
- tackling the gender pay gap in general practice.

1.33 We are committed to agreeing arrangements that will allow practices to make a more generous offer of Enhanced Shared Parental Leave to employed GPs, starting as soon as possible in 2020/21.

Ensuring sufficient space for additional staff

- 1.34 Sufficient building space is required to support the staff expansion. Where existing practice premises are insufficient, PCNs will be encouraged to engage now with their community provider partners to agree any necessary short-term actions. Together they should also start developing a fully joint vision of fit-for purpose future estate. We will work together to make the best use of any new capital funding available to primary care to support general practice and the PCN model.

2. More doctors in general practice

2.1 The NHS needs as many doctors working in general practice as it can get. Important recruitment and retention measures were started by the GP Forward View⁸. The headcount numbers of doctors working in primary care has grown by over 4,300 since September 2015. But this only equates to an increase of 433 GPs in full time equivalent terms as more GPs choose to leave the workforce early, or work on a more part-time basis in response to workload pressures⁹. Without further urgent investment and action now, the numbers of FTE doctors working in general practice is likely to remain static or grow only marginally – by fewer than a thousand in five years' time.

New investment to achieve 6,000 extra doctors

2.2 The Government is committed to funding Health Education England to increase the number of GP trainee places to 4,000. The Government is also now increasing NHS England and NHS Improvement's revenue budget by £94m/£117m/£114m/£103m for the four-year period 2020/21-2023/24 for the specific purpose of supporting a raft of additional recruitment and retention schemes aimed at GPs which are now set out in this agreement document and have been developed with a range of stakeholders including the Royal College of GPs and Health Education England. Designed as an interlocking package, these schemes build on existing local good practice, or expand the offer already available through nationally-led schemes, to support GPs at different points of their career pathway.

2.3 Taken together, these actions are intended to enable the NHS to meet the Government's target of increasing the number of extra doctors working in primary care by 6,000. The potential for further measures will be kept under consideration.

Solving pension issues

2.4 In 2019/20, NHS England and NHS Improvement has established a scheme which will mitigate the impact of the annual allowance and support GPs to offer additional time to the NHS over this winter. The government has agreed urgently to review the pensions annual allowance taper problem.

⁸ NHS England (2016) General Practice forward View. Available from:

<https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf>

⁹ NHS Digital (2019). General Practice Workforce 30 September 2019. Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-30-september-2019>

More GP trainees spending more of their time in general practice

- 2.5 More new GPs are now being trained in England than ever before, but we still have a structural imbalance between the number of GPs and the number of other medics. Since 1948, the number of GPs has doubled, whereas the number of hospital doctors has risen tenfold, with significant increases occurring this past decade.
- 2.6 In 2019, 3,540 doctors entered GP specialty training against a target of 3,250, and a further 3,500 places are now being offered¹⁰. **From 2021, HEE will increase the number of GP training places to 4,000 a year.**
- 2.7 A significant proportion of the extra GP trainees are likely to be international medical graduates. **From 2020/21, all international medical graduates entering general practice training will be offered a fixed five-year NHS contract.** This will include three years training and a new two-year fellowship programme (see below).
- 2.8 **The GP training model will also undergo significant reform, as proposed by the Royal College of GPs.** Out of their three-year training programme, GP trainees currently spend around half of this working in a hospital setting. From 2022, to support better training for GPs, and a more balanced distribution of trainee capacity across the NHS, the proportion of time that GP trainees spend in general practice during their training will rise from 18 months to 24 months.
- 2.9 Taken together these two changes to training will secure over 3,000 of the extra 6,000 doctors working in general practice. Alongside pre-existing plans, the array of additional measures is intended to help secure the remainder. **Working with the Government, RCGP, BMA and local systems, NHS England and NHS Improvement will keep open the precise mix of investment in the different schemes below according to what is proving most effective.**

More trainees in under-doctored areas

- 2.10 The Targeted Enhanced Recruitment Scheme (TERS) has proved highly successful in attracting GP trainees to the most under-doctored areas, with a fill rate of close to 100% last year and oversubscription in many parts of the country. It provides a one-off financial incentive of £20k to the trainee and also encourages them to settle in these communities. 276 places are currently being offered as part of 2019 recruitment round. **Backed by extra manifesto investment, NHS England and NHS Improvement will work with HEE to increase the number of TERS places offered to at least 500 by 2021, and at least 800 by 2022.**

¹⁰ The General Practice (GP) National Recruitment Office (2019). Available here: <https://gprecruitment.hee.nhs.uk/resource-bank/recruitment-figures>

Two-year Fellowship Programme for all newly qualified GPs and nurses

- 2.11 Over the past year, NHS England and NHS Improvement has worked with the profession and local health systems to design and pilot a new two-year primary care Fellowship Programme for newly qualified doctors and nurses entering general practice. Fellows will get guaranteed funded mentorship, funded continuing professional development (CPD) opportunities of one session per week, and rotational placements within or across PCNs to develop their experience and support their transition into the workforce in a local area.
- 2.12 The fellowship is intended to create a 'glide path' from being a trainee through to an ongoing employment relationship. **By 2021, every newly qualified GP coming out of training will have the guaranteed opportunity to benefit from enhanced support through the scheme**, through becoming an employee of a named practice, or a PCN. From 2021, all new entrants to GP trainee training will automatically be enrolled in the programme as part of signing up to the training programme and then be expected to enter the fellowship programme on qualification. The shared intention of NHS England and NHS Improvement, the BMA and RCGP is for as close to 100% of newly qualified GP trainees to enter the fellowship programme.
- 2.13 **To provide a major boost to general practice nursing, the Fellowship Programme will also be open to newly qualified nurses.**

New to Partnership Payment

- 2.14 As an extension of the practice contract, the PCN contract represents major investment in the GP partnership model. Partnerships and in particular the number of GP partners will be given a further boost by the New to Partnership Payment. This new national scheme is primarily designed to attract early to mid-career GPs into partnership opportunities.
- 2.15 **From 1 April 2020, new partners will benefit from £3,000 of business training allowance and a guaranteed one-off payment of £20,000 for a full-time GP** (calculated on a 37.5 hours a week basis) **to support their establishment as a new partner.** Initially a loan, we envisage that it will automatically convert to a permanent payment after an expected minimum number of years (for example, five) as a partner. With on-costs, and business training costs, the relevant practice would claim reimbursement of £25,500. We would require assurance from the practice that the pro-rata payment and associated business training allowance had been paid to the partner within a maximum time period.
- 2.16 The national scheme will be available to all GPs who have never before been partners and are offered partnerships. It will be open to other professional groups (e.g. nurses and pharmacists). Detailed guidance on its operation will be

published following ongoing engagement with the profession and wider stakeholders. The scheme is expected to evolve in the light of experience. Its initial phase is likely to run for two or three years.

Locum Support Scheme

2.17 Groups of PCNs will be directly supported to create an offer to GPs who want to continue to work on a locum basis. As well as helping to meet demand at practice and PCN level through additional sessions, locum GPs will benefit from greater peer support and networking opportunities. **Each locum GP engaged through the Locum Support Scheme will also receive a funded session of CPD per month in exchange for a minimum contribution of sessions per week to the group of PCNs.** In 2020/21, implementation will be supported by ICS/STPs and LMCs, working closely with training hubs and local PCNs. Full coverage will be established as soon as possible during the year. NHS England and NHS Improvement aims to support at least 500 GPs through Locum Support Schemes in their first year of operation.

National GP Retention Scheme

2.18 The GP Retention Scheme provides a package of financial and educational support and acts as a safety net to help GPs remain in clinical practice where they cannot undertake a regular part-time role, and might otherwise leave the profession. Statistics indicate 480 GPs were being supported on the scheme as at 30 September 2019, an increase of over 300 GPs since September 2015¹¹. **During 2020, NHS England and NHS Improvement will work with the RCGP, BMA and local systems to consider if changes to the scheme, for example increasing the number of sessions participants can provide, would provide a sufficiently worthwhile impact.**

Return to Practice

2.19 Through the existing Induction and Refresher Scheme, GPs who may have left practice (for example, to undertake extended maternity leave or due to a career break) are encouraged to return. The Scheme will be expanded and enhanced during 2020/21 to provide more support for GPs with caring responsibilities.

2.20 The cost of childcare acts as a disincentive to many parents considering returning to a career in general practice through this scheme. **From April 2020, GPs on the Induction and Refresher Scheme with children aged under 11 will be able to claim up to £2,000 towards the cost of childcare for each child whilst on the scheme** (or £1,000 for those on the Portfolio Route due to

¹¹ NHS Digital (2019). General Practice Workforce 30 September 2019. Available from: <https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services/final-30-september-2019>

the shorter length of their placements). GPs will be eligible for this support until 1 September after each child's 11th birthday.

Supporting Mentors Scheme

- 2.21 A new national scheme will offer highly experienced GPs the opportunity to mentor newly qualified GPs entering the workforce through the Fellowship Programme. Training will be provided to all mentors and practices will be reimbursed to release these GPs to do a session per week to undertake mentoring activity provided the GP is delivering at least three other clinical sessions in addition to the mentoring session. We expect this offer to be attractive to GPs nearing the end of their careers.
- 2.22 Implementation of the national offer will be led by ICSs/STPs, working closely with training hubs, and based on national guidance. This will allow some flexibility to build on existing local good practice. Schemes will be established from April 2020, with nationwide coverage as soon as possible during 2020/21. We will plan to support around 450 GPs through this scheme in its first year of operation.

3. Releasing time to care

3.1 By reducing unnecessary bureaucracy, more time can be released to care. The Government will instigate a swift and full Review of Cross-Government Bureaucracy in General Practice with the BMA. This will consider what actions the Government could take to reduce the bureaucratic burden on GPs and other health practitioners within general practice in order to free up valuable time. The review will conclude in 2020 and its recommendations will be agreed with the BMA and other partners.

3.2 **In parallel, NHS England and NHS Improvement will review, with GPC England, RCGP and wider stakeholders:**

- mandatory training requirements;
- how to reduce the time associated with the annual appraisal process, learning from the East of England pilots;
- how to make revalidation simpler for GPs, particularly those approaching retirement age and beyond;
- how to reduce the burden associated with annual coding requirements for patients with long-term conditions;
- how to remove unnecessary barriers for patient self-referral;
- how to improve the e-Referral and electronic prescribing systems, consistent with the outpatient reform programme;
- operation of the performers list; and
- how best to take more effective action to implement the NHS Standard Contract requirements intended to reduce the extent to which other NHS providers generate avoidable extra GP workload.

3.3 **Work is already underway to progress the digitisation of paper ‘Lloyd George’ Records. Subject to the piloting, publication of national guidance and ongoing work with the Joint General Practitioners Information Technology Committee (JGPITC), the implementation process could start from April 2020.** This nationally funded programme will also help free up physical space within practices for additional staff. We will look at how third-party redaction software could be made available to general practice as a matter of course to further support practices to deliver full historic online access to records for their patients.

- 3.4 **The newly established NHS Community Pharmacist Consultation Service will also relieve pressure on GP practices**¹². This went live in October 2019 and has so far taken over 150,000 referrals which would otherwise have been made to a GP. Subject to the successful evaluation of ongoing pilots, the service will be expanded, with referrals from other settings during 2020/21.
- 3.5 The Time for Care programme has delivered a range of service improvement interventions in the past four years to improve productivity in General Practice and enhance resilience¹³. NHS England and NHS Improvement will seek to build on its progress and increase impact as part of a single dedicated access improvement programme.

¹² NHS England (2019) Advanced Service Specification - NHS Community Pharmacist Consultation Service. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/10/advanced-service-specification-nhs-pharmacist-consultation-service.pdf>

¹³ NHS England (2019). Releasing time for care. Available from: <https://www.england.nhs.uk/gp/gpfv/redesign/gpdp/releasing-time/>

4. Improving access for patients

50 million more appointments

- 4.1 The additional Government investment in primary care capacity under this agreement is for the purpose of improving patients' experience of accessing primary care and cutting waiting times. Progress towards delivering the extra 50 million appointments as soon as possible will be driven mainly by increasing staff numbers.
- 4.2 **Initial actions arising from NHS England's review of access to General Practice have now been agreed and are set out below.** The review will complete in 2020, to inform contract discussions in 2020/21.

Better data

- 4.3 **An improved appointments dataset will be introduced in 2020 as part of the practice contract.** The details will be agreed as soon as possible between NHS England and NHS Improvement and the BMA. This will provide more comprehensive, granular, frequent and timely information. It will help practices understand their current relative position on how long patients are waiting to access services, the type of care they are receiving, and which professional is providing it. The date in 2020/21 when practices are required to use the dataset and provide quality data will depend on the timing of IT system changes during the course of the year. By March 2021, the dataset will be fully comprehensive, covering all practices without exception.
- 4.4 **As agreed in the five-year deal, a new, as close to real time as possible and transparent measure of patient experience will be designed and tested in 2020, for nationwide introduction by no later than 1 April 2021.** The details will be agreed as soon as possible between NHS England and NHS Improvement and the BMA.

Access Improvement Programme

- 4.5 **NHS England and NHS Improvement will establish a major new GP Access Improvement Programme in early 2020.** Working with PCNs, the programme will:
- identify best operational management methods proven to improve booking experience, reducing waiting times for both urgent and routine appointments, and moderating demand growth for A&E attendances;
 - in Q3 and Q4 of 2020/21, seek to apply these methods supportively for practices/PCNs whose patients are experiencing the longest routine waits;
 - incorporate the existing work on Time for Care;

- consider appropriately how to ensure continuity of care is supported and the continuing need to reduce health inequalities; and
- seek to learn from the mixed previous experiences of setting access standards in primary care.

4.6 Progress against the new patient reported experience metric will be supported by the new PCN Investment and Impact Fund in 2021/22, when at least £30m of the £150m Fund will be directed at improving access. However, we intend to introduce the measure as early as possible across all practices in England during 2020/21, and to begin incentivising performance against it at the equivalent rate of £30m/annum pro-rata. The work of the Access Improvement Programme will inform how at least at a third of funding under the Investment and Impact Fund can best directly support better experience and reductions in waiting times. This amounts to at least £75m in 2022/23 and at least £100m in 2023/24.

Digital-first services

4.7 **Every PCN and practice will be offering a core digital service offer to all its patients from April 2021.** This will be delivered through a new national supplier framework and other support activity, alongside improvements to IT infrastructure, more online services for patients and using digital tools to increase flexibility in how staff work and care for patients. This will be backed by additional STP/ICS support. Digital delivery can offer flexible working for GPs, and contribute to securing the additional 6,000 doctors working in general practice.

Extended hours

4.8 As agreed and set out in *Investment and Evolution*¹⁴, from April 2021 the funding currently in the Network Contract DES for extended hours access together with the wider CCG commissioned extended access service will fund a single, combined access offer as an integral part of the Network Contract DES. **A nationally consistent offer will be developed and discussed with GPC England and patient groups, reflecting what works best in existing local schemes.** In the meantime, we encourage PCNs and practices to work with their CCGs to enable more flex between existing in-hours and extended hours capacity, so that the latter is better used, for example for vaccinations, annual reviews of patients with long term conditions and screening appointments.

¹⁴ NHS England and the BMA (2019) Investment and evolution: a five year framework for GP contract reform to deliver the NHS Long Term Plan. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

Fuller join-up with urgent care services

- 4.9 NHS England and NHS Improvement will develop and then consult on options for creating a newly expanded role for PCNs in joining up and running urgent care in the community, as an option rather than an obligation. This would enable better integration of primary care with urgent care and increase their ability in being able to moderate increases in A&E demand.

5. Reforming arrangements for vaccinations and immunisations

5.1 **During 2019, NHS England and NHS Improvement undertook the most significant review of vaccination and immunisation payment mechanisms since 1990.** Overseen by an advisory group, with representation from GPC England, Pharmaceutical Services Negotiating Committee (PSNC), RCGP, NICE, Public Health England (PHE) and Royal College of Nursing (RCN), an interim report was published in October 2019¹⁵.

Review conclusions

5.2 General practice plays an invaluable role in the delivery of vaccination services, especially for children. But that the current payment system is far from optimal. It:

- is unnecessarily complicated, with wide variations in payment rates and approaches for different vaccines, and indeed different patients receiving the same vaccine;
- results in limited practice oversight of their current performance. This compares unfavourably with the Quality and Outcomes Framework (QOF), where practices are usually fully aware of their current and anticipated performance; and
- is outdated as it does not align with levels of coverage required for population protection, and the incentive structure could be redesigned to improve impact. The contract does not reflect known best practice in the delivery of vaccination services, such as consistent call/recall and flexible appointment availability¹⁶.

5.3 The reforms we have agreed have been devised to address these weaknesses. They will provide a more effective set of incentives to increase vaccine coverage and improve population outcomes, by giving practices confidence that more vaccinations lead to higher payments, and by giving timely performance data to act upon. The reforms also represent an investment in vaccination and immunisation services from the existing and agreed total contract resources of at least £30m by 2021/22.

¹⁵ NHS England and NHS Improvement (2019) Interim findings of the Vaccinations and Immunisations Review – September 2019. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/10/interim-findings-of-the-vaccinations-and-immunisations-review-2019.pdf>

¹⁶ NHS England and NHS Improvement (2019) Interim findings of the Vaccinations and Immunisations Review – September 2019. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/10/interim-findings-of-the-vaccinations-and-immunisations-review-2019.pdf>

Global sum payment and new core standards

- 5.4 **Vaccinations and immunisation becomes an essential service which should be available to the whole practice population, rather than an additional service.** All practices will be expected to offer all routine, pre and post-exposure vaccinations and NHS travel vaccinations to their registered eligible population, as the overwhelming majority already do.
- 5.5 **The global sum that practices receive will be protected, in line with the five-year agreement.** This is worth £164.5m in 2020/21. It will continue to cover NHS travel vaccinations and pre/post prophylaxis vaccinations. As now, significant outbreak management is not included in the global sum. We continue to expect commissioners to take the lead on response, working with practices and providing funding where necessary (for example if the vaccine does not already accrue payment).
- 5.6 **New contractual core standards have been agreed for the provision of vaccination and immunisation services** to address both the historical differences in practices' approaches to the organisation and delivery of these services and the opportunities of new technology.
- 5.7 We have defined five core components. These core components are:
- **All practices will have a named lead** for vaccination services who takes responsibility for ensuring that:
 - the core standards and contractual requirements described in this paper are met and that opportunities for vaccination are maximised;
 - appropriate liaison with others within and outwith the PCN, including NHS England and NHS Improvement public health commissioning teams and embedded PHE Screening and Immunisation Leads, Child Health Information Systems (CHIS) and Local Authority Public Health colleagues (who work with their Health visitor and school nursing teams).
 - **Practices should ensure the availability of sufficient trained staff and convenient, timely appointments to cover 100% of their eligible population.** Appointments should be available at a range of times across the working week, including using the PCN extended hours service on evenings and weekends. Additionally, appointments should be bookable online and over time be integrated with other digital developments such as the eRed Book and the NHS App;
 - **Practices should ensure their call/recall and opportunistic offers are being made in line with national standards.** These will be defined in supporting guidance for each vaccination programme and over time will be updated to reflect use of the most effective technology. Some areas already

use text-based reminders, and all practices must move towards this as soon as the infrastructure is in place. CCGs should ensure that there is access to sufficient text message capacity. Call/recall will be delivered by practices themselves as a default or may be delivered by the local CHIS on their behalf;

- **Practices should participate in agreed national catch-up campaigns.** For 2020/21, this will be a continuation of the MMR catch-up in 10/11 year olds. There will no longer be an Item of Service (IoS) fee linked to the call/recall activity. Practices will instead be eligible for an IoS fee for each vaccine delivered;
- **Practices should adhere to defined standards for record keeping and reporting of coverage data** for contract monitoring and payment purposes and for population coverage monitoring.

5.8 **We will work with the BMA to update, on the basis of expert advice, the current limited list of pre/post exposure vaccines set out in contractual arrangements. This will reflect current practice** and the indication for these modified to be more reflective of their clinical indication. This update will:

- provide greater clarity of the reasonable expectations of general practice in these circumstances;
- thereby remove the current administrative burden of determining responsibility for the provision of these vaccines; and
- also improve the timeliness of patient care.

5.9 **Further guidance will clarify the division of responsibilities between general practice, commissioners and public health in relation to pre/post-exposure prophylaxis.** This will be differentiated from outbreak management which will continue to be a responsibility of commissioners and would normally accrue additional funding (unless this relates to a vaccine which already accrues an IoS payment).

A standard Item of Service (IoS) fee

5.10 **We will standardise the IoS fees for the delivery of each dose of all routine and annual vaccines at £10.06, fixed for the remaining three years of this contract deal.** This will also apply to routine vaccines which are given outside of the routine schedule where clinically indicated from 2021/22. For 2020/21 the IoS payment will apply to all Measles, Mumps and Rubella (MMR) vaccines, with rollout the following year to the following childhood vaccines:

- Diphtheria, tetanus, poliomyelitis, pertussis, haemophilus influenza type B (HiB) and hepatitis B (6-in-1);
- Rotavirus;
- Pneumococcal conjugate vaccine (PCV);
- Meningococcal B Infant;
- Haemophilus influenza type B and Meningitis C (HiB/MenC).

Incentive payments

5.11 From 2021 there will be incentive payments for achieving specified levels of population coverage for vaccinations which benefit from a herd immunity effect or which are policy priorities, for example MMR. **For routine schedule vaccinations this incentive will operate at practice level and form part of a new QOF domain.** The new QOF domain will reward incremental improvements in performance, unlike the current dual threshold-based approach of the Childhood Immunisation DES, which does not offer many practices a real opportunity to gain.

5.12 Achievement will be measured in a more timely way, more closely aligned to the routine vaccination schedule than the current DES payment. All investment currently committed to routine vaccination that is not redistributed into IoS payments, will be used to fund this new routine vaccination QOF domain which we expect to have a value of at least £40m. We will work with clinical leads and experts from the BMA, PHE and other partners over the coming months to optimise the design of this new domain. We anticipate that the thresholds for MMR and the 6-in-one vaccine will be set at ~90%+, with points allocated to maximise the incentive and minimise negative redistributive effects.

5.13 **PCNs, as the vehicle for collaboration between GP practices and community pharmacy, are ideally placed to take the lead on improving flu vaccine coverage.** Additional general practice incentives for flu, beyond the IoS, will therefore ultimately be channelled through the PCN Investment and Impact Fund. This will start in 2020/21 with an indicator worth £8m for flu vaccination coverage in over 65s. We expect there to be an aligned incentive for community pharmacy in the Pharmacy Quality Scheme (PQS).

5.14 **During 2020/21 we will review the existing QOF indicators incentivising flu vaccination for specified at risk groups, worth around £20m, and consolidate an updated set of indicators within the IIF for 2021/22.** The QOF points which are freed up through this exercise will be redistributed into the new routine immunisation domain, or other public health indicators, meaning practice level investment will be protected. The redistribution of points will be discussed and agreed with GPC England in the next round of negotiations for April 2021.

Repayment for lower coverage

5.15 In the current system, practices achieving a combined coverage of less than 70% earn nothing from the Childhood Immunisation DES. This does not fairly reflect that every additional vaccination for a child has value. In general, the movement to an IoS payment means that practices will be rewarded for the extra work of an additional vaccine. **However, unless addressed directly, another effect of moving to IoS would be an increase in payments to practices with lower (less than 80%) population coverage at the expense of higher performers. Therefore, we have agreed that we will recoup a portion of the IOS paid from practices with lower coverage.** Where practices are not achieving a minimum of 79% coverage on the routine childhood vaccines (MMR, 6-in-1, rotavirus, PCV, Men B, Hib, Men C) then a repayment of a proportion of earnings will be triggered according to the following formula: *value of the IoS fee x 50% of eligible cohort size*. It is anticipated that this calculation will be made on an annual basis using data extracted directly from practice clinical systems. The detailed methodology will be published later in the year once agreed between NHS England and NHS Improvement and GPC England and applied to practice payments from April 2021 onwards.

5.16 **We have balanced the payment reforms such that all practices, apart from a very small number of the lowest performers, will gain from the new arrangements.** This is because they earn the full £10.06 IOS for every patient vaccinated after the first 50% of their eligible population. Previously no payments would have applied below 70% coverage for MMR and the 6-in-1 vaccine, and in other childhood vaccines a lower payment generally applied.

5.17 A baseline calculation of achievement on all the vaccines listed above will be completed in 2020/21 and the repayment arrangements will commence in April 2021. This means that practices have 1 year to prepare for the introduction of the scheme. **As a result, practices with low MMR coverage will receive a one-year boost in funding from the new MMR IoS fee which we expect to be fully reinvested in improving coverage rates.** It would be a huge success if in 2021/22 we require no practice repayments, because all practices are achieving 80% coverage.

- 5.18 A practice may very occasionally demonstrate extenuating circumstances, and therefore be exempt from the repayment. In this situation the practice would need to demonstrate that the core contractual requirements had all been met and that they had made appropriate efforts to improve the vaccination rate before a commissioner could consider it.
- 5.19 We are in the process of planning the implementation with NHS Digital and will provide further detail in 2020. **We anticipate that practices will be paid an aspiration payment on a monthly basis with a final balancing payment at year end which reflects actual achievement and any repayments, in a similar manner to QOF payments.** This best protects practice cash flow, whilst avoiding the need for practices to factor in the risk of managing a full repayment at year end. Vaccines not included in this repayment scheme will be paid on an IoS basis of £10.06 throughout the year. From 2021/22 we intend that all vaccine payments will be made via CQRS using an automated data extraction.

Two-year transition plan

- 5.20 These changes to vaccination and immunisation payments are the most significant for 30 years and require much work to implement. We will phase this over two years, to ensure that the process runs smoothly and that practices are supported with the change. In year one, starting in April 2020 we will:
- introduce the clearer core contractual requirements described in 5.7 and expect all practices to enact these;
 - introduce an IoS payment for MMR 1 and 2 at £10.06. Achievement in 2020/21 will provide the baseline figures for the repayment scheme being introduced in 2021/22; and
 - introduce an incentive worth £ m into the IIF for networks to improve seasonal flu vaccine coverage for the over 65 age group, in collaboration with community pharmacies.
- 5.21 This IoS payment will be funded largely from the planned rise in practice contract funding with the remainder coming from a marginal reduction to the value of the current Childhood Immunisation DES. This will bring a needed focus to improving MMR population coverage next year. We will not make changes to the vaccination incentives within QOF in year one, but will use the time to undertake collaborative design work on a new QOF domain for routine vaccinations.

5.22 In year two, 2021/22, we will:

- expand the application of the IoS of £10.06, and associated repayment system, to all outstanding routine vaccinations;
- introduce the new QOF domain for routine vaccinations worth at least £40m;
- restructure and consolidate all flu incentives at network level through the IIF in a set of indicators worth £30m; and
- retire the existing Childhood Immunisation DES from April 2021, in order to complete the expansion of the IoS and the new QOF domain.

6. Updating the Quality and Outcomes Framework (QOF)

- 6.1 **Further improvements have been agreed to the Quality and Outcomes Framework in 2020/21, in line with the findings of the 2018 QOF Review¹⁷.** QOF implementation guidance will be published by the end of March 2020. Associated changes to the Statement of Financial Entitlements will be made for 1 April 2020. Further details of the indicator changes are set out in annex B.

Indicator changes from April 2020

- 6.2 QOF currently comprises 559 points. **We have agreed to recycle 97 points into 11 more clinically appropriate indicators. NHS England is also investing an additional £10m into QOF** bringing the total points available to 567 from 2020/21.
- 6.3 **From 2020/21, we will introduce a number of improvements to the asthma, COPD and heart failure domains** as follows:

Asthma domain

- Practices will be required to establish and maintain a register of patients aged 6 years and over with a diagnosis of asthma, in line with NICE guidance;
- Practices will be expected to use a minimum of two diagnostic tests to confirm an asthma diagnosis. These tests should be performed up to 3 months before any date of diagnosis and up to 6 months after this date;
- The content of the asthma review has been amended to incorporate aspects of care positively associated with better patient outcomes and self-management;
- Practices will be required to record smoking exposure in children and young people under the age of 19 years.

COPD domain

- Entry to the COPD register will be determined by the presence of a clinical diagnosis plus a record of post bronchodilator spirometry FEV1/FVC ratio below 0.7 recorded between 3 months before or 6 months after diagnosis in diagnoses made on or after 1 April 2020;

¹⁷ NHS England (2018) Report of the Review of the Quality and Outcomes Framework in England. Available from: <https://www.england.nhs.uk/wp-content/uploads/2018/07/quality-outcome-framework-report-of-the-review.pdf>

- The annual review will include a requirement to record the number of exacerbations in order to help guide future management and potentially avoidable emergency admissions.

Heart Failure domain

- Any new diagnosis of heart failure should be confirmed by an echocardiogram or specialist assessment between 3 months before or 6 months after diagnosis;
- There will be changes to the denominator for treatment with beta-blockers;
- An annual review indicator has been agreed to provide a focus upon functional assessment and the up-titration of medication to address symptoms.

6.4 **A new indicator will be introduced to incentivise practices to offer an annual HbA1c test in people known to have non-diabetic hyperglycaemia.**

The aim of this test is to support early identification of those who would have gone on to develop Type 2 diabetes. This indicator will be worth 18 points. It will be supported through both new investment and the retirement of the current CVD-PP001 indicator¹⁸.

New Quality Improvement modules

- 6.5 We introduced in 2019/20 a new Quality Improvement domain worth 74 points. In year one, this comprised two modules: Prescribing Safety and End of Life Care. Whilst these modules will change in 2020/21, we encourage practices to continue to consolidate and mainstream the successful improvements made.
- 6.6 **In 2020/21, the modules will focus on improving care of people with a learning disability and supporting early cancer diagnosis.** These modules have been developed by the RCGP in collaboration with NICE and the Health Foundation.

¹⁸ CVD-PP001: In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of $\geq 20\%$ in the preceding 12 months: the percentage who are currently treated with statins.

6.7 The aims of the Early Cancer Diagnosis module are to:

- improve participation in the national breast, cervical and bowel cancer detection and screening programmes; and
- improve referral and safety netting practices for patients suspected of having cancer. It has been developed to support the roll out of the PCN early cancer diagnosis service specification. The full module can be read here: <https://www.england.nhs.uk/gp/investment/gp-contract/>.

6.8 The Care of People with a Learning Disability module builds upon the work published earlier this year to improve the identification of people with a learning disability in general practice. It aims to promote increased uptake of annual health checks, optimisation of medication in line with STOMP, identification and recording of reasonable adjustments and the patient engagement with community resources through social prescribing to maintain health and well-being. The full module can be read here: <https://www.england.nhs.uk/gp/investment/gp-contract/>

Payment thresholds

6.9 Payment thresholds for new indicators are based upon NICE recommendations and knowledge of practice performance, for example, as a result of previous activity. The points and payment thresholds for unchanged indicators will be held at 2019/20 levels for a further year, pending a full review of the threshold setting methodology in 2020. Payment thresholds for new and revised indicators are detailed in annex B.

Further development of QOF

6.10 The changes described represent the next step in implementing the recommendations of the QOF Review. **NHS England and NHS Improvement and GPC England have agreed to an ongoing programme of indicator review in key priority areas, including mental health in 2020/21.**

6.11 The following further QI modules are in development: (i) CVD prevention and detection, (ii) shared decision making, (iii) anxiety and depression, (iv) anti-microbial resistance including antibiotic prescribing, (v) wider primary prevention and (vi) preventing prescription drug dependency. An evaluation of the QI domain is currently underway, which will inform its further development in subsequent years.

Obesity

- 6.12 The Government has pledged to empower people with lifestyle related conditions such as obesity to lead healthier lives. Global obesity rates have tripled since 1975, and the UK ranks among the worst in Europe¹⁹, but recent research shows that referrals into weight management services can have a significant impact on population health²⁰.
- 6.13 From 2020/21, we will introduce a new non-contractual requirement for GPs to offer to refer people with obesity into weight management services, where this is clinically appropriate and where commissioned services exist. Local Authorities are the main commissioners of weight management services under their public health responsibilities, but NHS England will seek to commission additional weight management services for those who are both obese and living with either type 2 diabetes or hypertension in areas with the greatest unmet need from 2021/22 onwards.
- 6.14 As those plans develop over the next year, and as such approaches are further piloted and expanded for other cohorts, **we will explore the utility and timing of an incentive in QOF to ensure that patients are appropriately offered a referral to weight management services once commissioned and we can be sure they exist universally and in sufficient volume across England.**

Maternity Services

- 6.15 We have agreed a number of improvements to maternity medical services. From 2020/21:
- all practices will be required to deliver a maternal check at 6-8 weeks after birth (live and stillbirth), as an additional appointment to that for the 6-8 week baby check (see below);
 - the Maternity Medical Services additional service will become an essential service;
 - the child health surveillance additional service will also become an essential service; and
 - we will revise the contract's current definition of the "postnatal period" from 2 to 8 weeks, to bring it in line with NICE guidance on best practice, along with the needs of women following birth²¹.

¹⁹ Organisation for Economic Cooperation and Development (2017) Obesity Update 2017. Available from: <http://www.oecd.org/health/obesity-update.htm>

²⁰ Aveyard, P. et al. (2016) Screening and brief intervention for obesity in primary care: a parallel, two-arm, randomised trial. The Lancet 2016; 388: 2492-500. Retrieved from: <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2816%2931893-1>

²¹ National Institute for Health and Care Excellence (2015) Postnatal care up to 8 weeks after birth. Available from: <https://www.nice.org.uk/guidance/CG37>

6.16 NICE recommends a 6-8 week check for mothers to ‘ensure that the woman's physical, emotional and social wellbeing is reviewed’ (NICE Clinical Guideline 37 on post-natal care)²². The GP contract currently makes provisions for a newborn infant physical examination at 6 weeks as part of the additional service for child health surveillance, but there is no specific contractual requirement for practices to review the mother’s health. Recent research suggests that many practices already offer a postnatal check for new mothers, but not all²³. We want to make this a consistent offer for all mothers. **Therefore from 2020/21, we will introduce a new requirement for GPs to offer a 6-8 week postnatal check for new mothers, as an additional appointment to that for the baby. An additional £12m has been invested through global sum to support all practices to deliver this.**

6.17 In line with NICE guidance, the maternal check should focus on:

- a review of the mother’s mental health and general wellbeing, using open questioning;
- the return to physical health following childbirth, and early identification of pelvic health issues;
- family planning and contraception options; and
- any conditions that existed before or arise during pregnancy that require on-going management, such as gestational diabetes.

²² National Institute for Health and Care Excellence (2015) Postnatal care up to 8 weeks after birth. Available from: <https://www.nice.org.uk/guidance/CG37>

²³ The research was conducted by the NIHR Policy Research Unit in Maternal and Neonatal Health and Care which is based at the National Perinatal Epidemiology Unit, University of Oxford.

7. Delivering PCN service specifications

7.1 Chapter 6 of the five-year GP contract deal document described the agreement to introduce five service specifications to the Network Contract DES from 2020/21, with a further two following in 2021/22²⁴.

7.2 Drafts were developed through a process of engagement, including input from expert working groups comprising representation from patients, working GPs and other clinicians, voluntary sector organisations (such as Cancer Research UK, Macmillan, and Age UK), NHS Providers Community Network, Local Government Association, commissioners, Royal College of General Practitioners, Public Health England and the British Medical Association. NHS England and NHS Improvement took the unprecedented step of publishing those for engagement prior to negotiating them with GPC England so that there was an opportunity to shape the proposals.

7.3 This generated a high and unambiguous level of concern, particularly but not solely from general practice. NHS England published a summary of the feedback on 30 January²⁵.

7.4 The major concerns raised included:

- the **workforce and workload implications** of the initial drafts;
- the **resources** to support the work;
- the level of **specificity**; and
- the **implied performance management approach**.

7.5 We have agreed a significantly revised approach:

- **Final requirements for three of the service specifications for 2020/21 have been rewritten.** They are radically shorter at three pages in total, and also respond to the detailed feedback. They replace the previous draft and are set out below;
- Quality improvement and high achievement against the service specifications will be supported by metrics in the network dashboard and

²⁴ NHS England and the BMA (2019) Investment and evolution: a five year framework for GP contract reform to deliver the NHS Long Term Plan. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

²⁵ NHS England and NHS Improvement (2020) Network Contract DES – Engagement on Draft Outline Service Specifications Summary report. Available from: <https://www.england.nhs.uk/wp-content/uploads/2020/01/2020-01-30-pcn-services-engagement-report.pdf>

direct incentivisation through the national Investment and Impact Fund. The dashboard will include data and indicators relating to the seven PCN service specifications to support local quality improvement, as well as wider information on population health and prevention, workforce, access and hospital use. From 2021/22 onwards, at least a third of IIF funding will directly support achievement of service specification-related indicators (£50m/£75m/£100m). This will recognise PCN efforts in the successful delivery of the specifications:

- **Two of the five service specifications – Anticipatory Care and Personalised Care - are deferred until 2021/22.** These – and the CVD Diagnosis and Prevention, and Tackling Health Inequalities specifications - will now be reworked and negotiated with GPC England in a similar manner to the three finalised service specifications prior to their introduction in 2021/22. In place of the Personalised Care specification in 2020/21, each PCN must provide access to a social prescribing service in 2020/21, drawing on the workforce funded under the Network Contract DES;
- We have clarified explicitly that **the volume of SMRs undertaken will be determined and limited by the clinical pharmacist capacity of the PCN;**
- **The proposed requirement for fortnightly face to face medical input to the care homes is replaced with a requirement for medical input to be ‘appropriate and consistent’ but with the frequency and form of this medical input to be based on local clinical judgement by the PCN;**
- **A new ‘Care Home Premium’ will provide an additional and specific contribution, responding to concerns about care home distribution between PCNs. PCNs will be entitled to a recurrent £120 per bed per year,** based on CQC data on registered care home beds in England (latest figure: 457,110 beds), which will be payable on or after 31 July once CCGs have (a) agreed the allocation of care homes to PCNs, and (b) agreed that PCNs have appropriately and comprehensively coded residents in care homes using the SNOMED codes available for this. Given that the core requirements of the 2020/21 Enhanced Health in Care Homes service specification do not come into effect until 30 September 2020, this funding is on a half-year (£60 per bed) basis in the first year;
- **Where a LES/LIS already exists for a service that is duplicated by the DES requirements, no decommissioning of that service by the CCG should take place until the DES requirements commence.** For the care homes service, for example this will be 1 October 2020. **Where the requirements in an existing LES/LIS exceed those in the DES, commissioners must, engaging with PCNs and LMCs and taking account of the PCN employment liabilities directly linked to delivery of the LES/LIS, consider maintaining this higher level of service provision**

to their patients, alongside an appropriate portion of existing funding additional to the entitlements of the national contract. **And all funding previously invested by CCGs in LES/LIS arrangements which are now delivered through the DES must be reinvested within primary medical care.** LMCs should be engaged on reinvestment proposals and provided with an annual report – drawn from CCG annual accounts – of how the CCG has used its primary medical care funding allocation; and

- **PCNs do not carry contractual responsibility for any failure by community service providers to deliver their part of the service, and vice versa.**

Structured Medication Review and Medicines Optimisation

From 1 April 2020, each PCN will:

1	Use appropriate tools to identify and prioritise patients who would benefit from a Structured Medication Review, which will include those: <ul style="list-style-type: none">• in care homes;• with complex and problematic polypharmacy, specifically those on 10 or more medications;• on medicines commonly associated with medication errors²⁶;• with severe frailty²⁷, who are particularly isolated or housebound patients, or who have had recent hospital admissions and/or falls; and• using potentially addictive pain management medication.
2	Offer and deliver a volume of SMRs determined and limited by PCN clinical pharmacist capacity, demonstrating all reasonable on-going efforts to maximise that capacity.
3	Ensure invitations to patients explain the benefits and what to expect.
4	Ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs. These professionals will need to have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop this qualification and skills.
5	Clearly record all SMRs within GPIT systems.
6	Actively work with their CCG to optimise quality of prescribing of (a) antimicrobial medicines, (b) medicines which can cause dependency, (c) metered dose inhalers, where a low carbon alternative may be appropriate and (d) nationally identified medicines of low priority.
7	Work with community pharmacies to connect patients appropriately to the New Medicines Service which supports adherence to newly prescribed medicines.

In delivering these requirements, PCNs must have due regard to separate guidance.

²⁶ See NHS Business Services Authority (2019) Medication Safety -Indicators Specification. Available from: <https://www.nhsbsa.nhs.uk/sites/default/files/2019-08/Medication%20Safety%20-%20Indicators%20Specification%20%28Aug19%29.pdf>. This experimental analysis links prescribing data to admissions data at a national level and outlines a number of prescribing situations that have resulted in harm or hospitalisation. A set of 20 indicators have been developed to help reduce medications errors and promote safer use of medicines.

²⁷ Based on the validation of the eFI, on average around 3% of over 65s will be identified as potentially living with severe frailty. However, in some practices this number may be significantly higher. Severe frailty is defined as a person having an eFI score of >0.36. <https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/efi/>

Enhanced Health in Care Homes

Each PCN will:

1	By 31 July 2020, agree the care homes for which it has responsibility with its CCG, and have agreed a simple plan about how the service will operate with local partners (including community services providers). People entering the care home should be supported to re-register with the aligned PCN.
2	By 31 July 2020, ensure a lead GP or GPs with responsibility for this service is agreed for each aligned care home
3	By 30 September 2020, work with community service providers (whose contracts will describe their joint responsibility in this respect) and other relevant partners to establish and coordinate a multidisciplinary team (MDT) to deliver this service.
4	As soon as is practicable, and by no later than 31 March 2021, establish protocols between the care home and with system partners for information sharing, shared care planning, use of shared care records and clear clinical governance.
5	<p>From 30 September 2020, deliver a weekly 'home round' for people living in the care home(s) who are registered with practices in the PCN. The home round must:</p> <ul style="list-style-type: none">• prioritise residents for review according to need based on MDT clinical judgement and care home advice (this is not intended to be a weekly review for all residents);• have consistency of staff in the MDT, save in exceptional circumstances; and• include appropriate and consistent medical input from a GP or geriatrician, with the frequency and form of this input determined on the basis of clinical judgement. <p>Digital technology may support the weekly home round and facilitate the medical input.</p>
6	<p>By 30 September 2020 have established arrangements for the MDT to develop and refresh as required a personalised care and support plan with people living in care homes. Through these arrangements, the MDT will:</p> <ul style="list-style-type: none">• aim for the plan to be developed and agreed with each new resident within seven working days of admission to the home and within seven working days of readmission following a hospital episode (unless there is good reason for a different timescale);• develop plans with the person and/or their carer;• base plans on the principles and domains of a Comprehensive Geriatric Assessment including assessment of the physical, psychological, functional, social and environmental needs of the person including end of life care needs where appropriate;

	<ul style="list-style-type: none"> draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals; and make all reasonable efforts to support delivery of the plan.
7	From 30 September 2020, identify and/or engage in locally organised shared learning opportunities as appropriate and capacity allows.
8	From 30 September 2020, support discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 27.

For the purposes of these requirements, a ‘care home’ is defined as a CQC-registered care home service, with or without nursing.²⁸ Good practice guidance will be developed to support PCNs in delivery of these requirements.

Supporting Early Cancer Diagnosis

From 1 April 2020, and building in a manageable way on the quality improvement activity on early cancer diagnosis set out in QOF, PCNs will take reasonable steps to improve rates of early cancer diagnosis for their registered population, in line with the NHS Long Term Plan ambition to increase the proportion of people who are diagnosed at stage 1 and 2 and supported by wider action by others in the healthcare system.

Each PCN will:

1	<p>Review referral practice for suspected cancers, including recurrent cancers. This will be done by:</p> <ul style="list-style-type: none"> enabling and supporting practices to review the quality of their referrals for suspected cancer, in line with NICE Guideline 12. This should make use of: Clinical Decision Support Tools; practice-level data to explore local patterns in presentation, and diagnosis of cancer; and, the new Rapid Diagnostic Centre pathway for people with serious but non-specific symptoms where available; and building on current practice to ensure a consistent approach to monitoring patients who have been referred urgently with suspected cancer or for further investigations to exclude the possibility of cancer (‘safety netting’), in line with NICE Guideline 12. ensuring that all patients are signposted to or receive information on their referral including why they are being referred, the importance of attending appointments and where they can access further support.
2	Contribute to improving local uptake of National Cancer Screening Programmes by:

²⁸ Care Quality Commission. Service Types. Available from <https://www.cqc.org.uk/guidance-providers/regulations-enforcement/service-types>

	working with local system partners – including the Public Health Commissioning team and Cancer Alliance – to agree the PCN contribution to local efforts to improve uptake. This should build on any existing actions across practices and include at least one specific action to engage with a group with low-participation locally.
3	<p>Support delivery of 1) and 2) through a community of practice between practice-level clinical staff that will:</p> <ul style="list-style-type: none"> • support constituent practices to conduct peer to peer learning events that look at data and trends in diagnosis across a Network, including cases where patients presented repeatedly before referral and late diagnoses. • support engagement with local system partners, including Patient Participation Groups, secondary care, the relevant Cancer Alliance and Public Health Commissioning teams.

Good practice guidance will be developed to support PCNs in delivery of these requirements.

8. Introducing the Investment and Impact Fund

- 8.1 The Investment and Impact Fund (IIF) will be introduced as part of the Network Contract DES in 2020/21, with PCNs rewarded for delivering objectives set out in the NHS Long Term Plan and the five-year agreement document²⁹.
- 8.2 At least £30m of the £150m IIF for 2021/22 will reward better access, rising in 2023/24 to at least £100m of the £300m. From 2021/22 onwards an expected £30m will support implementation of the vaccinations and immunisation changes, and at least a third of IIF funding will be directly linked to indicators related to service specifications. In light of revisions to plans for the service specifications, in 2020/21 the IIF will be worth £40.5m with the rest of the original £75m reinvested within the wider GP contract package to support three new commitments set out in this document: postnatal checks, diabetes QOF points, and the care homes premium.
- 8.3 As described previously, monies earned from the Fund must be used for workforce expansion and services in primary care. Each PCN will need to agree with their CCG how they intend to reinvest monies earned. This can take the form of a simple reinvestment commitment.

Design principles

8.4 The IIF will operate in a similar way to the QOF:

- **It will be a points-based system.** The IIF will contain domains relating to the NHS 'triple aim' (prevention and tackling health inequalities; providing high quality care; and creating a sustainable NHS). In turn it will contain *areas* described by individual performance indicators, the number of which will grow during the scheme's expansion. Each indicator will be allocated a certain number of points, with the number of points indicating the relative allocation of funds. The number of points allocated to each indicator will be subject to annual revision, with clear expiry dates for each indicator. Each IIF point will be worth a defined amount of money, details of which will be set out in the Network Contract DES. Payments will be proportional to points earned, with an adjustment for list size and (where relevant) prevalence;
- **It will have aspiration payments from 2021/22.** Funds earned via the IIF will be paid partly through aspiration payments. The aspiration payment will need to be approved by the PCN's aligned CCG before any funds are disbursed. Any adjustment to payments necessary due to a gap between

²⁹ NHS England and the BMA (2019) Investment and evolution: a five year framework for GP contract reform to deliver the NHS Long Term Plan. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

aspiration and attainment will take place once annual attainment is calculated at the end of the financial year; and

- **It will fairly reward performance based on national priorities.** Indicators will reward PCNs for attainment in relation to national goals. They will be structured very similarly to QOF, albeit with calculation of attainment and payment at the network rather than practice level. Each indicator will have a lower performance threshold below which no payment is made, and an upper performance threshold above which no payment is made. There will be a sliding scale relating attainment to reward for performance between the lower and upper thresholds. Upper performance thresholds for achievement have been defined taking into account national targets, LTP commitments, and expert clinical advice; lower thresholds are typically based on the 40th centile of 2018/19 performance for each indicator (with the exception of seasonal flu vaccination for over 65s where a bespoke lower threshold of 70% coverage has been agreed, social prescribing referrals which are based on expectations of the capacity available to PCNs, and low priority prescribing). These thresholds have been set to strike an appropriate balance between rewarding good performance, and ensuring that all networks are able to access some IIF funds. Where indicators have a lifespan of multiple years, thresholds will be subject to annual review.

Network Dashboard

- 8.5 **A new Network Dashboard from April 2020 will include key metrics to allow every PCN to see the benefits it is achieving for its local community and patients.** It will include indicators on performance against the IIF, by PCN and constituent practice. It will also include data and indicators relating to the seven PCN service specifications to support local quality improvement, as well as wider information on population health and prevention, workforce, access and hospital use. The dashboard will be available to all PCNs, and help identify areas of opportunity to reduce variations within and across PCNs and improve services for patients. The dashboard will evolve during 2020/21.

TABLE 6: 2020/21 IIF INDICATORS AND THRESHOLDS

Indicator	Indicator value (£m)	Indicative value for average PCN	Upper Threshold	Lower Threshold
Percentage of patients aged 65+ who received a seasonal flu vaccination (1 September-31 March)	8	£6,400	77%	70%
Percentage of patients on the LD register who received an LD health check	6.25	£5,000	80%	49%
Number of patients referred to social prescribing per 1000	6.25	£5,000	8 referrals per 1000 population	4 referrals per 1000 population
Gastro-protective prescribing - Percentage of patients prescribed a non-steroidal anti-inflammatory drug without a gastro protective (age 65+)	6.25 ³⁰	£5,000	30%	43%
Gastro-protective prescribing - Percentage of patients prescribed an oral anticoagulant and anti-platelet without a gastro-protective (age 18+)			25%	40%
Gastro-protective prescribing - Percentage of patients prescribed aspirin and another anti-platelet without a gastro-protective (age 18+)			25%	42%
Metered Dose Inhaler prescriptions as a percentage of all inhaler prescriptions (excluding salbutamol)	6.25	£5,000	45%	53%
Spend per patient on 20 of the 25 medicines on the national list of items that should not routinely be prescribed in primary care	7.5	£6,000	PCN spending goal	60% above PCN spending goal

³⁰ The £6.25 million available to incentivise increased gastro-protective prescribing will be divided proportionately to the size of the target groups (i.e. the denominators) for each of these three indicators.

9. Network arrangements

Network Contract DES registration

- 9.1 Over 99% of practices across England are currently signed up to the Network Contract DES. The improvements to the contract agreement mean that PCNs can have certainty and confidence to develop.
- 9.2 PCN membership should be seen as a long-term decision. Frequently changing membership threatens the agreements which PCNs have strived to make, including on how services will be delivered, how workforce will be employed, how payments will operate and how liabilities will be shared.
- 9.3 NHS England and GPC England will support PCNs to have stable membership through the introduction in 2021/22 of auto-enrolment for existing practices and PCNs, combined with an annual one-month window in which practices will be able to opt-out of the Network Contract DES, or opt-in if they are not currently participating. Sign-up and opt-out will only be allowed outside the window in exceptional circumstances, at the discretion of the commissioner. This will also help to reduce those instances where an agreed PCN later becomes unviable due to one of its member practices choosing to serve notice on the DES mid-year, particularly where this has left the PCN below the necessary 30,000 population.
- 9.4 In 2020/21, commissioners will reconfirm with practices that they are continuing to participate in the DES on the basis of existing PCN footprints. Practices are strongly encouraged to confirm participation before local payment deadlines in April, to ensure there is no interruption in their PCN-related income. Practices may subsequently opt out of the DES, and will be able to serve the required one month's notice up until 31 May. Practices will also have until 31 May 2020 to sign up to the DES. Sign-up and opt-out after 31 May will only be allowed in exceptional circumstances, at the discretion of the commissioner.
- 9.5 To ensure that the whole of England benefits from the investment and service improvements that PCNs offer, CCGs must ensure 100% population coverage of PCNs. Existing practices have guaranteed preferential rights. But where they choose to opt-out, arrangements for alternative provision of core GMS with network services will automatically apply.

Equal opportunity to join a PCN

- 9.6 Every practice has the right to sign up to the Network Contract DES and join a PCN. It is voluntary. In unusual circumstances, we have seen practices wanting to sign up to the Network Contract DES but unable to find a PCN to join. Such occurrences will become rare over time as PCN membership stabilises. But

where it does occur, it does not deliver the best outcome for patients or for practices.

- 9.7 Where agreement between a practice that wishes to sign up to the Network Contract DES and a PCN is difficult to secure, CCGs, with their LMC, will, as has been the case this year, support the parties involved through mediation to come to agreement on the practice joining the PCN. We will introduce from April 2020 the ability for CCGs, in the unlikely circumstances that agreement cannot be secured through the mediation process, to assign such a practice to a PCN. This will require the CCG to work closely with the LMC on the decision given its sensitivity.

The Network Agreement

- 9.8 The Network Agreement documents the collaboration between all constituents of the PCN. Like the partnership agreement of a GP practice, it sets out the arrangements and responsibilities of each member. *Investment and Evolution* committed to amending the Network Contract DES from 2020/21 to include collaboration with non-GP providers as a requirement, and that the Network Agreement will be the formal basis for working with other non-GP providers and community-based organisations³¹. We expect that in many cases PCNs are already collaborating with local non-GP providers and have agreements in place about what this looks like. Cementing these relationships further, from April 2020, in order to deliver the requirements of the Network Contract DES, PCNs will need to agree with their local Community Services provider(s), community mental health provider(s), and Community Pharmacies how they will work together.
- 9.9 This will be supported by a requirement in the Network Contract DES for each PCN to outline in Schedule 7 of the Network Agreement the details of the collaboration agreement reached with its Community Services provider(s) and Community Pharmacy, particularly where this is necessary to deliver the DES service specifications. PCNs will need to work with community providers to deliver a consistent plan for service delivery across an area, for example in relation to delivery of the Care Homes service specification. Requirements in relation to delivering service specifications will be part of community services contracts from April 2020, as will an obligation to configure according to PCN footprints. There will also be a specific need for mental health providers to agree arrangements with PCNs for delivering integrated care across PCN footprints by April 2021.

³¹ NHS England and the BMA (2019) Investment and evolution: a five year framework for GP contract reform to deliver the NHS Long Term Plan. Available from: <https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf>

Annex A: List of 2020/21 contractual requirements and non-contractual agreements

2020/21 Contractual requirements

Additional Services

1. From October 2020, maternity medical services and child health surveillance will no longer be Additional Services but will become part of Essential Services. There will be no opt-out or reduction of global sum as a result.
2. As a component of Essential Services, GPs must provide all necessary maternity medical services to female patients whose pregnancy has terminated as a result of miscarriage or abortion. Where a GP has a conscientious objection to providing treatment required following an abortion, the GP may refer the patient to another GP in the practice who does not have an objection or where there is no such GP then they must sub-contract all or part of maternity medical services to another GP.
3. The Regulations will also be amended to revise the definition of the “postnatal period” from 2 to 8 weeks, to bring it in line with other guidance on best practice, along with the needs of women following birth.

Appointments data

4. From 2020, all general practices and primary care networks in England will be required to participate in NHS Digital's 'Appointments in General Practice' data collection. Providers will also be required to support improvements to the data quality of this collection by:
 - mapping each appointment slot type to the most appropriate 'national category', once the national category capability has been switched on by their system supplier.
 - taking additional action to improve the data quality as required by forthcoming guidance, which will be agreed with the BMA and may require a change to the Regulations; and
 - implementation support will be available for providers to draw upon during 2020-21, with an expectation that these actions will be completed by 1 October 2020, subject to availability of necessary system supplier capability.

The date in 2020/21 when practices are required to use the dataset and provide quality data will depend on the timing of IT system changes during the course of the year. By March 2021, the dataset will be fully comprehensive, covering all practices without exception

5. As agreed in the five-year deal, a new, as close to real-time as possible and transparent measure of patient experience will be designed and tested in 2020, for nationwide introduction by no later than 1 April 2021. Practices will be required to participate in this.

Digital

6. From April 2020:
 - GP practices should no longer use facsimile machines for either NHS or patient communications where there is a secure electronic alternative;
 - GP practices must offer all patients online access to all prospective data on their patient record unless exceptional circumstances apply. This will not affect the right of any patients registered from October 2019 until the new Regulations come into force to online access to their prospective record from their date of registration. In addition, GP practices will make online access to the full historic digital record available to patients on request. We will look at how third-party redaction software could be made available to general practice as a matter of course to further support practices deliver full historic online access to records for their patients; and
 - GP practices will need to have an up-to date and informative online presence, with key information being available as standardised metadata for other platforms to use.

The Regulations will be updated in April 2020 to incorporate these changes.

List cleansing

7. From October 2020, there will be a new requirement in the GP contract for practices to support NHS England to fulfil its statutory duties to maintain an accurate and up-to-date list of patients. The change will make it clear that this will only oblige practices to undertake activity that is reasonable.

MHRA CAS alert system

8. Since October 2019, practices have been contractually required to register a practice email address with the MHRA CAS alert system and monitor the email account to act on CAS alerts where appropriate; notify the MHRA if the email address changes to ensure MHRA distribution list is updated; and register a mobile phone number (or several) to MHRA CAS to be used only as an emergency back up to email for text alerts when email systems are down. In the interests of patient safety and business continuity, guidance in relation to this requirement will be amended to clarify that 'practice' email address means a generic email rather than an individual account.

Patient assignment

9. From October 2020, there will be a change to the arrangements for patients whose relationship with their practice has broken down, and who need to be reassigned to another practice. Currently, such patients can only be assigned to a practice in whose catchment area they live. With ever larger practices and catchment areas, increasingly that has limited the choice of a new practice. With this change, the new practice can be anywhere in the CCG where the patient lives. NHS E/I will produce guidance for commissioners emphasising that in making such assignments contractors should not be mandated to provide home visits outside their practice area so it may be necessary to register such patients as an out-of-area registered patient.
10. The Regulations will be amended to clarify commissioners' powers and responsibilities to assign patients whose practice has closed to a new GP practice, in discussion with that practice.

Pay transparency

11. From October 2020, the Regulations will be amended to require contractors and sub-contractors to submit self-declarations annually if their NHS superannuable earnings are over £150,000 per annum – starting with 2019/20 income. This threshold will rise each year in line with predicted Consumer Price Index (CPI) rises:

	19/20	20/21	21/22	22/23	23/24
Threshold	£150k	£153k	£156k	£159k	£163k

12. Salaried GPs and locums will also be expected to declare NHS earnings over £150,000 per annum along with:
 - company directors, employees and others engaged through companies contracted or sub-contracted to provide primary medical services, howsoever remunerated; and
 - any other person employed, engaged contracted or sub-contracted - howsoever remunerated - by any of the above or any other party to provide NHS-funded primary medical services.
13. For the purposes of pay transparency, NHS earnings will be defined initially as GP pensionable income³² although the scope may be broadened in future years. The self-declaration process will be aligned with the pensions return to minimise burden and potential costs for practices.

14. 2019/20 NHS earnings of over £150,000 will need to be declared in February 2021. Individuals with total NHS earnings above £150,000 per annum will be listed by name and earnings bands in a national publication.
15. Further guidance will be published later this year on the process.
16. In 2020/21, NHS England and NHS Improvement will also look to arrange for the publication of anonymous data on the NHS earnings of all GPs, along with their whole time equivalent status.

6-8 week postnatal checks for new mothers

17. From October 2020, the Regulations will be amended to include a new requirement for GPs to offer a maternal check at 6-8 weeks after birth, as an additional appointment to that for the baby. This should be provided for both live and still births. In line with NICE guidance, the maternal check should focus on:
 - a review of the mother's mental health and general wellbeing, using open questioning;
 - the return to physical health following childbirth, and early identification of pelvic health issues;
 - family planning and contraception options; and
 - any conditions that existed before or arise during pregnancy that require on-going management, such as gestational diabetes.
18. Following a birth, the maternity unit will write to the mother's practice notifying them of the outcome, along with any issues of relevance for future management. At this time, the GP practice should arrange an appointment for the mother at 6-8 weeks, as is already done for the baby check.
19. Scheduling this check 'back to back' with the baby check would reduce travelling burden on parents, and having mother and baby together aids insight into bonding and interaction. However, mothers may opt for these appointments to be separate.
20. Additional funding has been added to the core practice contract to support practices to deliver the requirements.

Quality and Outcomes Framework changes

21. See Chapter 6 and Annex B for further details of the QOF changes from April 2020.

Recruitment and Retention initiatives

22. The SFE will be updated where required to support delivery of the recruitment and retention schemes outlined in Chapter 2.

Removal of patients who are violent from the practice list

23. From October 2020, an existing requirement in the GMS Regulations relating to the removal of patients who are violent from the practice list will be updated. The Regulations currently enable a contractor to remove a patient from their list if they become aware the patient has previously been removed from another GP practice list for committing or threatening an act of violence. The change will clarify that patients should not be removed from the GP practice list if, having been previously removed from a GP practice list and entered into a Special Allocation Scheme for violent patients, they have subsequently been discharged for reintegration into mainstream primary care.

Removal of patients who live outside of the practice catchment area

24. From October 2020, when a patient is removed from a practice list because they have moved outside of the practice catchment area, once the contractor notifies the commissioner of that removal, the patient will continue to be registered with the practice for 30 days (or until they register with another practice, whichever is sooner) but the contractor will not be required to provide home visits during that period. This strikes an appropriate balance, in ensuring patients have continuous access to primary medical care while not requiring contractors to provide home visits at a distance from their practice. Patients requiring a home visit during this 30-day period will be advised either to register with a new local GP practice, or access the services commissioned locally for out-of-area registered patients.

Service requirements and associated data under the Network Contract DES

25. New service specifications under the Network Contract DES will be introduced as described in Chapter 7. Metrics are associated with the forthcoming service specifications to support local quality improvement initiatives and, in some cases, achievement of the IIF. The Network Contract DES will also contain specific requirements, agreed with GPC England, to improve data quality for the metrics associated with the service specifications and to ensure appropriate use of related clinical codes to be introduced during 2020/21.

Sub-contracting under the Network Contract DES

26. Restrictions on sub-contracting of clinical services under GMS and PMS arrangements are impacting on the ability of PCNs to enter into agreements with other organisations to support the delivery of the Network Contract DES. An example is where a practice sub-contracts a requirement of the Network Contract DES to another organisation. From October 2020, to support PCNs to deliver the requirements of the Network Contract DES, amendments to GMS and PMS arrangements will be made to make clear that onward sub-contracting of clinical matters will be allowed but only in relation to the Network Contract DES and where permission of the commissioner is granted.

Termination right

27. From October 2020, commissioners will be able to terminate a GMS contract if the contractor has already had its Care Quality Commission (CQC) registration permanently cancelled. In these circumstances the contractor can no longer provide primary medical services, and a termination right will make it easier for commissioners to arrange a new GP for the contractor's former registered patients.

Vaccinations and Immunisations

28. See Chapter 5.

Workforce data

29. Workforce data reported by practices via the National Workforce Reporting System (NWRS) is vital to understanding workforce pressures in primary care, and supporting effective workforce planning. We propose to introduce a new contractual requirement for practice updates to the NWRS to be made on a monthly basis as a minimum (currently quarterly). We will also continue to work with NHS Digital and wider stakeholders to strengthen the reporting and tools made available to practices and PCNs from this data to support their workforce planning activity.

Premises Costs Directions

30. We have agreed a number of changes to the Premises Costs Directions to allow commissioners to make larger investments in GP practices in a more flexible way and seek to provide contractors with reassurance about their premises liabilities. The new Directions also deliver some significantly improved terms for contractors, as well as technical updates:

- we have removed a long-standing restriction on commissioner contribution to premises improvements. Commissioners can now award improvement grants funding up to 100% of project value. Grant values have been increased, and abatement and guaranteed use periods have been reduced;
- we have agreed a number of measures to support contractors who may wish to retire but cannot find a successor partner from within the practice (“last partner standing”); and
- in addition, the new Directions mean:
 - commissioners will reimburse VAT on rent payments;
 - commissioners will reimburse Stamp Duty Land Tax (SDLT) on acquiring land or premises;
 - rent reviews will not require contractors to undertake their own valuation;
 - rent reviews will not lead to varying lease terms;
 - fewer restrictions around grants to assign or surrender a lease;
 - more formalised arrangements for third-party use of premises, with protections for the contractor and reimbursement of legal expenses;
 - improved provisions for minimum standards reviews;
 - reimbursement of Business Improvement District (BID) levies; and
 - rights to reclaim overpayments made after the Directions are published.

2020/21 Non-contractual changes

Improved employment practices

31. We have agreed a new *Core NHS Offer* statement for staff delivering primary medical services. This will be published in due course.
32. During 2020/21 we will review and agree changes in the following areas to be delivered within existing resources:
 - the minimum sickness and parental leave provisions all staff in primary care should be able to expect;
 - childcare support;
 - occupational health provision, aligned to wider NHS England and NHS Improvement work; and
 - tackling the gender pay gap in general practice.
33. We are committed to agreeing arrangements that will allow practices to make a more generous offer of Enhanced Shared Parental Leave to employed GPs, starting as soon as possible in 2020/21.

De-registration of Crown Servants overseas and their dependents

34. NHS England and NHS Improvement, the BMA, DHSC and the Foreign and Commonwealth Office (FCO) have agreed a programme of work to improve arrangements for Crown Servants overseas and their dependents in 2020/21, to ensure this cohort of patients have good continuity of care and access to secondary care services.

Domestic violence letters

35. Legal aid letters for victims of domestic violence will be considered as part of the 2020/21 Review of Cross-Government bureaucracy in general practice. The BMA will write to GPs to recommend that, while the review is taking place, they do not charge victims of domestic violence for the completion and signing of legal aid letters.

Obesity and referrals to weight management services

36. From 2020/21, we will introduce a new non-contractual requirement for GPs to offer to refer people with obesity into weight management services, where this is clinically appropriate and where these services exist.

Reducing the carbon impact of inhalers

37. The NHS has committed to reducing the carbon impact of inhalers used in the treatment of respiratory conditions by 50%. These impacts are described in the 2019 BTS/SIGN Asthma guidelines and by NICE in its 2019 Shared Decision Aid on Asthma. All inhaler prescriptions, Structured Medication Reviews or planned Asthma Reviews taking place in primary care should consider moving or facilitating patients to lower carbon options where it is clinically appropriate to do so.

Annex B: QOF indicator changes

Table 1: New and amended indicator wording agreed for 2020/21 - asthma

Current 19/20 indicator wording	Agreed new wording in 20/21	Points	Payment thresholds
AST001. The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	AST005. The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months (based on NM165)	4	NA
AST002. The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis (NM101)	AST006. The percentage of patients with asthma on the register from 1 April 2020 with either: 1) a record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before or 6 months after diagnosis; or 2) if newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after 1 April 2020 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration. (based on NM166)	15	45-80%

<p>AST003. The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions (NM23)</p>	<p>AST007. The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan (based on NM167)</p>	<p>20</p>	<p>45-70%</p>
<p>AST004. The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months (NM102)</p>	<p>AST008. The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months (based on NM168)</p>	<p>6</p>	<p>45-80%</p>

Table 2: New and amended indicator wording agreed for 2020/21: COPD

Current 19/20 indicator wording	Agreed new wording in 20/21	Points	Payment thresholds
<p>COPD001. The contractor establishes and maintains a register of patients with COPD</p> <p>COPD002. The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register (NM103)</p>	<p>COPD009. The contractor establishes and maintains a register of:</p> <ol style="list-style-type: none"> 1. Patients with a clinical diagnosis of COPD before 1 April 2020 and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2020 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV₁/FVC ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered in the preceding 12 months a record of an FEV₁/FVC ratio below 0.7 recorded within 6 months of registration); and 3. Patients with a clinical diagnosis of COPD on or after 1 April 2020 who are unable to undertake spirometry (based on NM169) 	8	NA
<p>COPD003. The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (NM104)</p>	<p>COPD010. The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale (NM170)</p>	9	50-90%

Table 3: New and amended indicator wording agreed for 2020/21 - Heart Failure

Current 19/20 indicator wording	Agreed new wording in 20/21	Points	Payment thresholds
<p>HF002. The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register (NM116)</p>	<p>HF005. The percentage of patients with a diagnosis of heart failure after 1 April 2020 which has been confirmed by:</p> <ol style="list-style-type: none"> 1. an echocardiogram or by specialist assessment between 3 months before or 6 months after entering on to the register; or 2. if newly registered in the preceding 12 months, with a record of an echocardiogram or a specialist assessment within 6 months of the date of registration. (based on NM71) 	<p>6</p>	<p>50-90%</p>
<p>HF003. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB (NM89)</p>	<p>HF003. The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with an ACE-I or ARB (NM172)</p>	<p>6</p>	<p>60-92%</p>
<p>HF004. In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure. (NM90)</p>	<p>HF006. The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure (NM173)</p>	<p>6</p>	<p>60-92%</p>

N/A	HF007. The percentage of patients with heart failure on the register, who had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximum tolerated doses (based on NM174)	7	50-90%
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Table 4: new indicator wording for 2020/21: non-diabetic hyperglycaemia

Agreed indicator wording	Points	Payment thresholds
The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or FPG test in the preceding 12 months	18	50-90%

Changes to INLIQ

There will be no changes to the INLIQ extraction in 2020/21.

Annex Bi: QOF Quality Improvement

The two topics areas agreed for 2020/21 are Early Cancer Diagnosis and Care of People with a Learning Disability.

Early cancer diagnosis

QI005. The contractor can demonstrate continuous quality improvement activity focussed upon early cancer diagnosis as specified in the QOF guidance

QI006. The contractor has participated in network activity to regularly share activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings

Learning disabilities

QI007. The contractor can demonstrate continuous quality improvement activity focussed upon learning disabilities as specified in the QOF guidance

QI008. The contractor has participated in network activity to regularly share activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings

Copies of the modules can be found: <https://www.england.nhs.uk/gp/investment/gp-contract/>

Annex C: Network contract DES Workforce Role Descriptions and Outputs

The Network Contract DES Additional Roles Reimbursement Scheme has been expanded to include pharmacy technicians, two new personalised care roles, and three allied health professional (AHP) roles, in addition to first contact social prescribing link workers, physiotherapists, physician associates, and paramedics. The six new roles will be:

- health and wellbeing coaches
- care coordinators
- podiatrists
- dieticians
- occupational therapists
- pharmacy technicians

These roles have been identified and chosen due to the benefits they would bring to primary care in terms of supporting capacity and patient care, as well as the further development of multi-disciplinary teams within the community. This annex below provides information on the core role requirements for the new roles that will be reimbursable under the Network Contract DES Additional Roles Reimbursement Scheme from April 2020 and April 2021 respectively. It does not provide a comprehensive list, and PCNs must determine the job descriptions for their staff ensuring they reflect the core requirements and enable delivery of the service requirements set out in the Network Contract DES Specification.

Clinical Pharmacists and Social Prescribing Link Workers were included within the scheme from July 2019. Information relating to these two roles is included in the 2019/20 Network Contract DES Specification³³. This specification will be updated in March 2020 to cover the period 1 April 2020 to 31 March 2021.

1. Workforce roles beginning from April 2020

There will be three personalised care roles based in primary care: social prescribing link workers, health and wellbeing coaches and care coordinators. These roles form a single resource for GPs and other primary care professionals to provide an all-encompassing approach to personalised care across PCNs.

The role outline for social prescribing link workers will be updated to reflect some minor additions and training requirements will include the following:

³³ <https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-des-specification-2019-20/>

- Completing the NHSE/I Health Education England online learning programme at <https://www.e-lfh.org.uk/programmes/social-prescribing/>
- Attend the peer support networks run by NHSE/I at ICS/STP level.
- Acquire basic health coaching training and have an introduction to Personal Health Budgets (PHBs).

i. Health and wellbeing coaches

Description of role/core responsibilities

- Up to indicative Agenda for Change band 5

Health and wellbeing coaches predominately use health coaching skills to support people with lower levels of patient activation to develop the knowledge, skills, and confidence to manage their health and wellbeing, whilst increasing their ability to access and utilise community support offers. They may also provide access to self-management education, peer support, and social prescribing.

Health and wellbeing coaches will take an approach that considers the whole person in addressing existing issues and encourages proactive prevention of new and existing illnesses. They will take an approach that is non-judgemental, based on strong communication and negotiation skills, that supports personal choice and positive risk taking, that addresses potential consequences, and ensures patients understand the accountability of their own decisions.

Health and wellbeing coaches will:

- a. Coach and motivate patients through multiple sessions to identify their needs, set goals, and support them to implement their personalised health and care plan.
- b. Provide personalised support to individuals, their families and carers to ensure that they are active participants in their own healthcare; empowering them to take more control in managing their own health and wellbeing, to live independently, and improve their health outcomes through:
 - providing interventions such as self-management education and peer support; and
 - supporting people to establish and attain goals set by the person based on what is important to them, building on goals that are important to the individual; and
 - working with the social prescribing service to connect them to community-based activities which support their health and wellbeing.

- c. Provide support to local community groups and work with other health, social care and voluntary sector providers to support the patients' health and well-being holistically.
- d. Ensure that fellow PCN staff are made aware of health coaching and social prescribing services and support colleagues to improve their skills and understanding of personalised care, behavioural approaches, and ensuring consistency in the follow up of people's goals where an MDT is involved.
- e. Raise awareness within the PCN of shared decision making and decision support tools and supporting people in shared decision-making conversations.
- f. Work with people with lower activation to understand their level of knowledge, skills and confidence (their "Activation" level) when engaging with their health and wellbeing.
- g. Explore and support access to a personal health budget, where appropriate, for their care and support.
- h. Utilise existing IT and MDT channels to screen patients, with an aim to identify those that would benefit from health coaching

Training requirements

- The Personalised Care Institute (live from April 2020) will set out what training is available and expected for Health coaching link workers.
- Health coaching link workers will be required to be trained in health coaching in line with the NHS England and NHS Improvement summary guide (document currently in development, and subject to discussion with GPC England). This is likely to include understanding the basics of social prescribing, plus 4-day health coaching training with regular supervision from health coaching mentor.

ii. Care Coordinators

Description of role/core responsibilities

- Agenda for Change band 4

Care coordinators provide extra time, capacity and expertise to support patients in preparing for or in following-up clinical conversations they have with primary care professionals. They will work closely with the GPs and other primary care professionals within the PCN to identify and manage a caseload of identified patients, making sure that appropriate support is made available to them and their carers, and ensuring that their changing needs are addressed. They focus delivery of the comprehensive model to reflect local priorities, health inequalities or population health management risk stratification.

Key role requirements

Care coordinators will:

- a. Proactively identify and work with a cohort of people to support their personalised care requirements, using the available decision support aids.
- b. Bring together all of a person's identified care and support needs, and explore their options to meet these into a single personalised care and support plan, in line with PCSP best practice.
- c. Help people to manage their needs, answering their queries and supporting them to make appointments.
- d. Support people to take up training and employment, and to access appropriate benefits where eligible.
- e. Raise awareness of shared decision making and decision support tools, and assist people to be more prepared to have a shared decision making conversation.
- f. Ensure that people have good quality information to help them make choices about their care,
- g. Support people to understand their level of knowledge, skills and confidence (their "Activation" level) when engaging with their health and wellbeing, including through use of the Patient Activation Measure.
- h. Assist people to access self-management education courses, peer support or interventions that support them in their health and wellbeing.
- i. Explore and assist people to access personal health budgets where appropriate.
- j. Provide coordination and navigation for people and their carers across health and care services, alongside working closely with social prescribing link workers, health and wellbeing coaches and other primary care roles.
- k. Support the coordination and delivery of MDTs within PCNs.

Training requirements

- The Personalised Care Institute (live from April 2020) will set out what training is available and expected for Care Coordinators.

iii. First Contact Physiotherapists

Description of role/core responsibilities

- Indicative Agenda for Change band 7-8a

First contact physiotherapists operate at an advanced level of clinical practice, with skills to assess, diagnose, treat and manage musculoskeletal (MSK) problems and undifferentiated conditions. This will involve seeing patients, without prior referral from their GP, to establish a rapid and accurate diagnosis and management plan, thus streamlining pathways of care. They work independently in clinical practice and do not require day to day supervision. Patients can either self-refer or be referred by the network's members.

The following sets out the key role responsibilities for first contact physiotherapists:

- a. They will work as part of a multi-disciplinary team in a patient facing role, using their expert knowledge of Musculoskeletal (MSK) issues, to create stronger links for wider MSK services through clinical leadership, teaching and evaluation skills.
- b. They will assess, diagnose, triage and manage patients, taking responsibility for the management of a complex caseload etc
- c. They will receive patients who self-refer (where systems permit) or from a clinical professional within the network.
- d. First contact physiotherapists will progress and request investigations (such as x-rays and blood tests) and referrals to facilitate diagnosis and choice of treatment regime, understanding the limitations of investigations, interpret and act on results and feedback to aid diagnosis and the management plans of patients.
- e. They will develop integrated and tailored care programmes in partnership with patients and provide a range of first line treatment options, including self-management and referral to rehabilitation focussed services and social prescribing provision. These programmes will facilitate behavioural change, optimise patients' physical activity and mobility, support fulfilment of personal goals and independence and reduce the need for pharmacological interventions.
- f. They will develop relationships and a collaborative working approach across the PCN supporting the integration of pathways in primary care.
- g. They will develop and make use of their full scope of practice, including skills relating to independent prescribing, injection therapy and investigation.

- h. They will provide learning opportunities for the whole multi-professional team within primary care, as determined by the PCN. They will also work across the multi-disciplinary team to develop and evaluate more effective and streamlined clinical pathways and services.
- i. They will liaise with secondary care MSK services, community care MSK services and local social and community interventions as required, to support the management of patients in primary care.
- j. Using their professional judgement, they will take responsibility for making and justifying decisions in unpredictable situations, including in the context of incomplete/contradictory information.
- k. They will manage complex interactions, including working with patients with psychosocial and mental health needs, referring to social prescribing when appropriate.
- l. Communicate effectively and appropriately, with patients and carers, complex and sensitive information regarding diagnosis, pathology, prognosis and treatment choices supporting personalised care.
- m. Implement all aspects of effective clinical governance for own practice, including undertaking regular audit and evaluation, supervision and training.
- n. They will be accountable for decisions and actions via Health and Care Professions Council (HCPC) registration, supported by a professional culture of peer networking/review and engagement in evidence-based practice.
- o. Encourage collaborative working across the health economy and be a key contributor to the primary care networks providing leadership and support on MSK clinical and service development across the network
- p. Support regional and national research and audit programmes to evaluate and improve the effectiveness of the FCP programme. This will include communicating outcomes and integrating findings into own and wider service practice and pathway development.
- q. First contact physiotherapists will develop integrated and tailored care programmes in partnership with patients through:
 - effective shared decision making with a range of first line management options (appropriate for the person's level of activation);
 - assessing levels of Patient Activation to confirm levels of knowledge, skills and confidence to self-manage and to evaluate and improve the effectiveness of self-management support interventions, particularly for those at low levels of activation; and
 - agreeing appropriate support for self-management through referral to rehabilitation focussed services and social prescribing provision. These programmes will facilitate behavioural change, optimise patient's physical activity and mobility, support fulfilment of personal goals and independence and reduce the need for pharmacological interventions

Training requirements

In order to qualify as a first contact physiotherapist working across a primary care network, the individual will need to have:

- completed an undergraduate degree in physiotherapy;
- be registered with the Health and Care Professions Council;
- be a member of the CSP or appropriate professional body;
- a Masters Level qualification or equivalent specialist musculoskeletal knowledge, skills and experience;
- completed Level 7 Modules in MSK related areas of practice (advanced assessment / diagnosis / treatment); and
- Hold credentials in imaging i.e. diagnostic or procedural.

iv. Podiatrists

Description of role/core responsibilities

- Indicative Agenda for Change band 7

Podiatrists are healthcare professionals that have been trained to diagnose and treat foot and lower limb conditions. Podiatrists provide assessment, evaluation and foot care for a wide range of patients, which range from low-risk to long-term acute conditions. Many patients fall into high risk categories such as those with diabetes, rheumatism, cerebral palsy, peripheral arterial disease and peripheral nerve damage.

Key role requirements

- a. Provide treatments for patients of all ages whilst autonomously managing a changing caseload as part of the PCN's MDT team.
- b. Assess and diagnose lower limb conditions and foot pathologies, commence management plans, deliver foot health education to patients and colleagues.
- c. Liaise with PCN colleagues, community and secondary care staff, and named clinicians to arrange further investigations and onward referrals.
- d. Use and provide guidance on a range of equipment including surgical instruments, dressings, treatment tables, and orthotics.
- e. Provide treatment for high-risk patient groups such as the elderly and those with increased risk of amputation.
- f. Use therapeutic and surgical techniques to treat foot and lower leg issues (e.g. carrying out nail and soft tissue surgery using local anaesthetic).
- g. Prescribe, produce, and fit orthotics and other aids and appliances.
- h. Undertake continued professional development to understand the mechanics of the body in order to preserve, restore and develop movement for patients.
- i. Undertake a range of administrative tasks such as ensuring stock levels are maintained and securely stored, and equipment is kept in good working order.

Entry requirements and training

- BSc in Podiatry under an approved training programme
- Registered member of Health and Care Professions Council (HCPC)

v. Dieticians

Description of role/core responsibilities

- Indicative Agenda for Change band 7

Dieticians are healthcare professionals that diagnose and treat diet and nutritional problems, both at an individual patient and wider public health level. Working in a variety of settings with patients of all ages, dieticians support changes to food intake to address diabetes, food allergies, coeliac disease and metabolic diseases.

Dietitians also translate public health and scientific research on food, health and disease into practical guidance to enable people to make appropriate lifestyle and food choices.

Key role requirements

- a. Provide specialist nutrition and diet advice to patients, their carers and healthcare professionals through treatment and education plans and prescriptions.
- b. Educate patients with diet-related disorders on how they can improve their health and prevent disease by adopting healthier eating and drinking habits.
- c. Make recommendations to PCN staff regarding changes to medications for the nutritional management of patients, based on interpretation of biochemical, physiological, and dietary requirements.
- d. Provide dietary support to patients of all ages (from early-life to end-of-life care) in a variety of settings including nurseries, patient homes, and care homes.
- e. Work as part of a multidisciplinary team to gain patients' cooperation and understanding in following recommended dietary treatments.
- f. Develop, implement and evaluate a seamless nutrition support service that is aimed at continuously improving standards of patient care and wider MDT working.
- g. Work with clinicians, MDT colleagues, and external agencies to ensure the smooth transition of patients discharged from hospital back into primary care, so that they can continue their diet plan.
- h. Ensure best-practice in clinical practice, caseload management, education, research and audit, to achieve corporate PCN and local population objectives.
- i. Undertake a range of administrative tasks such as ensuring stock levels are maintained and securely stored, and equipment is kept in good working order.

Key role requirements

- BSc pre-reg MSc in Dietetics under an approved training programme
- Registered member of Health and Care Professions Council (HCPC)

vi. Occupational therapists

Description of role/core responsibilities

- Indicative Agenda for Change band 7

Occupational therapists (OTs) support people of all ages with problems resulting from physical, mental, social, or developmental difficulties. OTs provide interventions that help people find ways to continue with everyday activities that are important to them. This could involve learning new ways to do things, or making changes to their environment to make things easier. As patients' needs are so varied, OTs must take a holistic approach to each individual patient; managing physical, social, psychological, and environmental needs alongside good clinical practice.

Key role requirements

- a. Assess, plan, implement and evaluate treatment plans, with an aim to increase patients' productivity and self-care.
- b. Work with patients through a shared-decision making approach to plan realistic, outcomes-focused goals.
- c. Undertake both verbal and non-verbal communication methods to address the needs of patients that have communication difficulties.
- d. Involve MDT colleagues, physiotherapists, social workers, alongside patients' families, teachers, carers and employers in treatment planning, to aid rehabilitation.
- e. Where appropriate, support the development of discharge and contingency plans with relevant professionals to arrange on-going care in residential, care home, hospital, and community settings.
- f. Periodically review, evaluate, and change rehabilitation programmes to rebuild lost skills and restore confidence.
- g. Where appropriate, advise on home, school, and workplace environmental alterations, such as adjustments for wheelchair access, technological needs, and ergonomic support.
- h. Teach coping strategies and support adaptation to manage long term conditions for physical and mental health.
- i. Advise on specialist equipment and organisations to help with daily activities.

Entry requirements and training

- BSc or pre reg MSc in Occupational Therapy under an approved training programme
- Registered member of Health and Care Professions Council (HCPC)

vii. Physician Associates

Description of role/core responsibilities

- Indicative Agenda for Change Band 7

A physician associate (PA) is a trained healthcare professional who works directly under the supervision of a doctor as part of the medical team. They are usually generalists with broad medical knowledge but can develop expertise/specialisms in a particular field.

The responsibilities of the role include direct patient contact through assessment, examination, investigation, diagnosis and treatment. Physician associates will have a key role in supporting delivery of Network Contract DES Services.

The following sets out the key role responsibilities for a physician associate:

- a. Physician associates will provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems utilising history-taking, physical examinations and clinical decision-making skills to establish a working diagnosis and management plan in partnership with the patient (and their carers where applicable).
- b. They will also review, analysis and action diagnostic test results.
- c. They will deliver integrated patient centred-care through appropriate working with the wider primary care multi-disciplinary team and social care networks.
- d. They will undertake face-to-face, telephone and online consultations for emergency or routine problems, as determined by the PCN, including management of patient's with long-term conditions. Where required by the PCN, physician associates can offer specialised clinics following appropriate training including (but not limited to) family planning, baby checks, COPD, asthma, diabetes and anticoagulation.
- e. They will undertake home visits and participate in duty rotas.
- f. Physician associates will provide health/disease promotion and prevention advice to patients.
- g. Physician associates will utilise clinical guidelines and promote evidence-based practice and partake in clinical audits, significant event reviews and other research and analysis tasks.
- h. Through participating in continuing professional development opportunities Physician associates will keep up to date with evidence-based knowledge and competence in all aspects of their role, meeting clinical governance guidelines for continuing professional development (CPD).

All physician associates will develop and agree a personal development plan (PDP) utilising a reflective approach to practice. They will operate under appropriate clinical supervision, with the PCN member practice's identifying a suitable named GP supervisor for each physician associate. The GP supervisor is not required to be physically present but must be readily available for consultation.

Training requirements

- PAs will be required to undertake the UK PA National Re-Certification Exam every six years and maintain professional registration working within the latest code of professional conduct (CIPD).

viii. Pharmacy Technicians

Description of role/core responsibilities

- Indicative Agenda for Change band 5

Pharmacy technicians play an important role, complementing clinical pharmacists, community pharmacists and other members of the PCN multi-disciplinary team. Pharmacy technicians are different to clinical pharmacists as they are not able to prescribe or make clinical decisions, instead working under supervision to ensure effective and efficient use of medicines.

Pharmacy technicians' core role responsibilities will cover clinical, and technical and administrative categories. The following sets out the key role responsibilities for pharmacy technicians:

Clinical:

- a. Undertaking patient facing and patient supporting roles to ensure effective medicines use, through shared decision-making conversations with patients.
- b. Carrying out medicines optimisation tasks including effective medicine administration (e.g. checking inhaler technique), supporting medication reviews and medicines reconciliation. Where required, utilise consultation skills to work in partnership with patients to ensure they use their medicines effectively.
- c. As determined by the PCN, supporting medication reviews and medicines reconciliation for new care home patients and synchronising medicines for patient transfers between care settings, linking with local community pharmacists, and referring to the pharmacist for structured medication reviews.
- d. Providing specialist expertise, where competent, to address both the public health and social care needs of patients, including lifestyle advice, service information, and help in tackling local health inequalities.
- e. Taking a central role in the clinical aspects of shared care protocols and liaising with specialist pharmacists for more complex patients.
- f. Supporting initiatives for antimicrobial stewardship to reduce inappropriate antibiotic prescribing.

Technical and Administrative:

- g. Working with the PCN multi-disciplinary team to ensure efficient medicines optimisation, including implementing efficient ordering and return processes and reducing wastage.

- h. Providing training and support on the legal, safe and secure handling of medicines, including the implementation of the Electronic Prescription Service (EPS).
- i. Developing relationships with other pharmacy technicians, pharmacists and members of the multi-disciplinary team to support integration of the pharmacy team across health and social care including primary care, community pharmacy, secondary care and mental health.
- j. Supervising practice reception teams in sorting and streaming general prescription requests, so as to allow GPs and clinical pharmacists to review the more clinically complex requests.

The role will also require pharmacy technicians to support the implementation of national prescribing policies and guidance within GP practices, care homes and other primary care settings. This will be achieved through undertaking clinical audits (e.g. use of antibiotics), supporting quality improvement measures and contributing to the Quality and Outcomes Framework and enhanced services. In addition, pharmacy technicians will assist in the delivery of medicines optimisation incentive schemes (e.g. medicines switches) and patient safety audits.

Training requirements

Pharmacy technicians are registered healthcare professionals, who have been undertaking clinical and technical roles in hospitals, community and primary care. Their initial 2-year training is mandated by the General Pharmaceutical Council (GPhC), which specifies [criteria to register as a pharmacy technician](#) and this covers the education, training and experience requirements.

The new curriculum for pre-registration trainee pharmacy technicians is being tested with placements in general practice through the Pharmacy Integration Fund (PhF).

Eligibility for reimbursement under the Network Contract DES and proposals for reimbursement

All pharmacy technicians must have completed or be enrolled in, be undertaking or be prepared to start an approved 18-month training pathway (e.g. Primary care pharmacy educational pathway (PCPEP) or Medicines Optimisation in Care Homes (MOCH)). Pharmacy technicians must be registered with the General Pharmaceutical Council. Entry to the PCPEP programme will include the option for an accreditation of Prior Learning (APEL) process.

2. Workforce roles beginning from April 2021

i. Paramedics – Advanced Paramedic Practitioners

Description of role/core responsibilities

- Indicative Agenda for Change band 7

Advanced paramedic practitioners work autonomously within the community, using their enhanced clinical assessment and treatment skills, to provide first point of contact for patients presenting with undifferentiated, undiagnosed problems relating to minor illness or injury, abdominal pains, chest pains and headaches. They are health professionals who practice at an advanced level having the capability to make sound judgements in the absence of full information and to manage varying degrees of risk when there are complex, competing or ambiguous information or uncertainty.

The following sets out the key role responsibilities for advanced paramedic practitioners:

- a. They will assess and triage patients, including same day triage, and as appropriate provide definitive treatment or make necessary referrals to other members of the primary care team.
- b. They will advise patients on general healthcare and promote self-management where appropriate, including signposting patients to other community or voluntary services.
- c. They will be able to:
 - perform specialist health checks and reviews;
 - perform and interpret ECGs;
 - perform investigatory procedures as required, and;
 - undertake the collection of pathological specimens including intravenous blood samples, swabs etc.
 - perform investigatory procedures needed by patients and those requested by the GPs
- d. They will support the delivery of anticipatory care plans and lead certain community services (e.g. monitoring blood pressure and diabetes risk of elderly patients living in sheltered housing)
- e. They will provide an alternative model to urgent and same day home visits for the network and undertake clinical audits
- f. They will communicate at all levels across organisations ensuring that an effective, patient centred service is delivered
- g. They will communicate proactively and effectively with all colleagues across the multi-disciplinary team, attending and contributing to meetings as required

- h. 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
- i. Prescribe/issue medications as appropriate following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways
- j. Enhance own performance through continuous professional development, imparting own knowledge and behaviours to meet the needs of the service.

Training requirements

- In order to qualify as an advanced paramedic practitioner working across a primary care network, the individual will need to have a relevant Masters degree – Framework for Higher Education Qualification (FHEQ) Level 7 or Scottish Credit and Qualifications Framework (SCOF) Level 11.

Glossary of Terms

A&E	Accident and Emergency
AfC	Agenda for Change
AHP	Allied Health Professional
APEL	Accreditation of Prior Learning
BID	Business Improvement District
BMA	British Medical Association
BTS	British Thoracic Society
CAS alert	Central Alerting System
CCG	Clinical Commissioning Group
CHIS	Child Health Information Systems
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continuing Professional Development
CPI	Consumer Price Index
CQRS	Calculating Quality Reporting Service
CSP	Chartered Society of Physiotherapy
CVD	Cardiovascular Disease
DES	Directed Enhanced Service
DHSC	Department of Health and Social Care
EPS	Electronic Prescription Service
FCO	Foreign and Commonwealth Office
FeNO	Fractional Exhaled Nitric Oxide
FEV1	Forced Expiratory Volume
FHEQ	Framework for Higher Education Qualification
FVC	Forced Vital Capacity
GMS	General Medical Services
GP	General Practitioner
GPC (England)	General Practitioners Committee in England
GPSoC	GP System of Choice
HCPC	Health and Care Professional Council
HEE	Health Education England
Hib	Haemophilus influenzae type B
IAPT	Increasing Access to Psychological Therapies
IIF	Investment and Impact Fund
IoS	Item of Service
HPV	Human Papilloma Virus
ICS	Integrated Care System
LD	Learning Disability
LES	Local Enhanced Service
LIS	Local Incentive Scheme
LMC	Local Medical Committee
LTP	Long Term Plan
MDT	Multidisciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency

MMR	Measles, Mumps, and Rubella
MOCH	Medicines Optimisation in Care Homes
MSK	Musculoskeletal
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NWRS	National Workforce Reporting System
ONS	Office for National Statistics
OT	Occupational Therapist
PCN	Primary Care Network
PCPEP	Primary Care Pharmacy Educational Pathway
PCV	Pneumococcal Conjugate Vaccine
PDP	Personal Development Plan
PHB	Personal Health Budget
PHE	Public Health England
PMS	Personal Medical Services
PQS	Pharmacy Quality Scheme
PSNC	Pharmaceutical Services Negotiating Committee
QI	Quality improvement
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
SCOF	Scottish Credit and Qualifications Framework
SDLT	Stamp Duty Land Tax
SFE	Statement of Financial Entitlements
SIGN	Scottish Intercollege Guidelines Network
SMR	Structured Medication Review
SNOMED	Systematised Nomenclature of Medicine
STOMP	Stopping Over Medication of people with a learning disability, autism or both with psychotropic medicines
STP	Sustainability and Transformation Partnership
TERS	Targeted Enhanced Recruitment Scheme
TUPE	Transfer of Undertakings (Protection of Employment)
WTE	Whole Time Equivalent

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Criteria for
registration as a
pharmacy
technician in Great
Britain

September 2019

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About the GPhC

Who we are

We regulate pharmacists, pharmacy technicians and pharmacies in Great Britain.

We work to assure and improve standards of care for people using pharmacy services.

What we do

Our role is to protect the public and give them assurance that they will receive safe and effective care when using pharmacy services.

We set standards for pharmacy professionals and pharmacies to enter and remain on our register.

We ask pharmacy professionals and pharmacies for evidence that they are continuing to meet our standards, and this includes inspecting pharmacies.

We act to protect the public and to uphold public confidence in pharmacy if there are concerns about a pharmacy professional or pharmacy on our register.

Through our work we help to promote professionalism, support continuous improvement and assure the quality and safety of pharmacy.

About this document

This document sets out the qualifications and work experience requirements for registration as a pharmacy technician in Great Britain. There are three routes to registration:

1. Initial registration by UK- and non-EEA trained pharmacy technicians¹.
2. Initial registration by EEA-trained/registered pharmacy technicians (excluding UK-trained pharmacy technicians)².
3. Returning to registration as a pharmacy technician.

As well as education and training requirements, the registration process also includes checks on:

- health
- character
- knowledge of English language, and
- identity

You can find **further information about how to apply to join our register** in the application forms and guidance notes on how to apply for registration as a pharmacy technician in Great Britain.



¹ Persons who do not possess rights under Directive 2005/36/EC (as amended by Directive 2013/55/EU) or EC Treaty rights.

² Persons who possess rights under Directive 2005/36/EC (as amended by Directive 2013/55/EU) or EC Treaty rights.

Routes to registration as a pharmacy technician in Great Britain

Route 1: Criteria for initial registration for UK- and non-EEA-trained pharmacy technicians

Overview

- 1.1 This route applies to applicants who trained in the United Kingdom (UK) or outside the European Economic Area (EEA) and are making their initial application for registration as a pharmacy technician in Great Britain (GB) on or after 1 September 2019. Such applicants must have completed:
 - the integrated, or linked, knowledge and competence qualification(s)³ ⁴as set out on the GPhC website; and
 - a minimum of two years' work-based experience in the UK set out in paragraphs 1.5-1.7 or by meeting the alternative requirements set out in section in paragraphs 1.8-1.12
- 1.2 Applicants must apply for registration as a pharmacy technician within five calendar years of commencement on a recognised course, or within two years of completing the last recognised course, whichever is sooner. Extenuating circumstances will be considered where there are legitimate, documented grounds for exceeding these timeframes.

Qualifications

- 1.3 A list of all eligible qualifications can be found on the GPhC's website.
- 1.4 There are no exceptions to the qualification requirement for registration as a pharmacy technician. All UK and non-EEA applicants must have completed both competency-based and knowledge-based qualifications whilst completing work-based experience in the UK.

Work-based experience

- 1.5 Applicants must provide evidence they have completed a minimum of two years' relevant work-based experience in the UK under the supervision, direction or guidance of a pharmacist or pharmacy technician to whom the applicant was directly accountable for not less than 14

³ 'Qualifications' in this document means qualifications listed in national qualifications frameworks and other courses accredited by the GPhC which deliver the learning outcomes in *Standards for the initial education and training of pharmacy technicians* (GPhC, 2017).

⁴ Pharmacy technician apprentice trainees in England must pass the apprenticeship end point assessment (EPA) in order to apply to register as a pharmacy technician.



hours per week. A pre-registration trainee pharmacy technician must commence or register for the required qualifications (set out on the [***Approved pharmacy technician courses page***](#) in the 'Education' section of the GPhC website) within three months of commencing contracted, relevant work experience.

- 1.6 Within the two-year period of training and work experience a minimum of 1260 hours of work experience must be undertaken under the supervision, direction or guidance of a pharmacist or pharmacy technician to whom the applicant is directly accountable, excluding sickness absence, maternity or paternity leave and holidays. A minimum of 315 hours of work experience under the supervision, direction or guidance of a pharmacist or pharmacy technician to whom the applicant is directly accountable must be undertaken in each of the two years.
- 1.7 In certain circumstances (for example, prolonged serious ill health or maternity or paternity leave) an extension of the two-year qualifying period of work experience may be granted on application to the registrar if supported by cogent and sufficient evidence. The registrar has the discretion to grant such an extension up to a maximum of one year.

Exceptions related to the work-based experience requirement

Non-EEA applicants

- 1.8 The two years' relevant work-based experience requirement described above may be reduced in the case of applicants wishing to register as a pharmacy technician who already hold non-EEA pharmacist or pharmacy technician qualifications.
- 1.9 These applicants must have completed relevant qualifications whilst working in the UK under the supervision, direction or guidance of a pharmacist or pharmacy technician to whom the applicant was directly accountable for no less than 14 hours per week.
- 1.10 In addition to the relevant qualification(s), applicants must provide evidence of:
 - their non-EEA pharmacist or pharmacy technician qualification which entitles them to practise as a pharmacist or pharmacy technician in their original country of qualification; and
 - being registered or otherwise eligible to practise as a pharmacist or pharmacy technician in their country of qualification.

Pharmacist pre-registration training

- 1.11 A period of pharmacist preregistration training in the UK, the Channel Islands or the Isle of Man that can be validated by the GPhC and has been completed within two years of commencing a recognised pharmacy technician training course may be offset against the work experience requirements for registration.

Effective from September 2019

- 1.12 The time limits for completing registration still apply. Applicants must apply for registration as a pharmacy technician within five calendar years of commencement of the validated period of pre-registration training or within two years of completing the last recognised qualification whichever is sooner. This may only be included if it is within five calendar years of the date of application for registration.

Transitional provisions

- 1.13 Qualifications leading to registration as a pharmacy technician accredited or recognised prior to 1 September 2019 remain accredited or recognised until the listed expiry date. Trainees registered on them currently may continue to study on them until the listed expiry date and, on successful completion, can use them as part of an application for initial registration as a pharmacy technician.
- 1.14 These **qualifications can be found on the *Approved pharmacy technician courses page*** in the 'Education' section of the GPhC website.



Route 2: Criteria for initial registration for EEA-trained pharmacy technicians (excluding UK-trained pharmacy technicians)

2.1 Applicants will have rights under Directive 2005/36/EC (as amended by Directive 2013/55/EU) or EC Treaty rights if:

- they hold a pharmacy qualification gained outside an EEA member state that entitled them to practise as a pharmacist or pharmacy technician in their country of qualification, and subsequently that qualification has been recognised by an EEA member state and they have been permitted to work as a pharmacy technician in that EEA member state; or
- they hold a pharmacy technician qualification from another EEA member state. The EEA member state of qualification may either regulate the profession of pharmacy technician or if the profession of pharmacy technician is not regulated in that Member State, the education and training to obtain the qualification is regulated.
- if neither the profession of pharmacy technician nor the education and training is regulated in the EEA member state of qualification then in addition to the pharmacy technician qualification they must also have completed one-year of full-time professional experience as a pharmacy technician, or an equivalent period on a part-time basis, during the previous 10 years.

2.2 An application for registration under Route 2 (EEA) will be subject to scrutiny and evaluation. This is a comparative assessment of the applicant's qualification and work experience against the GB requirements for registration. The applicant may be required to complete an adaptation period not exceeding three years or pass an aptitude test where either:

- the training the applicant has received covers substantially different matters from those covered by the GPhC-recognised pharmacy technician qualification(s); or
- the pharmacy technician profession in GB comprises one or more professional activities which are not part of the pharmacy technician profession in the applicant's home member state, and those professional activities require specific training which the applicant has not covered in their home member state.

Route 3: Criteria for returning to registration as a pharmacy technician

- 3.1 This applies to applicants who had been previously registered with the Royal Pharmaceutical Society of Great Britain or the GPhC, regardless of their initial route to registration.
- 3.2 Applicants wishing to return to registration must submit a portfolio of evidence demonstrating their professional competence against the scope of practice they propose to practise within once registered. Applications will be evaluated and assessed to determine their professional competence.



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