

Investment and evolution:

A five-year framework for GP contract reform to implement *The NHS Long Term Plan*

31 January 2019



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Foreword and summary

General practice is the bedrock of the NHS, and the NHS relies on it to survive and thrive.

This agreement between NHS England and the BMA General Practitioners Committee (GPC) in England, and supported by Government, translates commitments in *The NHS Long Term Plan*¹ into a five-year framework for the GP services contract. We confirm the direction for primary care for the next ten years and seek to meet the reasonable aspirations of the profession.

In our discussions we shared five main goals:

- secure and guarantee the necessary extra investment;
- make practical changes to help solve the big challenges facing general practice, not least workforce and workload;
- deliver the expansion in services and improvements in care quality and outcomes set out in *The NHS Long Term Plan*, phased over a realistic timeframe;
- ensure and show value for money for taxpayers and the rest of the NHS, bearing in mind the scale of investment;
- get better at developing, testing and costing future potential changes before rolling them out nationwide.

Specifically, this agreement:

1. **Seeks to address workload issues resulting from workforce shortfall.**

Through a new *Additional Roles Reimbursement Scheme*, Primary Care Networks (PCNs) will be guaranteed funding for an up to estimated 20,000+ additional staff by 2023/24. This funds new roles for which there is both credible supply and demand. The scheme will meet a recurrent 70% of the costs of additional clinical pharmacists, physician associates, first contact physiotherapists, and first contact community paramedics; and 100% of the costs of additional social prescribing link workers. By 2023/24, the reimbursement available to networks amounts to £891 million of new annual investment. Practices will continue to fund all other staff groups including GPs and nurses in the normal way through the core practice contract, which grows by £978 million of new annual investment by 2023/24 and will support further expansion of available nurse, GP and other staff numbers. NHS England will also create and part-fund a new primary care *Fellowship Scheme*² aimed at newly qualifying nurses and GPs, as well as *Training Hubs*. Current NHS England recruitment and retention schemes under the *General Practice Forward View*³ will be extended. Rises in

employer superannuation contributions will be fully funded. We have asked the Government to introduce a partial pension scheme.

2. **Brings a permanent solution to indemnity costs and coverage.** The new and centrally-funded *Clinical Negligence Scheme for General Practice* will start from April 2019. All of general practice will be covered, including out-of-hours and all staff groups. Membership will be free. The scheme is funded through a one-off permanent adjustment to the global sum. Practice contract funding nonetheless rises in 2019/20 by 1.4%, as a result of the overall investments agreed. Future costs of NHS practice under the scheme will be funded centrally, not met individually by practices.
3. **Improves the Quality and Outcomes Framework (QOF).** We are implementing the findings of the QOF Review⁴. 28 indicators, worth 175 points in total, are being retired from April 2019. 74 points will be used to create a new Quality Improvement domain. The first two *Quality Improvement Modules* for 2019/20 are prescribing safety and end-of-life care. 101 points will be used for 15 more clinically appropriate indicators, mainly on diabetes, blood pressure control and cervical screening. The current system of exception reporting will be replaced by the more precise approach of the *Personalised Care Adjustment*. This will better reflect individual clinical situations and patients' wishes. In 2019, we will review the heart failure, asthma and chronic obstructive pulmonary disease domains. In 2020, we will review the mental health domain for change in 2021/22. Long term Quality Improvement module and indicator development will benefit from the new primary care testbed programme.
4. **Introduces automatic entitlement to a new Primary Care Network Contract.** In *The NHS Long Term Plan*, Primary Care Networks are an essential building block of every Integrated Care System, and under the *Network Contract Directed Enhanced Service (DES)*, general practice takes the leading role in every PCN. The Network Contract is a DES established in accordance with Directions given to NHS England. Eligibility depends on meeting registration requirements. The Network Contract DES supports practices of all sizes, working together within neighbourhoods. Like existing GMS, the Network Contract DES will be backed by financial entitlements. If every network takes up 100% of the national *Network Entitlements* we intend, including a recurrent £1.50/patient support, plus a new contribution to clinical leadership, £1.799 billion would flow nationally through the Network Contract DES by 2023/24. CCGs could also add local investment through *Supplementary Network Services*. We expect 100% geographical coverage of the Network Contract DES by July 2019, so that no patients or practices are disadvantaged. Each network must have a named accountable *Clinical Director* and a *Network Agreement* setting out the collaboration between its members. Together, the Clinical Directors will play a critical role in shaping and supporting their Integrated Care System and dissolving the historic divide between primary and community medical services. A new *Primary Care Network development programme* will be centrally funded and delivered through Integrated Care Systems.

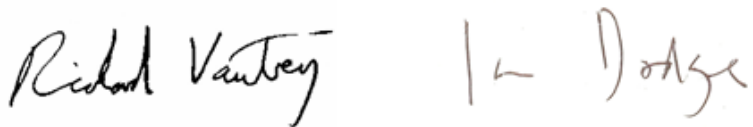
5. **Helps join-up urgent care services.** *The NHS Long Term Plan* envisages Primary Care Networks joining up the delivery of urgent care in the community. Funding and responsibility for providing the current CCG-commissioned enhanced access services transfers to the Network Contract DES by April 2021 latest. From July 2019, the Extended Hours DES requirements are introduced across every network, until March 2021. Following an *Access Review* in 2019, a more coherent set of access arrangements will start being implemented in 2020 and reflected in the Network Contract DES with coverage everywhere in 2021/22. 111 direct booking into practices will be introduced nationally in 2019. As part of these access arrangements, £30 million of additional annual recurrent funding will be added to the global sum from 2019/20. Working with NHS Digital, GP activity and waiting times data will be published monthly from 2021, alongside hospital data. Publication of the data will expose variation in access between networks and practices and we will include a new measure of patient-reported experience of access.
6. **Enables practices and patients to benefit from digital technologies.** NHS England will continue to ensure and fund IT infrastructure support including through the new *GP IT Futures* programme, which replaces the current *GP Systems of Choice*⁵. Additional national funding will also give Primary Care Networks access to digital-first support from April 2021, from an agreed list of suppliers on a new separate national framework. All patients will have the right to digital-first primary care, including web and video consultations by April 2021. All patients will be able to have digital access to their full records from 2020 and be able to order repeat prescriptions electronically as a default from April 2019. A *Review of Out-of-area Registration and Patient Choice* will start in 2019. The rurality index payment and London adjustment will be changed from April 2019 to avoid unwarranted redistribution between different types of provider. To safeguard the model of comprehensive NHS primary medical care, from 2019 it will no longer be possible for any GP provider either directly or via proxy to advertise or host private paid-for GP services that fall within the scope of NHS-funded primary medical services. NHS England will consult in 2019 on expanding this ban on private GP services to other providers of mainly NHS services. In recognition of income loss and workload from subject access requests, £20 million of additional funding will be added to the global sum for the next three years.
7. **Delivers new services to achieve *NHS Long Term Plan* commitments.** The scale of the investment in primary medical care under this agreement was secured for phased and full delivery of all relevant *NHS Long Term Plan* commitments. The annual increase in funding for the Additional Roles Reimbursement Scheme is subject to agreeing seven national *Network Service Specifications* and their subsequent delivery. Each will include standard national processes, metrics and expected quantified benefits for patients. The specifications will be developed with GPC England as part of annual contract negotiations and agreed as part of confirming each year's funding. Five of the seven start by April 2020: structured medication reviews, enhanced health in care homes, anticipatory care (with community services), personalised care and

supporting early cancer diagnosis. The other two start by 2021: cardio-vascular disease case-finding and locally agreed action to tackle inequalities. A *Review of Vaccination and Immunisation* arrangements and outcomes under the GP contract will take place in 2019 and also cover screening. Available by 2020, a new *Network Dashboard* will set out progress on network metrics, covering population health, urgent and anticipatory care, prescribing and hospital use. Metrics for the seven new services will be included. A national *Network Investment and Impact Fund* will start in 2020, rising to an expected £300 million in 2023/24. This is intended to help networks make faster progress against the dashboard and *NHS Long Term Plan* goals. Part of the Investment and Impact Fund will be dedicated to NHS utilisation, which could cover: (i) A&E attendances; (ii) emergency admissions; (iii) hospital discharge; (iv) outpatients; and (v) prescribing. The Fund will be linked to performance and its design will be agreed with GPC England and Government. We envisage that access to the Fund becomes a national network entitlement, with national rules as well as locally agreed elements. Networks will agree with their Integrated Care System how they spend any monies earned from the Fund.

8. **Gives five-year funding clarity and certainty for practices.** Resources for primary medical and community services increase by over £4.5 billion by 2023/24, and rise as a share of the overall NHS budget. This agreement now confirms how much of this will flow through intended national legal entitlements for general practice under the practice and network contracts. GPC England and NHS England have agreed that we do not expect additional national money for practice or network contract entitlements, taken together, until 2024/25. Funding for the practice contract is now agreed for each of the next five years, and increases by £978 million in 2023/24. As a result, DDRB will not make recommendations on GP partner net income. Under this agreement, we assume that practice staff, including salaried GPs, will receive at least a 2.0% increase in 2019/20, but the actual effect will depend on indemnity arrangements within practices. NHSE and GPC have asked the government to ask the DDRB not to make recommendations for salaried GPs for the 2019 pay round. We have further asked the Government to continue to include recommendations on the pay of salaried GPs in the DDRB remit from the 2020 pay round onwards. Recommendations will need to be informed by affordability and in particular the fixed contract resources available to practices under this deal and will inform decisions by GP practices on the pay of salaried GPs. We have asked the Government to ensure that DDRB continues, as usual, to recommend on GP trainees, educators and appraisers. As now, the Government will decide how to respond to DDRB recommendations. A new *Balancing Mechanism* will, if required, adjust between the global sum and the workforce reimbursement sum in the Network Contract DES, depending on real terms partner pay levels. This will be designed by NHS England and GPC England in 2019. As a corollary of major investment, and to safeguard public trust in the GP partnership model, pay transparency will increase. GPs with total NHS earnings above £150,000 per annum will be listed by name and earnings *in a national publication, starting with 2019/20 income. The Government will look to introduce* the same pay transparency across other independent contractors in the NHS at the same time.

9. **Tests future contract changes prior to introduction.** A new *testbed* programme will be established to provide real-world assessment. Under this, different clusters of GP practices in Primary Care Networks will each develop or test a specific draft contract change such as a service specification, QOF indicator or QI module. Some clusters will work with innovators to discover promising approaches and develop prototypes. Testing is likely to include rapid cycle evaluation, with assessment of costs and benefits. Each cluster will be commissioned nationally, topic by topic, normally through open calls for practice or network participation. Network participation in research will also be encouraged from 2020/21, given the proven link to better quality care.

This document marks the expansion of a major programme of collaboration between NHS England and the BMA over the next five years. We include a schedule of planned work. We now need to get the further design work and implementation detail right. The profession and patients expect the benefits we intend to bear fruit.

The image shows two handwritten signatures in brown ink. On the left is 'Richard Vautrey' and on the right is 'Ian Dodge'.

DR RICHARD VAUTREY
GPC ENGLAND CHAIR

IAN DODGE
NHS ENGLAND NEGOTIATING TEAM CHAIR

1. Addressing the workforce shortfall

1.1 **By far the biggest challenge facing general practice is that it doesn't have enough people to do the work required.** This is creating unsustainable workload pressures. Helping to fix this problem is our top priority. This five-year plan and funding settlement works towards resolving these issues.

1.2 The causes of the workforce shortfall are many and well-known, including:

- the rising frailty and complexity of patients;
- the growth in population;
- nearly a decade of declining share of NHS investment, prior to NHS England's establishment in 2013/14;
- the declining average time commitment from GPs struggling to cope with their workload, as well as a new generation of GPs choosing a different work-life balance;
- concern about the level of risk associated with the partnership model, with early and mid-career GPs finding it undesirable⁶;
- the lifetime and annual pension caps prompting earlier retirement and reduced time commitments;
- the fall in the proportion of nurses working in primary and community services, as hospital nurse numbers have expanded. This is in the context of an NHS-wide nursing shortfall⁷.

Increasing the numbers of nurses and GPs

1.3 *The NHS Long Term Plan* recommits to increasing the number of doctors in general practice by a net extra 5,000 'as soon as possible'. Much as we would like a bigger number, this would not be credible. The number of new recruits has been increasing⁸. But this has been more than offset by the number of GPs leaving the profession or opting for part-time working. 2017/18 saw a marginal net increase, after two years of slight decline⁹.

1.4 To help deliver against the extra 5,000 doctors in general practice, **NHS England will now extend the following general practice programmes for the duration of the five year period 2019/20-2023/24:**

- **international recruitment**, supplementing the UK-trained GP workforce with qualified doctors from EEA and non-EEA countries;

- **retained doctors**, supporting experienced GPs to continue to practice rather than retire¹⁰;
- **GP retention programmes**, ensuring support is available to retain GPs rather than reduce their commitment or leave the profession;
- **the practice resilience programme**, ensuring continuing support for practices in acute need of help, often as part of a network¹¹;
- the **specialist mental health service for GPs** who need help¹²; and
- the ***Time for Care National Development Programme***¹³, supporting thousands of practices across the country, often in networks, to make sustainable improvements to the way they work, and help ease workload pressures.

1.5 **Increasing the number of nurses and doctors working in General Practice will be boosted by increased funding for the core GP practice contract**, which rises by £978 million a year by 2023/24 as a result of investments under this agreement.

1.6 The *GP Forward View* committed to increase the number of full time equivalent nurses working in general practice by 1,000. Good progress is being made, with an increase in over 600 between September 2015-18. This will now be further supported by guaranteed placements in primary care for undergraduate nurses, supported by Health Education England; an increase in apprenticeships; and credentialing of the Royal College of Nursing's Advanced Level Nurse Practitioner¹⁴. Experienced nurses in primary care who may be considering roles in other settings or retirement will be able to broaden their roles to include nurse education, mentoring, supervision and leadership roles.

1.7 As recommended by the *GP Partnership Review*¹⁵, **NHS England will also now introduce a new voluntary two-year *primary care fellowship programme* for newly qualified nurses and doctors entering general practice**. This will offer a secure contract of employment alongside a portfolio role tailored, where possible, to the aims of the individual and the needs of the primary care system. This will enable newly qualified nurses to consider primary care as a first destination role, in the knowledge that they will receive support in their early years to become confident in practice and work in supportive multi-disciplinary teams across Primary Care Networks. There is emerging evidence that such approaches will also for example increase the number of GP trainees taking up substantive roles in primary care. On completing their fellowship, these clinicians may be more encouraged to become full partners. The arrangements will be designed in 2019.

1.8 **Working with Health Education England, NHS England will establish primary care training hubs from 2020/21**. These will enable more consistent

provision of training and continuing professional development for primary care staff in the community.

- 1.9 ***The NHS Long Term Plan* commits to a major expansion in the community mental health workforce and integration between physical and mental health. Building on the co-location of IAPT workers in primary care, a significant proportion of community mental health staff will become aligned with Primary Care Networks.** This will particularly help older people with mental health problems, dementia and co-morbid frailty, as well as the primary care workforce.

Pensions

- 1.10 The annual allowance cap creates an incentive for GPs to either cut their time commitment to the NHS, or quit the NHS pension scheme altogether, thus leaving themselves and their families without coverage for ill-health retirement or death-in-service. This could be resolved by creating a new 'partial pension' option. Under this, GPs could choose to halve the rate at which their pension builds up, and in return pay half rate contributions. **The Local Government Pension Scheme¹⁶ already has a 50% pension option and we have asked Government to consider this for GPs.**
- 1.11 In December 2018, the Department for Health and Social Care launched a consultation¹⁷ to increase the employer contribution rate from 14.3% to 20.6% from April 2019. For this reason, alongside the five-year settlement for NHS England in June 2018, the Government committed to provide additional funding for the full costs arising from this actuarial revaluation for the NHS in England. **General Practice will not have to bear any additional costs.**

Additional roles reimbursement

- 1.12 In the absence of sufficient levels of GP and nurse supply, practices have been creating other roles faster than anticipated: over 5,000 extra in the past three years, achieving NHS England's target two years early.
- 1.13 **Expansion of the multi-disciplinary team will now be given a major boost, through a new reimbursement mechanism within the Network Contract DES.** As a means of building capacity, direct reimbursement has distinguished antecedence in the form of the 1965 *General Practice Charter*¹⁸. Proposed by the BMA and implemented in 1966, the *Charter* successfully established nurses and receptionists within general practice through a 70% reimbursement model.
- 1.14 The *Additional Role Reimbursement Scheme* will now be established as part of the new Network Contract DES. This will provide certainty for newly joining staff and practices alike. The scheme will start from 1 July 2019.
- 1.15 **This scheme is the biggest new investment offered under this agreement. In 2023/24, NHS England will make £891 million available. That equates to**

£726,000 new annual funding for a network with an averagely-weighted 50,000 population. This calculation is derived from ONS population growth forecasts applied to registered populations.

- 1.16 The reimbursement will be recurrent and not subject to any taper. For each of the next five years, the total funding under the scheme will rise substantially to pay for workforce expansion. The scale of that increase will be confirmed through annual contract changes, and is subject to agreeing the seven new national service specifications to support different facets of *The NHS Long Term Plan*, outlined in Chapter 6.

TABLE 1: INTENDED FUNDING FOR ADDITIONAL ROLE REIMBURSEMENT

| | 2019/20 (from July) | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|--|---------------------------|-----------------|------------------|-----------------|-----------------|
| National total | £110 m | £257 m | £415 m | £634 m | £891 m |
| Average maximum per 50k typical network | £92,000 | £213,000 | £342, 000 | £519,000 | £726,000 |

Scale and scope

- 1.17 The funding for the scheme is intended to create up to an estimated 20,000+ additional posts in five specific different primary care roles. **These five reimbursable roles are clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and first contact community paramedics.** Model role specifications will be published by March 2019 as a guide for networks. Networks will decide the job descriptions of their own staff, and in so doing they will want to bear in mind the new service requirements in the Network Contract DES. These staff are in addition to the additional nurses and GPs that will be funded through the real terms increases in the core GP contract.
- 1.18 The roles have been chosen by NHS England and GPC England for four pragmatic reasons:
- (i) we estimate that we can get enough supply;
 - (ii) we see strong practice demand;
 - (iii) the tasks they perform help reduce GP workload, improve practice efficiency and deliver *NHS Long Term Plan* objectives; and
 - (iv) they are relatively new roles, where it is possible to demonstrate additional capacity, unlike GPs and practice nurses.

1.19 The five roles are becoming more widespread in primary care in different parts of the country, enriching the skill mix of the general practice team and enabling GPs to ‘work at the top of their license’. They will now be established nationwide, and at much greater scale. By 2024, clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and first contact community paramedics will have become an *integral part of the core general practice model throughout England* – not just ‘wrap around’ support that could instead be redeployed at the discretion of other organisations.

1.20 **The scope of the scheme extends gradually.** This reflects available supply and funding:

- in 2019 it starts with clinical pharmacists and social prescribing link workers only;
- in 2020 physician associates and first contact physiotherapists are added; and
- in 2021 it also includes first contact community paramedics. Only at this point do enough additional paramedics come out of training; and we want to avoid net transfer from the ambulance service.

1.21 **GPC England’s longstanding ambition for every practice is to benefit from having a pharmacist¹⁹. By 2023/24, a typical network of 50,000 patients could choose to have its own team of approximately six whole time equivalent clinical pharmacists: enough to give equivalent effect to that ambition.** Alternatively, the network could decide on a higher, or lower number, depending on local context. A dedicated team makes it possible to create varied and tailored roles: undertaking structured medication reviews, improving medicine optimisation and safety, supporting care homes, as well as running practice clinics. Clinical pharmacists should be supervised by a senior clinical pharmacist, and through this model it will be easier to support pharmacist professional and career development at network rather than practice level. We will also bring onto the scheme the pharmacists funded under the existing Clinical Pharmacists in General Practice Scheme²⁰ and the separate Pharmacists in Care Homes Scheme²¹. The latter will involve reimbursing some pharmacy technicians currently funded by CCGs. During 2019, we will explore the practicality of allowing the reimbursement of pharmacy technicians as a part of the pharmacist team, as a complement to clinical pharmacists.

1.22 NHS England and GPC England are committed to making *funding* available for up to an estimated 20,000+ additional staff across these five groups by 2024, but the **actual distribution of the workforce increase across the five roles will depend on the choices that individual networks make, working with their system partners, given the flexibility they will have** under their ‘additional roles sum’ and taking in to account their existing workforce.

Reimbursement levels

- 1.23 **70% of the actual ongoing salary costs of additional clinical pharmacists, physician associates, first contact physiotherapists and community paramedics - and 100% of the actual on-going salary costs for social prescribing link workers - will be met, up to the relevant maximum amounts.**
- 1.24 By reimbursing 100% of the social prescribing link workers, the NHS is making its full financial contribution to social prescribing and personalised care delivery. Emerging practice suggests that many networks may choose to fund a local voluntary sector organisation to employ the link workers and run the service of behalf of the network.
- 1.25 **The reimbursement proportion will be fixed at these percentages within the new Network Financial Entitlements. The percentages will neither taper nor increase during the next five years.** This gives networks maximum confidence to recruit to the full.
- 1.26 The eligible maximum pay against which the 70% (or 100%) reimbursement will apply is the sum of (a) the weighted average salary for the specified *Agenda for Change* band²²; plus (b) the associated employer on-costs. It will not include any recruitment and retention premiums that networks may choose to offer. Networks will need, if required, to be able to justify the salary offered to new staff. On-costs will be revised to take account of any pending change in employer pension contributions, if and when these are confirmed. Table 2 sets out the AfC bands for the five groups and the maximum reimbursable amounts for clinical pharmacists and social prescribing link workers in 2019/20. The maximum reimbursement amounts for subsequent years will be confirmed in line with applicable *Agenda for Change* rates.

TABLE 2: MAXIMUM REIMBURSABLE AMOUNTS AT 2019/20 LEVELS

| Role | AfC band | Maximum reimbursable amount in 2019/20 (with on costs) |
|-----------------------------------|----------|--|
| Clinical pharmacist | 7-8A | 37,810 |
| Social prescribing link worker | Up to 5 | 34,113 |
| First contact physiotherapist | 7-8A | N/A – reimbursement available from 20/21 |
| Physician associate | 7 | N/A - reimbursement available from 20/21 |
| First contact community paramedic | 6 | N/A – reimbursement available from 21/22 |

Funding extra capacity, not existing workers

- 1.27 The intention of the scheme is to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage. It is not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care, whether funded by a practice, a CCG or a local NHS provider. **Reimbursement through this route will only be for demonstrably additional people** (or, in future years, replacement of those additional people as a result of staff turnover). This additionality rule is also essential for demonstrating value for money for the taxpayer.
- 1.28 NHS England will work with CCGs and NHS Digital to establish the baseline for all five groups in March 2019 and how on-going assessment of delivery can be supported. **As part of this agreement, NHS England will expect CCGs to continue any local schemes which fund posts in the five reimbursable roles, and to confirm their plans with their Local Medical Committees.** For example, if a CCG is currently funding the local community provider for a physiotherapist or community paramedic working in a local practice, that local funding continues and cannot be claimed under the new additional role reimbursement scheme.
- 1.29 The only exception to the 'additionality' rule is existing clinical pharmacists reimbursed under either (i) the national Clinical Pharmacists in General Practice scheme, or (ii) the national Pharmacists in Care Homes scheme. Both schemes have tapered funding. Both will be subsumed into the new more generous arrangement.
- 1.30 **These rules will be reinforced by explicit monitoring and assurance arrangements with payment clearly linked to additional staff recruited. Funding will be released from 1 July 2019 onwards on an actual salary claims basis up to the maximum amount, at the point networks can demonstrate that the additional staff have been recruited.**
- 1.31 **Each network will be able to decide which provider organisation employs the staff.** This could be a single lead practice, a GP federation, or a community, mental health or an NHS trust (or voluntary sector organisation) if the network and that party agree.

The Additional Roles Sum

- 1.32 **From 2020/21, each network will be allotted a single combined *maximum reimbursement sum, covering all five staff roles*.** This additional roles sum will be a fair share of the annual national expenditure amounts shown in table 1.
- 1.33 **Each network's share will be based on weighted capitation.** The basis for weighting will be confirmed in 2019.
- 1.34 Networks will be able to claim up to the maximum sum each year, in line with the reimbursement rules set out in paragraphs 1.9-1.30. Every network has a different local starting point and faces different circumstances. And so **we are giving networks the flexibility to decide how many of each of the reimbursable staff they wish to engage, within their Additional Roles Sum.** This could mean, for example, that in 2020/21, one network chooses to employ more physician associates, but fewer clinical pharmacists. However, the national supply will be limited; and each network will need sufficient of each of the different groups in order to perform the associated national service specifications.
- 1.35 **GPC England and NHS England will develop and agree detailed guidance for the scheme as part of discussions for the 2020/21 contract.** We will work to ensure that everyone can have confidence in the transaction processing arrangements; in the data and monitoring; in the assurance and audit; and the evaluation.
- 1.36 **By no later than 2023, we will have undertaken and published a full review of the scheme, to inform future options that could apply from 2024/25 onwards.** Our intention has been to pump-prime these additional roles during the first five years of *The NHS Long Term Plan*. One possibility is to consider whether there are other additional roles that should be pump-primed in future, and for the 2023/24 funding for these five roles to become a single 'Network Global Sum' from 2024/25 onwards. GPC England and NHS England share a bigger ambition for core general practice to expand further, and through Primary Care Networks, become the default footprint of community-based care.

Introductory arrangements for 2019/20

- 1.37 **2019/20 will be an introductory year, with simpler rules, prior to the full scheme taking effect.** Rather than introduce a capitated sum, between 1 July 2019 until 31 March 2020, every network of at least 30,000 population will be able to claim 70% funding as above for *one* additional whole-time equivalent (WTE) clinical pharmacist and 100% funding for *one* additional WTE social prescribing link worker. This will deliver by 2020 on the government's commitment in the loneliness strategy that by 2023 all local systems will have implemented social prescribing connector schemes.

- 1.38 Beyond 100,000 network size, the 2019/20 reimbursement scheme doubles to two WTE clinical pharmacists and two social prescribers; with a further WTE of each, for every additional 50,000 network population size. Were a single 'super-practice', covering 200,000 patients, agreed as a network by its CCG in line with national rules, it would be eligible for four additional of each in 2019/20.
- 1.39 With agreement from the CCG, the 2019/2020 entitlement could be used to vary between numbers of clinical pharmacists and social prescribers, e.g. a typical network could hire two clinical pharmacists **or** two social prescribing link workers instead of one of each.
- 1.40 **Fuller guidance on the introductory scheme for 2019/20 will be developed and issued by March 2019.**

2. Solving Indemnity Costs

- 2.1 In recent years, the spiralling cost of purchasing professional indemnity cover has not only cast a shadow over the profession, but also contributed to specific NHS problems such as filling out-of-hours rotas.
- 2.2 Costs were unexpectedly high in 2016/17 and 2017/18. Additional one-off funding of £30m and £60m was made available by NHS England and paid to practices²³. **NHS England confirms that, based on the evidence, it will provide one-off funding in 2018/19 to meet its assessment of inflation in actual indemnity costs in 2018/19.**
- 2.3 These payments have been important temporary fixes. But the lack of a permanent solution has hindered recruitment and retention. That is one of the reasons why the Government announced in October 2017 its intention to introduce a new state-backed scheme from April 2019²⁴. Solving the indemnity issue has been a top priority for everyone. GPC England and NHS England established a dedicated indemnity sub-group in August 2018 to drive timely progress, to inform the Government's plans.
- 2.4 We have now agreed the following:
- **the new Clinical Negligence Scheme for General Practice will start from 1 April 2019**, operated by NHS Resolution. It will be established through government regulations;
 - **all NHS GP service providers including out-of-hours provision will be eligible to become members of the Scheme. They will not have to pay a subscription for membership, either now or in future.** Instead, the future costs of this scheme will be met by NHS England, through a centrally-held primary care allocation;
 - **coverage of the scheme will extend to all GPs and all other staff working in delivery of primary medical services, as defined in forthcoming regulations. It will automatically cover contractor and salaried GPs, GP locums, prison GPs, nurses, Allied Health Professionals and all other professional groups delivering those services;** and
 - **it will also cover their wider NHS primary care work, including out-of-hours cover.** This will remove the perverse limitation to participation, and serve to ease the out-of-hours participation challenge.
- 2.5 The purpose of the new state-backed scheme is to solve the indemnity problem, not to deliver at the same time either a reduction in GP pay or a windfall increase. Following extensive discussion, NHS England and GPC England have agreed a one-off permanent adjustment to the global sum figure that takes account of the existing contributions from general practice for

indemnity. **Given other investment made under this agreement (including the Network Participation Practice Payment and funding to meet the costs of subject access requests), investment in the practice contract overall will still rise by 1.4% in 2019/20, even after accounting for the indemnity change.**

- 2.6 **NHS England and GPC England confirm that the global sum increase in 2019/20 represents the full and fair settling by general practice of their contribution to indemnity costs for future NHS practice.**
- 2.7 **The Government and NHS Resolution will provide further details in February 2019 on next steps that practices and professionals need to take to ensure that they are covered after 1 April 2019.** Practices and staff will still need to take out separate medical defence organisation cover for professional practice, additional advisory services, and private work.
- 2.8 Current arrangements for indemnity costs of practice staff vary. Some pay their own indemnity, whilst others have it paid by their practice. What constitutes a fair solution for practice staff will therefore vary and will be a matter for practices to decide. Locums will no longer need to pay indemnity when working for GP practices or networks. The cost of locums for practices should therefore be adjusted accordingly.
- 2.9 In order to maximise resources going directly into primary care provision, it will be important to analyse and tackle the modifiable underlying causes of financial settlements under the new scheme. To that end, the Government, NHS England, GPC England, and NHS Resolution all commit to further joint work. All parties will also seek to keep under review how well the new NHS Resolution service is working for its new primary care members.

3. Improving the Quality and Outcomes Framework (QOF)

- 3.1 **In 2017, NHS England started the most significant review of the Quality and Outcomes Framework (QOF) since it began in 2004.** This involved extensive analysis of the evidence, as well as engagement with practices, voluntary sector organisations and members of the public. Following the 2018/19 contract agreement and with the support of GPC England, the review was published in July 2018²⁵.
- 3.2 The Review concluded that a significant refresh would be desirable, to support a broader definition of high quality care, recognise changes in clinical evidence, and align better with professional values. **In England, unlike Scotland²⁶ and Wales²⁷, the broad consensus has been for evolution of the QOF, rather than its wholesale or partial abolition.** This is in line with a Local Medical Committee Conference resolution in 2017.
- 3.3 **The Quality and Outcomes Framework has many aspects that are both valued and valuable.** The strong focus on specific biomedical markers is evidence-based, and has demonstrably improved care: most notably, it achieved a 16.6% drop in emergency admissions in the incentivised conditions of asthma, chronic obstructive pulmonary disease, coronary heart disease, congestive heart failure, hypertension, stroke, diabetes and epilepsy²⁸. QOF also provides vital core income to cover practice staff pay and expenses.
- 3.4 Quality achievement can go backwards when indicators are dropped. A recent retrospective analysis of indicators no longer in use showed, for example, that reported hypertension control for under 79s with no co-morbidity dropped by 13.7% in 2014/15²⁹. Care is required when making decisions about which indicators to retire and when.
- 3.5 **The QOF also has three notable weaknesses:**
- **first, it can feel excessively like ‘tick-box medicine’.** A better outcome, particularly for people with complex needs, may come from taking a more holistic, personalised and targeted approach;
 - **second, arrangements for exception reporting are too crude, as well as lacking transparency;** and
 - **third, the scheme has been much slower than it should have been in adapting to the changing evidence base** (e.g. to take on board recommendations on cervical screening).
- 3.6 To implement the Review, and address QOF’s weaknesses, a dedicated NHS England and GPC England sub-group has developed proposals. **We have now agreed to introduce a number of significant improvements from April 2019. These improvements are also designed to help secure early progress on clinical priorities identified in *The NHS Long Term Plan*.**

- 3.7 **QOF implementation guidance will be issued by end March 2019, with full details about the 2019/20 changes.** Associated changes to the Statement of Financial Entitlements will also be completed by end March 2019. Annex A lists all the indicator changes.

Retiring the least useful indicators

- 3.8 QOF currently comprises 559 points. **We have agreed that 28 indicators worth 175 points in total – i.e. 31% of the complete scheme - will be retired from April 2019.** This follows advice from the QOF Technical Working Group, on the development of an objective indicator assessment methodology. The 28 are 'low value' indicators which either: (a) do not now align with national evidence-based guidance; or (b) have poor measurement properties; or (c) are now viewed as a core professional responsibility.

Recycling points into more clinically appropriate indicators

- 3.9 **Of these 175 points, 101 points will be recycled into 15 more clinically appropriate indicators.**

- 3.10 The new indicators cover five areas. They are:

- **reducing iatrogenic harm and improving outcomes in diabetes care (43 points).** The changes seek to address the problems with the current 'one size fits all' approach: the potential over-treatment of frail patients and under-treatment of patients without frailty. Intensive glucose lowering treatment of Type 2 diabetes in older people is of limited benefit and there is increasing evidence of harm, including severe hypoglycaemia and congestive heart failure, which outweighs potential benefits³⁰. In the current indicator set we seek to mitigate against this by incentivising a range of glucose targets. As these are not stratified to patient groups, they risk rewarding under-treatment of younger adults who are at greater risk of the macro and microvascular complications of diabetes. The proposed changes should address this by focusing achievement of lower glycaemic targets upon this patient population. It is anticipated that the resulting improvements in glycaemic control will lead to improved patient outcomes, reduced complications and associated health care utilisation;
- **aligning blood pressure control targets with NICE guidance (41 points).** We have agreed to: (a) reintroduce HYP003 (blood pressure controlled to 140/90 mmHg or less in patients aged 79 years or younger with hypertension), and (b) extend age-stratified targets to patients with coronary heart disease and stroke or transient ischaemic attack (TIA). The benefits of blood pressure lowering treatment for the prevention of cardiovascular disease are well established. A recent meta-analysis identified a significantly reduced risk of major cardiovascular events, including coronary heart disease, stroke and heart failure for every 10mmHg reduction in systolic

blood pressure³¹. These are all significant causes of morbidity, mortality and healthcare utilisation;

- **supporting an age-appropriate cervical screening offer (11 points).** The changes will bring QOF into alignment with National Screening Committee recommendations³². They should ensure that women receive age-appropriate advice and care that is determined by the Committee as being the optimal approach to the identification and prevention of cervical cancers. More importantly, the changes ensure that we do not continue to incentivise poor quality care; and will help with earlier cancer diagnosis;
- offering pulmonary rehabilitation for patients with Chronic Obstructive Pulmonary Disease (2 points);
- improving focus on weight management as part of physical health care for patients with schizophrenia, bipolar affective disorder and other psychoses (4 points).

Introducing the *Personalised-Care Adjustment*

3.11 Exception reporting is a necessary feature. But the existing system fails to distinguish between those patients who have not received or been offered care, and those who have done so on the basis of informed choices. As a result, high levels of exception reporting are often unhelpfully perceived to equate to poor quality care.

3.12 To solve this issue, **NHS England and GPC England have agreed to replace the current blunt system of exception reporting with a more precise ‘personalised care adjustment’**. It will also allow practices to differentiate between five different reasons for adjusting care and removing a patient from the indicator denominator:

- *unsuitability* for the patient, e.g. because of medicine intolerance or allergy, or contra-indicated polypharmacy;
- *patient choice*, following a shared-decision making conversation. Other parts of this agreement document outline the additional support to help practices focus on personalising care, and tackling over-medicalisation and over-medication;
- the patient *did not respond* to offers of care – recording of this will change to capture actual invitations sent to patients;
- the specific service is *not available* (in relation to a limited number of indicators only: HF002, AST002, COPD002, DM014 and the new pulmonary rehabilitation indicator); or

- *newly diagnosed or newly registered* patients, as per existing rules.

3.13 A further problem with exception reporting is that some IT systems remove decision-support prompts when the patient is recorded as an exception. As a result, some practices decide to leave exception coding to the end of the year, resulting in increased workload, and associated stress and scrutiny. **We are aiming to reduce the end of year coding burden, by changing the data extraction process** to ensure that the prompts remain available to support opportunistic care, especially when these codes relate to patients not responding to invitations. QOF guidance will also be amended with the aim of improving the quality of invitations for care.

Focusing on quality improvement

3.14 QOF is based on quantified target delivery against evidence-based indicators. It is not designed to nurture a broader sense of professionalism and quality improvement, which we know underpins the technical attainment of good care. Previous attempts to tackle this within the QOF have been notably weak and unsuccessful (for example, aspects of the Quality and Productivity Indicators between 2011-14)³³.

3.15 Nonetheless, we wish to empower and support professionals working in primary care to focus on quality improvement and, learning from the current approaches in Scotland and Wales, we have agreed to introduce provision in the QOF to support professionally-led quality improvement cycles, within and between practices. Our purpose is to support activities that are highly valued by patients and professionals, do not easily lend themselves to traditional QOF metrics, and which are expected to improve significantly the quality of care.

3.16 **In 2019/20, the remaining 74 points arising from indicator retirement will be used to create two Quality Improvement modules within a new quality improvement domain.** NHS England and GPC England have worked with the Royal College of General Practitioners, NICE and the Health Foundation to develop these, and they are attached at Annex B. Each module will be supported by QOF for one year, before being replaced by different topics. **For 2019/20, the modules will cover:**

- **prescribing safety.** Extensive literature exists on the opportunity to cut errors and adverse drug reactions. Evidence from Scotland suggests that improvements will be sustained beyond the duration of the incentive³⁴. And this module will dovetail with at least four complementary changes: (a) the expansion of clinical pharmacists in general practice; (b) the nationally-backed roll-out of the pharmacist-led information technology intervention for medical errors (PINCER or equivalent) by the AHSNs³⁵; (c) the drive to tackle polypharmacy for complex patients, including in care homes; and (d) the quality payment scheme for community pharmacy;

- **end-of-life care.** The Royal College of GPs has already been developing a QI module in this area; and we can also benefit from the work undertaken by Macmillan.³⁶ The current QOF indicator on end of life care, which is being retired, has had limited impact upon patient and carer experience. A less formulaic approach could reap bigger benefits. This is also a neglected aspect of care, which the *NHS Long Term Plan* highlights as ripe for more personalised approaches.

3.17 We anticipate that many CCGs will already be funding schemes to drive improvement in these two areas. If there is duplicative funding, we expect CCGs to reinvest this money in alternative ways, and do so in collaboration with their constituent LMCs.

3.18 **Through a rapid evaluation process, we will seek to learn early lessons from the introduction of the QI domain, to inform its subsequent development.** We will seek to understand four core questions: (a) is it improving patient care? (b) is it valued by practitioners? (c) is it a smart investment, given other possibilities? And (d) should QI investment continue to be channelled through QOF, or would a different approach be better?

Payment thresholds

3.19 Payment thresholds for new indicators are based upon NICE recommendations and knowledge of practice performance, for example, as a result of previous activity. In the light of the wider changes to QOF, we have again agreed to defer for 2019/20 only the QOF threshold increases which were due to be implemented in 2014. During 2020, we will undertake further work on the optimal approach to threshold setting, for implementation in 2021/22. This will take account of 2019/20 experience of the personalised care adjustment.

Further development of QOF

3.20 The changes described represent significant first steps in implementing the recommendations of the QOF Review. **NHS England and GPC England have agreed to an ongoing programme of indicator review in key priority areas, including heart failure, asthma and COPD care in 19/20, and mental health in 2020/21 for any subsequent changes to be implemented as soon as possible.**

3.21 Through the new testbed programme described in section 9 of this agreement, **we will also aim to develop and test a pipeline of further potential indicators and Quality Improvement modules for national roll-out.** We would welcome additional contributions to developing new QI modules, especially from national voluntary sector organisations.

3.22 Some of these could become available for potential use in the last four years of this five-year agreement. **We have agreed to prioritise development of**

potential QI modules that if well-designed and supported would support the seven service specifications set out in chapter 6.

- 3.23 Furthermore, an extensive, well-evidenced array of further proven enhancements to QOF could also help position us to make the case for an additional funding boost for primary care in the second five years of the *NHS Long Term Plan*, based on funding additional QOF points. This would need to be considered as part of future negotiations, alongside other investment choices.

4. Introducing the Network Contract DES

- 4.1 Joint working between practices is nothing new. Recent GP interest has focused on joint provision through GP federations or Primary Care Networks (PCNs). This draws on successful past experience: notably, the out-of-hours GP co-operative movement, which rapidly flourished after the 1995 national contract deal.
- 4.2 **In *The NHS Long Term Plan*, Primary Care Networks (PCNs) become an essential building block of every Integrated Care System, and under the *Network Contract DES*, general practice takes the leading role in every Primary Care Network.** This will mean much closer working between PCNs and their Integrated Care System, not just their Clinical Commissioning Group. CCGs are becoming leaner, more strategic organisations, with commissioning arrangements simplified and this will typically involve a single CCG for each ICS area.
- 4.3 This chapter focuses primarily on the Network Contract DES for general practice, but the Primary Care Network concept is wider. It is intended to dissolve the historic divide between primary and community health services. PCNs are about provision not commissioning, and are not new organisations.

Purpose

- 4.4 By October 2018, 88% of practices in England had chosen to join or lead a Primary Care Network, based on CCG returns³⁷. Motivations vary and include:
- **stability.** Many practices have faced increased pressure and being part of a Primary Care Network may be able to help avoid a practice closure, obviating the need to consider alternative provision, including possible procurement. We intend the PCN model as a way of helping GP partnerships survive and evolve over the coming decade, and provide a means of mutual support for better workload management;
 - **different roles.** It is easier to create more varied GP and nurse roles for 30-50,000 patients than 8,000. Large enough to run a full multi-disciplinary team, the Primary Care Network still operates on a human scale, with clinicians able to know each other;
 - **investment.** By creating the Primary Care Network as a dedicated joint investment and delivery vehicle, the profession is able to offer services that the NHS couldn't reasonably ask of every individual practice;
 - **better health and care.** The Primary Care Network is the natural unit for integrating most NHS care. Collective general practice can become the footprint on which other NHS community-based services can then dock. And by serving a defined place, the Primary Care Network brings a clear geographical locus for improving health and wellbeing; and

- **community leadership.** Primary Care Network Clinical Directors will provide strategic and clinical leadership to help support change across primary and community health services.

A new *Network Contract DES* for Primary Care Networks

- 4.5 Initial investment in Primary Care Networks has been variable, uncertain, and modest. That changes with the Network Contract. It goes live from 1 July 2019. Network resources are set over a five year funding period of the *NHS Long Term Plan*. By 2023/24, the Network Contract is expected to create national entitlements worth £1.799 billion, or £1.47 million for a typical network covering 50,000 people, in return for phased and full implementation of all relevant *NHS Long Term Plan* commitments. Of this £1.235 billion is new investment. The remaining £564 million is a combination of enhanced access, the extended hours DES, and £1.50 a head support in cash rather than in kind. The £1.799 billion is before adding supplementary local CCG investment for integrated primary and community care.
- 4.6 **The Network Contract will be a very large Directed Enhanced Service (DES).** As a DES, it is an extension of the core GP contract, not literally a separate contract. It is established in accordance with Directions given to NHS England. This compels CCGs (through delegated functions from NHS England) or NHS England to offer the Network Contract DES to all practices. The commissioner of the Network Contract DES is therefore the CCG in nearly all instances.
- 4.7 Eligibility applies to all existing and future holders of in-hours (essential) primary medical services contracts. This includes General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS).
- 4.8 **The Network Contract DES has three main parts:**
- first, the national **Network Service Specifications**. These sections set out what all networks have to deliver. National investment and services grow in tandem;
 - second, the national schedule of **Network Financial Entitlements**, akin to the existing Statement of Financial Entitlements for the practice contract. National entitlement increases financial certainty for everyone. Alongside these entitlements come clear transparency requirements, including for subcontracting arrangements;
 - third, the **Supplementary Network Services**. CCGs and Primary Care Networks may develop local schemes, and add these as an agreed supplement to the Network Contract, supported by additional local resources.

Preparatory work to go live in July 2019

- 4.9 **GPC England and NHS England are committed to 100% geographical coverage of the Network Contract DES by the Monday 1 July 2019 ‘go live’ date.** Close working is needed between Clinical Commissioning Groups and Local Medical Committees to help ensure this goal is met.

Registering for the Network Contract DES

- 4.10 **To be eligible for the Network Contract DES, a Primary Care Network needs to submit a completed registration form to its CCG by no later than 15 May 2019, and have all member practices signed-up to the DES.** The form is attached at Annex C. It asks for six factual pieces of information:

- (i) the names and the ODS codes of the **member practices**;
- (ii) the **Network list size**, i.e. the sum of its member practices’ registered lists as of 1 January 2019;
- (iii) a map clearly marking the **agreed Network area**;
- (iv) the initial **Network Agreement** signed by all member practices;
- (v) the **single practice or provider that will receive funding** on behalf of the PCN; and
- (vi) the **named accountable Clinical Director**.

- 4.11 Many PCNs will find it easy to meet these requirements. For others, significant discussion may be needed during the first quarter of 2019.

- 4.12 **CCGs are responsible for confirming that the registration requirements have been met by no later than Friday 31 May 2019.** For the small number of CCGs without delegated primary care commissioning, the task remains with the NHS England local team. As part of confirming its support, the CCG must secure an explicit pledge of support from the leadership of the local Integrated Care System/Sustainability and Transformation Partnership. NHS England Regional teams will need to agree departures from the requirements in exceptional circumstances.

- 4.13 **Rather than approve each Network Contract one at a time, all the Network Contracts within a single CCG will be confirmed at the same time.** This is to ensure that both: (a) every constituent practice of a CCG, and (b) 100% of its geographical area, are included with Primary Care Networks. Taken together, the Network boundaries within a CCG must always fully cover the CCG’s own boundary.

- 4.14 Once the registration requirements are met and GMS/PMS/APMS contracts have been varied to include the DES, the Primary Care Network can start receiving national investment from 1 July 2019.

Timetable for introduction

- 4.15 The timetable for introducing the Network Contract DES is set out in table 3 below:

TABLE 3: TIMETABLE FOR NETWORK CONTRACT DES INTRODUCTION

| Date | Action |
|-------------------|---|
| Jan-Apr 2019 | PCNs prepare to meet the Network Contract DES registration requirements |
| By 29 Mar 2019 | NHS England and GPC England jointly issue the Network Agreement and 2019/20 Network Contract DES |
| By 15 May 2019 | All Primary Care Networks submit registration information to their CCG |
| By 31 May 2019 | CCGs confirm network coverage and approve variation to GMS, PMS and APMS contracts |
| Early Jun | NHS England and GPC England jointly work with CCGs and LMCs to resolve any issues |
| 1 Jul 2019 | Network Contract DES goes live across 100% of the country |
| Jul 2019-Mar 2020 | National entitlements under the 2019/20 Network Contract start: <ul style="list-style-type: none"> • year 1 of the additional workforce reimbursement scheme • ongoing support funding for the Clinical Director • ongoing £1.50/head from CCG allocations |
| Apr 2020 onwards | National Network Services start under the 2020/21 Network Contract DES |

(i) Member practices

- 4.16 The success of a Primary Care Network will depend on the strength of its relationships, and in particular the bonds of affiliation between its members and the wider health and social care community who care for the population. The main reason NHS England and GPC England are backing Primary Care Networks now is because they have emerged from a practice-led process.
- 4.17 Equally, an entirely 'bottom-up' Primary Care Network formation may not generate a solution that works for absolutely every practice, right across the country. **In some CCGs, marginal adjustment to PCN membership and boundaries may prove necessary.** We do not want a 'two-tier' system, and this would be contrary to NHS England's wider duties. We cannot leave a small

number of practices and their patients behind, excluded from joining a Primary Care Network and the benefits of investment and new services.

4.18 Practice rights, plus CCG obligations, will help generate 100% coverage.

Every practice will have the right to join a Primary Care Network in its CCG and have a right to participate in the Network Contract DES. Akin to an additional service, a *Network Participation Practice Payment* will start in 2019 and will be a practice entitlement. A typical practice will receive over £14,000 each year from April 2019, in return for their initial and then continued active participation in a Primary Care Network as demonstrated by signing up to the Network Contract DES by 1 July 2019 and their subsequent participation. CCGs, working with LMCs, must ensure all practice lists are covered by a Primary Care Network in their area for the provision of network services.

4.19 In the highly unlikely event that a practice doesn't want to sign-up to the Network Contract DES, its patient list will nonetheless need to be added into one of its local Primary Care Networks. That PCN then takes on the responsibility of the Network Contract DES for the patients of the non-participating practice through a locally commissioned agreement. For those patients, it receives all the Network Financial Entitlements, and it delivers the Network Service Specifications as well as Supplementary Network Services.

4.20 The arrangement described in paragraph 4.19 is a necessary backstop. We neither expect nor wish to see it widely used. GPC England and NHS England will work together to support Local Medical Committees and Clinical Commissioning Groups resolve difficult issues.

(ii) Network list size

4.21 **A Primary Care Network will typically serve a population of at least 30,000 people.** It needs critical mass to do its job. Low population density across a large rural and remote area could be a legitimate reason for a slightly smaller network list size. That is likely to be the only permissible exception to the 30,000 population rule.

4.22 **A Primary Care Network will not tend to exceed 50,000 people.** Operating on a small-enough scale to make relationships work is an essential facet of the 'Primary Care Home' sites³⁸, whose experiences have informed these plans. 50,000 is a suggested upper level, not a strict requirement. Some individual practices are already bigger. If a large 'super-practice' (of say 200,000 patients) meets all the other registration requirements, it can serve as a single very large Primary Care Network. In reality, it will be organising itself into say 4 separate neighbourhood teams, each covering a mean of 50,000 people. But it would create extra bureaucracy to require each of these internal teams to register as a separate network.

(iii) The 'Network Area'

- 4.23 **Each Primary Care Network must have a boundary that makes sense to: (a) its constituent practices; (b) to other community-based providers, who configure their teams accordingly; and (c) to its local community,** given it marks the extent of PCN accountability for the health and wellbeing of a defined place. While it is possible that a single geography could be served by more than one PCN (building on current multi-practice arrangements) most areas are likely to have a single PCN. Through the registration process, all the 'Network Areas' will be agreed with the local CCG at the same time. The CCG does this on behalf of, and with the agreement of, the local Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP). Subsequent changes to network areas will require CCG approval. Boundaries will require active support from both the local CCG and NHS England.
- 4.24 **Normally a practice will only join one network.** It is likely that most network areas will not overlap, but this is not an absolute rule: for example a large town of 100,000 population could have two different 50,000 networks operating on exactly the same footprint. They would have to collaborate together on wider place-based goals. And a practice's catchment area may continue to span more than one network, just as it can currently span across more than one CCG (or across into Wales or Scotland).
- 4.25 The establishment of networks could have implications for the existing rules for example on practice boundaries, list closure and 'patient assignment'. NHS England and GPC England will consider further in 2019.

(iv) The Network Agreement

- 4.26 **All Primary Care Networks will have a Network Agreement, even those with one large practice.** This is because the Network Agreement is both the means by which the Primary Care Network sets out its collective rights and obligations as well as how it will partner with non-GP practice stakeholders. It is needed for the PCN to claim its financial entitlements (collectively, rather than as individual practices) and deliver national and local services to its whole Network list and area. Delivery and achievement of the contract requirements will depend on collaborative working by network members.
- 4.27 The Network Agreement strengthens the collaboration between all constituent practices. Like the partnership agreement in a GP practice, it is the vehicle under which constituent members agree how they work together and share resources and responsibilities. In order to meet the terms of the Network Participation Practice Payment, all practices must be active participants.
- 4.28 **The Network Agreement is also the formal basis for working with other community-based organisations.** A Primary Care Network cannot exist without its constituent practices, but its membership and purpose goes much wider. *The NHS Long Term Plan* sets out a clear ambition to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. The Primary Care Network is a foundation of all

Integrated Care Systems; and every Integrated Care System will have a critical role in ensuring that PCNs work in an integrated way with other community staff such as community nurses, community geriatricians, dementia workers, and podiatrists/chiropractors. Collaboration arrangements with other local organisations including community health providers will form a distinct part of every Network Agreement.

- 4.29 **The Network Agreement must be signed by all constituent GP practices.** A national template version will be mandated to reduce avoidable legal and transaction costs. Jointly developed by GPC England and NHS England, it will be available by March 2019. It will include a patient data-sharing requirement, in order to support safe and effective delivery of patient care. The network will also be required to share its non-clinical data within the network and its CCG, to support network analysis or assessment of compliance of the requirements of the contract.
- 4.30 **Performance of the contract requirements will depend on collaborative working between all practices in a network, just as the introduction of QOF in 2004 called for collaborative working between all clinicians in a practice.** A core duty of every network will be to deliver all network services equally effectively across all constituent practices, so that no patients are disadvantaged. To this end, every practice will need to meet any local network protocols that are developed and included in the Network Agreement.

(v) Delivery model for the Network Contract DES

- 4.31 Under the Network Contract DES, only the individual GMS, PMS and APMS contract holders (offering essential services) have the legal right to sign up, but it is the PCN as a whole that becomes responsible for delivery.
- 4.32 It is for each PCN to decide its delivery model for the Network Contract DES. It could be through a lead practice, GP federation, NHS provider or social enterprise partner.
- 4.33 Payment systems will be amended to take account of the Network Contract DES for 20/21, but some manual claims processes will be required for 19/20.
- 4.34 A CCG cannot register itself to be, or host, one or more Primary Care Networks.

(vi) The Clinical Director

- 4.35 **A Primary Care Network must appoint a Clinical Director as its named, accountable leader, responsible for delivery.**
- 4.36 Together, the Clinical Directors will play a critical role in shaping and supporting their Integrated Care System. They will help ensure the full engagement of primary care in developing and implementing local system plans to implement the *NHS Long Term Plan*. These local plans will go much further than the

national parts of the Network Contract DES in addressing how each ICS will achieve the triple integration.

- 4.37 In recognition of the importance of this role and as a contribution to the costs, we have agreed that **each Network will receive an additional ongoing entitlement to the equivalent of 0.25 FTE funding per 50,000 population size**. The amount will vary in proportion to network list size. The legal entitlement under the Network Contract DES starts from 1 July 2019.

Primary Care Network support

4.38 Primary Care Networks will benefit from five categories of external support:

- (i) **Clinical Director support funding** as described above;
- (ii) **Primary Care Networks will also be guaranteed a cash payment of £1.50 per registered patient**. From 1 July 2019, this will become a Network Financial Entitlement and will be based on the agreed network list size (based on practices' registered lists) as of 1 January each year. This payment is a recurrent extension of the existing £1.50 per head support scheme, which was set out in the December 2018 NHS planning guidance³⁹. It is a contribution to network effectiveness. As they do now, CCGs will continue to fund this out of their general CCG allocations, rather than the specific NHS England primary medical care allocation. Taken with the Clinical Director together, the two funds combine to create a £2.19 per head fund each year (£2.01 in 19/20), equating to over £109,000 for a typical 50,000 population network each year;
- (iii) many CCGs also provide **support in kind for their Primary Care Networks**, e.g. through seconding and paying for staff to help with particular functions. Devolved support to PCNs is likely to increase as CCGs evolve, and this local help and assistance will be an important factor in their success;
- (iv) during 2019, **NHS England will establish a significant new national development programme for PCNs**, working with Integrated Care System leaders and national bodies including GPC England, the Royal College of GPs, the National Association of Primary Care and the NHS Confederation Community Network; and
- (v) the new NHS Chief People Officer will ensure there is a strong focus on **supporting and developing future generations of Primary Care Network Clinical Directors** as part of the national work on NHS leadership development.

5. Going ‘digital-first’ and improving access

IT infrastructure

- 5.1 **NHS England will continue to ensure and resource IT infrastructure for general practice via the *GP IT Operating Model*⁴⁰.** The next version will be developed with GPC England and the Joint General Practitioners Information Technology Committee (JGPITC) by March 2019. It will include: (i) ‘GP2GP’ functionality; (ii) system standards; (iii) standards for digitisation of care records; (iv) cyber security; and (v) that investment decisions take account of CCG-led ‘maturity assurance’ of digital primary care.
- 5.2 ***GP IT Futures* will replace the current GP Systems of Choice (GPSoC) framework from December 2019.** GP IT Futures has four goals:
- to provide clinically safe and useful digital and data services for patients and general practice;
 - to provide real-time and secure access to data for patients and NHS users;
 - to allow interoperability between systems, underpinned by common standards;
 - to allow better comparison of activity and outcomes.
- 5.3 Through their Integrated Care Systems, **NHS England will also ensure that predictive analytical tools are available** to Primary Care Networks. These will help them identify those groups of people who are most at risk of adverse health outcomes and increasingly predict which individuals are most likely to benefit from different health and care interventions. This is an important enabler for the new Anticipatory Care requirements outlined in chapter 6.
- 5.4 Additional annual global sum funding of £20 million for the next three years will support practices to manage Subject Access Requests. This recognises loss of charging income and the additional burdens arising from the introduction of the General Data Protection Regulations. The extra funding ends in 2022, by when three changes will have happened that remove the burden on subject access requests: (i) the digitalisation of Lloyd-George paper records is completed; (ii) patients have access to these full digital records; and (iii) DHSC guidance makes clear that patients or their representatives can now access all the necessary information directly.
- 5.5 In addition, CCGs will be responsible for offering a Data Protection Officer (DPO) function to practices in addition to their existing DPO support services, whether by the CCG directly or through its commissioning support service. Appointing a DPO remains a practice’s legal responsibility, but this arrangement will be more efficient for the NHS as a whole.

Introducing digital-first primary care across England

- 5.6 **The best way of digitising primary care is to help existing practices.** That's why *The NHS Long Term Plan* announced that a new centrally-funded programme will create a framework for digital suppliers to offer their platforms on standard NHS terms. The framework will be available for use in 2021. Programme details will be developed in 2019.
- 5.7 **All patients should have access to digital primary care services, as rapidly as possible.** The new national support programme will help. A number of different digital models are rapidly emerging across England, and are being well received by practices and patients alike. Used well, these can also help alleviate workload challenges facing practices. For example, digital consultations can be more efficient for certain patients, thus helping free up time for more complex patients. Some digital models also offer practices the opportunity to buy-in additional clinical capacity.
- 5.8 Digital primary care has the potential to improve access, quality and outcomes, including through better data, more accurate diagnosis, and support tools for patients. For many patients, digital will become their channel of choice when interacting with the NHS. This is likely to be particularly true of 16-25 year olds. Increasingly they forgo traditional GP appointments. Progress on digital delivery will be important to maintain social solidarity behind the general practice model, and contract requirements will be updated annually as part of wider contract negotiations, to reflect advances in technology and delivery of the support promised in this agreement.
- 5.9 NHS England will work with Universities UK on developing digital primary care support for students. We will include a focus on mental health.

Specific digital improvements

- 5.10 **NHS England and GPC England have agreed eight specific improvements, backed by agreed contract changes, in areas where it is realistic to make early progress, given available functionality:**
- (i) **all patients will have the right to online and video consultation by April 2021;**
 - (ii) all patients will have **online access to their full record**, including the ability to add their own information, as the default position from April 2020, with new registrants having full online access to prospective data from April 2019, subject to existing safeguards for vulnerable groups and third party confidentiality and system functionality;
 - (iii) all practices will be offering and promoting **electronic ordering of repeat prescriptions** and using **electronic repeat dispensing** for all patients for whom it is clinically appropriate, as a default from April 2019;

- (iv) all practices will ensure at least 25% of appointments are available for online booking by July 2019. This is staging post towards a shared ambition that all patients should have the maximum possible access to online appointment booking. NHS England will launch a public campaign in 19/20 to raise awareness of the ability to book appointments online. Subject to systems capability, where patients wish, and as part of concluding the NHS 111 call, NHS 111 could book into these appointments on their behalf where that is appropriate, rather than requiring patients to do so in a separate process;
- (v) whilst a practice leaflet remains important, to recognise the changing habits of patients, all practices will need by April 2020 to have an up-to-date and informative **online presence**, with key information being available as standardised metadata for other platforms to use (for example the Access to Service Information (A2SI) Directory of Services Standard);
- (vi) all practices will be giving all **patients access online to correspondence** by April 2020, as the system moves to digital by default (with patients required to opt-out rather than in);
- (vii) by April 2020, practices will no longer use **facsimile machines** for either NHS or patient communications; and
- (viii) from October 2019, practices will register a practice email address with 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.

5.11 With appropriate governance in place recognising patients' preferences, practices will be expected to share data for digital services as outlined in the *NHS Long Term Plan*, like the NHS App and including contributing data to Local Health and Care Record initiatives as they come online to support information sharing with other services, in line with LHCR expectations for timeliness of data sharing.

5.12 As a critical enabler of the Personalised Care service specification outlined in chapter 6, **practices will also have the critical role in creating and updating care plans for all appropriate patients**, in as near to real-time as possible, to the Summary Care Record and to Local Health and Care Records when they are available. This will enable patients, their carers and professionals involved in their care are able to see the same information.

Fair payment for digital-first delivery

5.13 A founding principle of the NHS is patient choice of practice with which to register. Funding follows, as a patient moves from one practice to another. The emergence of digital-first providers, who directly register patients, raises the question of whether the consequential redistribution of the general practice funding pot is fair. In July 2018, NHS England started a public engagement process on this this asking some specific questions to inform subsequent contract discussions with GPC England⁴¹.

5.14 **Practice funding will be revised to improve fairness.** As first steps, two changes will be made in 2019/20 to the distribution of primary care resources:

- (i) the rurality index payment will be amended to apply to patients living within a practice catchment area only, rather than to all patients. This is to better reflect costs; and
- (ii) the London adjustment will be amended to apply to patients resident in London, rather than registered in a London-based practice.

5.15 These changes are not intended to reduce funding nor determine overall funding levels. NHS England and GPC England will not make any further changes to the Carr-Hill funding formula in 2019-20 to provide stability to practices.

5.16 **In 2019 NHS England will further analyse and review the current 46% year one premium for registering new patients, for potential change in 2020/21.**

5.17 **In 2019, NHS England will also undertake a wider review of out-of-area registration arrangements and patient choice of digital-first primary care.** The out-of-area rules were originally set up to allow a relatively small number of patients to choose to register with a practice in a more convenient location than their home address (for example for commuters to register near where they work). But the rules were not designed with digital registration in mind, and they need to be revisited.

5.18 In undertaking the review, NHS England will work closely with patients, interested providers, and GPC England. The review has four goals:

- (i) to ensure that digital-first models can have appropriate links with other local services;
- (ii) to develop appropriate mechanisms for allowing patient choice of digital-first practices and meet *The Long Term Plan* commitment that all patients will have a new right to choose a digital-first provider;
- (iii) to avoid reducing flexibility for those patients who benefit from the current rules; and

- (iv) to maintain the integrity of essential NHS systems including financial allocations to CCGs.

Protecting the comprehensive model of NHS primary care

5.19 This agreement reaffirms our commitment that primary medical care will always remain a fully comprehensive NHS service, free at the point of use. And so **from 2019 it will no longer be legal for any NHS GP provider – either directly or via proxy to advertise or host private paid for GP services** that fall within the scope of NHS-funded primary medical services. NHS England will consult on expanding this specific ban on the provision of paid-for GP services to other providers of mainly NHS services.

Joining-up the urgent care system

5.20 In parallel with digital access, the emergence of Primary Care Networks provides an opportunity to bring more coherence to the way extended access is currently provided.

5.21 **By April 2021 we intend that the funding for the existing *Extended Hours Access DES* and for the wider CCG commissioned *extended access service* will fund a single, combined access offer as an integral part of the Network Contract DES, delivered to 100% of patients including through digital services like the NHS App.**

5.22 **NHS England will work with stakeholders including GPC England to evolve and implement a single coherent access offer that PCNs will make, for both physical and digital services. This will deliver convenient appointments ‘in hours’, reduced duplication and better integration between settings such as 111, urgent treatment centres and general practice. The review will start in 2019, for full implementation by 2021/22** but we expect local Integrated Care Systems and their Primary Care Networks to go faster and we encourage them to do so. An expanded role for PCNs in running urgent care in the community will be made easier by the flexibility for CCGs to add Supplementary Network Services to the new Network Contract, on a voluntary basis, described in section 4. It could also see networks benefit from payments reflecting their impact on A&E attendances, as part of the new Network Investment and Impact Fund described in chapter 6.

5.23 The access review has four goals:

- (i) learn from the existing GP extended hours and enhanced access schemes, including evidence of the costs of service provision;
- (ii) take account of *The NHS Long Term Plan* commitments to improve urgent care in the community and ensure it is joined up, including for example how PCNs work with Urgent Treatment Centres and GP streaming services provided in A&E;

- (iii) seek to improve patient reported access and reduce variation in experience of long waits; and
- (iv) take account of digital advances, so that physical and digital access are considered together including by delivering via services such as the NHS App.

5.24 The funding available through the Network Contract DES for improving access amounts to £454 million a year in 2021/22, in addition to £30m added to global sum recurrently through the practice contract. The £454m comprises £367m from the *Improving Access to General Practice* programme⁴², and £87m transferred in from the Extended Hours Access DES.

5.25 Many of the enhanced access services are currently provided across more than one PCN. Their transfer into the Network Contract DES will need joint working across PCNs to deliver at the right scale. Transition will begin on 1 July 2019. Instead of allowing the Extended Hours Access DES to draw to a close, removing £87m a year from general practice contract funding, we have agreed to **transfer the Extended Hours Access DES requirements and existing funding to the Network Contract DES from July 2019 until it becomes part of the funding for the combined access offer in April 2021. The DES requirements will be delivered to 100% patients in every PCN, rather than those of the 75.7% of practices currently participating** so that an average network with a population of 50,000 would need to provide 25 hours extended access per week, shared between morning, evening and weekends. All extended hours slots would, as now, need to be delivered by the constituent practices of the network.

5.26 To reflect the increased population coverage of the extended hours access requirements, funding will also increase accordingly. We have agreed that this takes the form of recurrent investment of £30m per annum (in 2019/20) in the practice global sum, which also recognises the introduction of 111 direct booking.

Joining up with 111

5.27 The *NHS Long Term Plan* commits to joining up the NHS urgent care system so that it works better for everyone. **The North-East 111 pilot has shown that many patients who would normally be advised to attend general practice for minor ailments, or urgent repeat medicines, can be successfully diverted to community pharmacies**⁴³. NHS England will now explore how these services can be rolled out nationwide as rapidly as possible, as part of negotiations led by the Department of Health and Social Care with the Pharmaceutical Services Negotiating Council (PSNC) on the Community Pharmacy Contractual Framework (CPCF). These potential changes, if implemented, will have an impact in helping to reduce in-hours and out-of-hours workload for GPs. In parallel, NHS England will also test models of redirecting

patients who present in general practice to community pharmacy, described in *The NHS Long Term Plan* as a 'pharmacy connection scheme'.

- 5.28 111 also ensures that only patients who genuinely need to attend A&E or use the ambulance service are advised to do so, directing patients to other healthcare settings where this is clinically appropriate. This includes in a small number of cases directly booking into a patient's own GP for continuity. Over 40% of practices are already involved. NHS England and GPC England have agreed that for 2019/20 this will be at the level of 1 practice appointment per day, per 3,000 patients, with a minimum of 1 appointment per practice per day. The number of appointments required will rise in increments of 3,000 patients. For example, a practice with a list size of 7,500 patients would need to provide a minimum of 2 appointment slots per day, whilst a practice with a list size of 9,000 patients would provide a minimum of 3 appointment slots per day. This becomes a core GP contract requirement. Taken with the intended pharmacy scheme, we anticipate that 111 could be directing more patients away from general practice to pharmacists, than are directly booked into general practice.

Understanding of GP activity level and waiting times

- 5.29 **Clearer recording and collection of data on access to general practice will be essential over the next five years.** It will help us assess adoption of new digital approaches, measure workload pressure more accurately, evaluate the impact of workforce diversification and also to measure patient experience of primary care services. Over the period to 2021 we will develop a comprehensive and structured dataset describing access to general practice based on better and more consistent recording via standards defined in consultation with the Joint General Practitioners Information Technology Committee in 2019/20 and reported through practice systems. Practices will be expected to ensure that data is captured accurately and in a timely manner to enable real time reporting on activity, capacity and waiting times. We will also create a new transparent measure of patient reported satisfaction with access. The aim is to end up with published robust activity and waiting time data at individual practice and PCN level no later than 2021, to allow time for systems to embed this properly alongside the equivalent hospital data, as part of a combined set of statistics.

6. Delivering new network services

Meeting *NHS Long Term Plan* commitments

- 6.1 By 2021, Integrated Care Systems will cover the whole country. Primary Care Networks will be a fundamental building block of every Integrated Care System, essential to achieving Integrated Care System goals.
- 6.2 *The NHS Long Term Plan* made the major decision to guarantee primary medical and community health services a bigger share of total NHS resources, on the grounds that this will prove the best answer for patients and the NHS itself.
- 6.3 In turn, **the crux of this agreement between NHS England and GPC England is that in return for major investment over the next five years, four things will happen:**
- **general practice will be *able* to implement the relevant *NHS Long Term Plan* commitments in a phased way**, thanks to investment in workforce (chapter 1), the indemnity solution (chapter 2), and the creation of Primary Care Networks (chapter 3);
 - **general practice will *deliver* specific improvements**, such as better support for care homes, or CVD case finding, which will be implemented nationwide. This isn't only because there is enough capacity, but also because the commitments themselves are evidence-based, and command professional and patient support. NHS England and Integrated Care Systems will also help by supplying analytical tools and data on comparative performance, identifying best practice, and encouraging peer assistance and quality improvement activity;
 - **in so doing, we will be able to point to impact achieved and *demonstrate* clear sufficient quantified benefits** for patients, the NHS as a whole, and value for money for the taxpayer;
 - **as a result, we will create a *virtuous circle*** and make a strong investment case for the second five years of the Plan.

Seven national service specifications

- 6.4 **The increase in investment under this agreement includes the introduction of seven specific national service specifications under the Network Contract DES.** These seven specifications give effect to most of the specific *NHS Long Term Plan* goals for primary care, not already covered through the improvements to QOF, access and digital. We encourage PCNs to make early progress in each of these areas ahead of formal introduction of the

requirements and will work to provide early detail of the evolving service specifications to facilitate that.

6.5 The seven are focused on areas where Primary Care Networks can have significant impact against the 'triple aim':

- improving health and saving lives (for example from strokes, heart attacks and cancer);
- improving the quality of care for people with multiple morbidities (for example through holistic and personalised care and support planning, structured medication reviews, and more intensive support for patients who need it most including care home residents);
- and helping to make the NHS more sustainable (for example, by helping to reduce avoidable hospital admissions).

6.6 **During 2019 and 2020, NHS England will develop the seven specifications and seek to agree these with GPC England as part of annual contract changes.** They will also be agreed with Government to ensure value for money from the overall contract deal. All seven specifications will set out standard processes, metrics, and intended quantified benefits for patients. The annual funding increase under the Additional Roles Reimbursement Scheme will be tied to agreeing the service specifications nationally, and their subsequent delivery. This will also be reflected in the wording of the Network Contract DES.

6.7 NHS England will use the primary care testbed programme to test and improve the draft contract specifications, for example on hypertension case-finding. To assist with implementation, and we will also prioritise the early development of potential QOF Quality Improvement modules in these areas, for example on cancer diagnosis. Every Integrated Care System will be developing its own local delivery plan to implement *The NHS Long Term Plan*, aided by its Primary Care Network Clinical Directors closely engaging with LMCs. In these local ICS plans, delivery and impact of the seven service specifications will be important markers of success.

6.8 **The seven national service specifications are:**

- Structured Medications Review and Optimisation;***
- Enhanced Health in Care Homes,*** to implement the vanguard model;
- Anticipatory Care requirements*** for high need patients typically experiencing several long term conditions, joint with community services;
- Personalised Care,*** to implement the NHS Comprehensive Model;

(v) ***Supporting Early Cancer Diagnosis;***

(vi) ***CVD Prevention and Diagnosis;*** and

(vii) ***Tackling Neighbourhood Inequalities.***

6.9 **Much work is already underway in primary care in these areas. The national service specifications build on that energy, and simply create a set of national minimum requirements that must be delivered everywhere. We encourage PCNs to make early and strong progress. This will help them maximise their potential income from the new Investment and Impact Fund. The pace will reflect the phased expansion in Primary Care Network workforce capacity:**

- none of the formal contract specifications start in 2019/20;
- the new national structured medication review and care homes requirements apply in full from 2020/21 onwards;
- personalised care, anticipatory care and supporting early cancer diagnosis requirements commence in 2020/21 and develop over the subsequent years; and
- the CVD and inequalities requirements will start in 2021/22, following development and testing of the best delivery models. The specifications will develop over time, for example as diagnostic capacity expands in primary care (e.g. echocardiography to aid early detection of heart failure and valve disease) and secondary care.

6.10 **NHS England will work with the full range of relevant stakeholders in developing the draft specifications**, prior to formal contract discussions with GPC. This includes for example the RCGP, relevant voluntary sector partners, patients, care home providers, and local system leaders. The specifications will be published in draft before being finalised.

(i) Structured Medications Review and Optimisation

6.11 **The new Structured Medication Review requirements will be directly enabled by the expansion of clinical pharmacists working in networks. It will directly tackle over-medication of patients** including inappropriate use of antibiotics, supporting the government's antimicrobial resistance strategy⁴⁴, withdrawing medicines no longer needed and through NHS England led-programmes such as low priority prescribing⁴⁵, **as well as support medicines optimisation more widely.** Up to 10% of hospital admissions in the elderly population are medicines-related⁴⁶. Research shows that as many as 50% of patients do not take their medicines as intended⁴⁷. Through structured reviews, clinical pharmacists will support patients to take their medicines to get the best

from them, reduce waste and promote self-care. Digital technology will also help.

- 6.12 In line with *The NHS Long Term Plan* commitments, this service will have a dedicated focus on particular priority groups, including but not limited to: (i) asthma and COPD patients; (ii) the Stop Over Medication for People with learning disabilities or autism programme (STOMP)⁴⁸; (iii) frail elderly; (iv) care home residents; and (v) patients with complex needs, taking large numbers of different medications. We will expect a particular focus on tackling inequalities. PCNs will be assisted by analytical tools to help identify the right patients for whom the service should be offered.

(ii) The Enhanced Health in Care Homes Service

- 6.13 **Enhanced Health in Care Homes requirements will support implementation of the delivery model tested in the six care home vanguards between 2014/15 and 2017/18.** This comprises a structured set of evidence-based interventions, and is already being widely implemented across the country, supported by CCGs. They also reduced ambulance conveyances, over-medication, and improved the quality of care for residents⁴⁹.
- 6.14 **The Enhanced Health in Care Homes requirements will ensure that all care homes are supported by a consistent team of multi-disciplinary healthcare professionals delivering proactive and reactive care, led by named GPs and nurse practitioners, organised by the Primary Care Network.** Typically this involves a comprehensive weekly visit. This will be more efficient for practices as well as avoiding care homes having multiple different practices making uncoordinated visits. Care home residents will also get regular clinical pharmacist-led medicine reviews. Primary Care Networks will be responsible for working with emergency services to provide emergency support, including where advice or support is needed out-of-hours. It includes effective care planning including for residents nearing the end of their lives. The model also includes helping care homes ensure their residents have good oral health, stay hydrated and well-nourished, and that they are supported in their recovery following ill-health, by speech and language therapists. This last part of the service specification requires input from wider community services as part of the wider Primary Care Network. NHS England will also help enable social care partners to communicate effectively and securely with Primary Care Networks using NHSmail and other digital tools such as video consultations.
- 6.15 Many CCGs already have local enhanced services for some form of care home support supplementing funding that is already provided to practices with whom each care resident is registered. Through this national Network Service, we will now achieve 100% coverage of the full model, which goes much further than most local schemes.
- 6.16 **Every care home in England will benefit from this comprehensive service, provided free by the NHS, delivered by their Primary Care Network under the**

Network Contract DES. In return, NHS England and the Government will work with care homes providers to maximise the contribution they can also make to improving the health and wellbeing of their residents.

(iii) Anticipatory Care

- 6.17 **The NHS Long Term Plan set out an ambition to dissolve the historic divide between primary and community medical services.** The Anticipatory Care requirements are central to that goal.
- 6.18 By working on 30-50,000 patient footprints, and by joining up GP services with other community and hospital based staff, the new care models programme showed it is possible to improve outcomes and value for the NHS by **introducing more proactive and intense care for patients assessed as being at high risk of unwarranted health outcomes** including patients receiving palliative care⁵⁰. GPs are already using the Electronic Frailty Index to routinely identify people living with severe frailty. Based on individual needs and choices, under the Anticipatory Care Service, people identified as having the greatest risks and needs will be offered targeted support for both their physical and mental health needs, which include musculoskeletal conditions, cardiovascular disease, dementia and frailty. Typically, this involves a structured programme of proactive care and support in which patients with multi-morbidities will have greater support– including longer GP consultations where appropriate - from the wider multidisciplinary team.
- 6.19 Anticipatory care is not something that either community providers or GP practices can deliver in isolation. As integration supplants competition as the NHS's dominant rulebook, general practice will no longer go it alone. Instead, **the Anticipatory Care Service can only be delivered by a fully integrated primary and community health team.** This involves input from community providers, general practice, social care and hospitals. Accordingly, from July 2019, community providers are being asked to configure their community teams on PCN footprints.
- 6.20 **The full requirements will be developed across the country by Integrated Care Systems, and commissioned by CCGs from their Networks.** It will involve bringing together pre-existing teams and resources, supplemented by additional funding from *The NHS Long Term Plan* funding guarantee for community health and primary medical services. Community health teams and primary medical care are being funded to make this happen between them. Delivery of the requirements will only be possible through excellent working relationships and close collaboration with community partners.
- 6.21 Through the national requirements in the Network Contract DES, general practice will also need to play its part in partnership with community services. Working with Integrated Care Systems, **NHS England will develop the national requirements for the essential contribution required under the Network Contract DES, to form part of the wider service that Integrated**

Care Systems will be organising. As part of this work, we will also design the core national primary care contribution for the **new community-led urgent response and reablement service** promised in *The NHS Long Term Plan*. As funding increases over time, so the specifications will extend.

(iv) Personalised Care

- 6.22 ***The NHS Long Term Plan committed to the full roll out of the NHS Comprehensive Model for Personalised Care*⁵¹.** This model has been developed and tested over the past three years, and **it will now be delivered in full by Primary Care Networks under the Network Contract DES by 2023/24.**
- 6.23 In England, general practice is based on traditions that are partly psycho-social as well as bio-medical. Consistent with that heritage, **this service specification is intended to avoid over-medicalising care**, and ensure patients are asked by the primary care team “*What matters to you?*”, not just “*What’s the matter with you?*”⁵². It is about engaging people fully, sharing control, and connecting them to wider societal support. The model partly reflects the wider movement led by doctors for ‘rethinking medicine’.
- 6.24 NHS England is publishing its plans for implementing the Comprehensive Model in January 2019, following close working with over 50 different organisations including the RCGP. This sets out the full array of different delivery support actions that will be taken nationally to ensure effective implementation. **The Comprehensive Model of Personalised Care has six main evidence based components: (i) shared decision-making; (ii) enabling choice, including legal rights to choice; (iii) personalised care and support planning; (iv) social ‘prescribing’ and community -based support; (v) supported self-management; and (vi) personal health budgets and integrated personal budgets.** The elements have been proven to improve health and wellbeing outcomes, increase patient satisfaction as well as reducing the direct costs of care (for example of continuing healthcare packages, and through social prescribing reducing GP attendances and wider NHS use)⁵³.
- 6.25 A significant cost barrier for general practice in being able to implement the Comprehensive Model is the cost of additional social prescribing link workers, and that is why under this agreement 100% of their cost will now be reimbursed. **As with the Anticipatory Care requirements, the minimum national activity levels for all elements of the model will increase gradually over time in line with increases in capacity.** The Comprehensive Model is expected to benefit 2.5 million people by 2023/24, including over 900,000 referrals for social prescribing. For both the complex care and personalised care service specifications, requirements and expectations will increase over the following three years in line with workforce expansion. As part of the national requirements, a Primary Care Network will need to contribute to their ICS plan, and the ICS will also need to set out what it is doing locally, given

some of the services are best delivered within a framework of wider local coordination and support.

(v) Supporting Early Cancer Diagnosis

- 6.26 The Global Burden of Disease study point to the further significant scope for the NHS to improve early cancer diagnosis at stage 1 and 2⁵⁴. These patients have the best chance of curative treatment and long term survival. The national ambition in *The NHS Long Term Plan* is that by 2028, the proportion of cancers diagnosed at stage 1 and stage 2 will rise from about half now to three-quarters of cancer patients. It is also vital that patients receive care that is tailored to their individual needs so that their experience of care is on a par with clinical outcomes. *The NHS Long Term Plan* commits to delivering personalised care to all cancer patients by 2021, ensuring that every person with cancer has the best possible care, quality of life and system resources are utilised effectively. **Primary Care Networks will have a responsibility for doing their part, alongside the Cancer Alliances and other local partners, and this will be reflected in the service specification.**
- 6.27 Cancer screening programmes will be critical in diagnosing cancer earlier, including for bowel cancer using FIT, and HPV primary screening. Sir Mike Richards is leading a national review of current arrangements, which concludes in summer 2019. **Practices are likely to have a key role in helping ensure high and timely uptake of screening and case finding opportunities within their neighbourhoods.** We expect to make early progress by 2020 with agreed changes arising from the review to be implemented via the core practice contract.
- 6.28 **Primary Care Networks will have a key role in helping to ensure that all their GPs are using the latest evidence-based guidance to identify people at risk of cancer; recognise cancer symptoms and patterns of presentation; and make appropriate and timely referrals for those with suspected cancer.** A typical network with a patient population of 50,000 will have approximately 270-280 new diagnoses of cancer a year, of which only about half are currently diagnosed at stage 1 and 2⁵⁵. **We will develop a QOF Quality Improvement module for national use in 2020/21 to help practices and networks understand their own data, and work through what they can do to achieve earlier diagnosis.** This might for example include direct engagement with particular local groups of their community where there is the greatest opportunity for making a difference; all staff to play a role in raising awareness of symptoms and the importance of screening; changes in clinical practice e.g. referrals; as well as working with their local ICS to tackle diagnostic bottlenecks. **Alongside the QI module, we will start the Network Specification by 2020/21.**

(vi) Cardiovascular disease prevention and diagnosis

- 6.29 **Better prevention, diagnosis and management of cardiovascular disease is the biggest single area where the NHS can save lives over the next ten years, through fewer strokes and heart attacks. Primary Care Networks have the critical role in realising this *NHS Long Term Plan* ambition, principally through secondary prevention**, building on the progress already made through the Quality and Outcomes Framework.
- 6.30 In 2019/20 we will make significant further progress in CVD management through the QOF changes on blood pressure control, and the review of the heart failure domain for any subsequent changes to be implemented as soon as possible.
- 6.31 Too many patients are still living with undetected and under-treated high risk conditions such as high blood pressure, raised cholesterol, and atrial fibrillation. 80% of heart failure is currently diagnosed in hospital, despite 40% of patients having symptoms that should have triggered an earlier assessment⁵⁶. We will confirm the scale of the opportunity nationally, and what this means for an individual network. A new CVD national prevention audit for primary care will support continuous improvement, potentially through a QI module. This will be supported through a benchmarking tool. Through a testbed cluster, NHS England will also test the most promising approaches to detecting hitherto undiagnosed patients, including through local pharmacies, as well as managing patients with high risk conditions who are on suboptimal treatment. The initial network service specification will be introduced by 2021/22.

(vii) Inequalities

- 6.32 **The seventh service specification funded nationally will cover the challenge of tackling inequalities in health and healthcare.** We will develop this through a testbed cluster, involving Primary Care Networks with high levels of inequalities. This testbed could benefit from significant national and local partnering. Drawing on the existing evidence and programme, some of which is summarised in Chapter 2 of the *NHS Long Term Plan* and its annex on wider social goals, the cluster will seek to work out what practical approaches have the greatest impact at the 30-50,000 neighbourhood level and can be implemented by Primary Care Networks. The service specification will include good practice can be adopted everywhere, tailored to reflect the specific context of their neighbourhood and agreed with their CCG. **An initial service specification will developed in 2020, to start by 2021/22.**
- 6.33 NHS England has continued to target a higher share of overall CCG funding towards geographies with high health inequalities⁵⁷. The primary care component of the funding formula includes the greatest weighting for inequalities, given evidence of the inverse care law. And so for areas with the highest inequalities, NHS England expects that CCGs will be using some of their additional funding for inequalities to boost primary care capacity and access. All Integrated Care Systems will need to set out how they will reduce inequalities by 2023/24, with Primary Care Networks playing their part.

Vaccination and Immunisation Review

6.34 **A review of Vaccination and Immunisation procurement, arrangements and outcomes will take place in 2019 with its output implemented through the 2020 and 2021 contracts.** The review's purpose is to reduce complexity, improve value and increase impact and not cut practice income. As part of the review, NHS England will consider how screening and vaccination programmes could be designed to support a narrowing of health inequalities.

6.35 NHS England will apply the same collaborative and co-design approach deployed as part of the recent QOF review and we plan to use this review to:

- ensure the system incentivises achievement of appropriate uptake rates for immunisations in line with national public health uptake rates;
- reduce the administrative burden on general practices by simplifying the system if possible;
- clarify what is expected on call/recall for all S7a immunisations;
- address anomalies in the system that directly incentivise some vaccines but not others;
- look at how we deal with outbreaks and catch-up programmes;
- consider whether we extend the list of chargeable travel vaccines.

6.36 It will also be the forum for developing proposals on changes to the GP payments system to reflect a potential central flu vaccine procurement route, including any revised arrangements to improve the rate of uptake. It is possible that in the future some vaccination programmes could be delivered more efficiently at network level rather than at individual practice level, freeing up time for GPs and practice staff to undertake other activities.

Network Dashboard

6.37 From April 2020, every network will be able to see the benefits it is achieving for its local community and patients. **It will see its relative progress on key metrics contained a comprehensive new national Network Dashboard.**

6.38 The dashboard will include population health and prevention, urgent care and anticipatory care, prescribing and hospital use. It will also cover metrics for all the new national service specifications.

Investment and Impact Fund

- 6.39 **A major new national network Investment and Impact Fund will start in 2020 as a means of supporting Integrated Care System delivery of *The NHS Long Term Plan*, with funding rising from £75 million in 2020/21, to a minimum expected £300 million in 2023/24.**
- 6.40 **The purpose of the Investment and Impact Fund is to help PCNs plan and achieve better performance against metrics in the network dashboard.** NHS England will develop national rules and guidance. The Scheme will be overseen by Integrated Care Systems. Networks will need to agree with their Integrated Care System how they spend any monies earned from the Fund. These are intended to increase investment for workforce expansion and services, not boost pay.
- 6.41 **Part of the Fund on wider NHS utilisation will be dedicated to *The NHS Long Term Plan* commitment to the principle of ‘shared savings’.** NHS England anticipates that this will eventually cover five elements:
- (i) **avoidable A&E attendances**, which Primary Care Networks will increasingly be able to impact through the changes described in Chapter 5 including 111 direct booking;
 - (ii) **avoidable emergency admissions**, which will particularly be impacted through the Anticipatory Care Service and Enhanced Health in Care Homes
 - (iii) **timely hospital discharge**, helped by the development of integrated primary and community teams;
 - (iv) **outpatient redesign**. This will be aided by the national ambition set out in the *NHS Long Term Plan* to redesign outpatients services using digital technology to avoid up to 30 million outpatient appointments a year. Primary Care Networks will have a critical role in supporting this ambition, whilst also increasing referrals for cancer, e.g. direct access diagnostics;
 - (v) **prescribing costs**. NHS England will review past and existing prescribing incentive schemes in 2019 to develop a standard national model.
- 6.42 **This wider NHS utilisation part of the fund will be introduced in a phased way.** And unlike many shared savings schemes, the utilisation part of Investment and Impact Fund will not create unfunded risk for either CCGs or hospital contracts. Instead, the funding is pre-identified and capped. The exception to this is the prescribing element, which will be funded through the existing primary care drugs budget and the savings opportunity on prescribing

is not therefore capped but will depend on the extent to which networks can achieve greater efficiencies than those already planned by their CCGs.

- 6.43 The Fund will be linked to performance and its design will be agreed with Government. **We envisage access to the Fund being a network entitlement from 2020/21.** NHS England will also consider whether the CCG Quality Premium scheme should be subsumed into the Impact and Investment Fund. This could add additional funding.

7. Guaranteeing investment

- 7.1 *The NHS Long Term Plan* committed to increase investment in primary medical and community health services as a share of total NHS revenue spend across the five years from 2019/20 to 2023/24. This means that spending on these services will be at least £4.5 billion higher in five year's time. This is the first time in the history of the NHS that real terms funding for primary medical and community services is guaranteed to grow faster than the rising NHS budget overall.
- 7.2 This chapter now confirms how much of this flows through national GP contract, via the practice contract and its extension through the Network Contract DES. **It gives general practice five-year funding clarity and certainty for the first time.** Beyond contract funding, investment worth hundreds of millions of pounds will continue to be made in central programmes benefiting general practice.

Funding for the Practice Contract

- 7.3 **Funding for the core practice contract (i.e. excluding the network DES) is now agreed and fixed for each of the next five years, and increases by £978 million in 2023/24.**

TABLE 4: PRACTICE CONTRACT FUNDING

| | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|-----------------------------------|---------|---------|---------|---------|---------|---------|
| Practice contract baseline | £8,007m | £8,116m | £8,303m | £8,532m | £8,748m | £8,985m |
| Cumulative increase | | £109m | £296m | £525m | £741m | £978m |
| % annual increase | | 1.4% | 2.3% | 2.8% | 2.5% | 2.7% |

- 7.4 **This settlement covers all aspects of practice income and expenses** and incorporates:
- (i) the agreed adjustment of global sum as part of the indemnity settlement (paragraph 2.7);
 - (ii) £105m payable as a network participation payment, which includes 1% pay for staff in general practice, deferred from 2018/19 and incorporated here⁵⁸;
 - (iii) the transfer out of the Extended Hours DES to network level as part of the access changes (paragraph 5.26) and subject access request costs (paragraph 5.4).

Pay

- 7.5 As a result of fixing the practice contract funding for the next five years, GPC England and NHS England have agreed that **DDRB will not make recommendations on GP partner net income.**
- 7.6 **Under this agreement, GPC England is recommending that practice staff, including salaried GPs, receive at least a 2.0% increase in 2019/20**, but the actual effect for individuals will depend on how indemnity cover is currently funded within practices.
- 7.7 NHSE and GPC have asked the government to ask the DDRB not to make recommendations for salaried GPs for the 2019 pay round. We have further asked the Government to continue to include recommendations on the pay of salaried GPs in the DDRB remit from the 2020 pay round onwards. Recommendations will need to be informed by affordability and in particular the fixed contract resources available to practices under this deal and will inform decisions by GP practices on the pay of salaried GPs. We have asked the Government to ensure that DDRB continues, as usual, to recommend on GP trainees, educators and appraisers. As now, the Government will decide how to respond to DDRB recommendations.
- 7.8 **A new Balancing Mechanism will, if required, adjust between the practice level global sum and the network level Additional Roles Reimbursement Sum** depending on levels of real terms partner NHS earnings. It will enable global sum adjustment equally in either direction. The mechanism is intended to provide confidence to the profession and taxpayers alike, by protecting against unexpectedly large increases in either inflation or partner drawings. The effect would also be to increase or decrease number of extra staff funded through the Network Contract DES. The balancing mechanism will be designed in 2019 by NHS England and GPC England to commence from 2020/21, taking account of the most recent available data, and it will be agreed with Government.
- 7.9 **As a corollary of major investment, and to safeguard public trust in the GP partnership model, pay transparency will increase.** GPs with total NHS earnings above £150,000 per annum will be listed by name and earnings in a national publication, starting with 2019/20 income. The Government will look to introduce the same pay transparency across other independent contractors in the NHS at the same time.

Funding for the Network Contract DES

- 7.10 Table 5 shows how the new Network Contract DES will rise over the five years to be worth up to £1,799 billion in 2023/24. It comprises four different funding components:

- (i) **the new Additional Roles Reimbursement Scheme.** Whether or not the whole £891 million of funding is spent will depend on the extent to which networks draw down their entitlement;
- (ii) **network support**, through a combination of the existing recurrent £1.50/head and the new 0.25 WTE contribution for the Clinical Director, which equates to £2.01/head in 2019/20. From July 2019 these will be minimum funding requirements. Many CCGs provide additional financial support, as well as support in kind from CCG staff;
- (iii) **access**, through a combination of the transferred Extended Hours Access DES and the £6/head CCG-commissioned enhanced access arrangements. These become a combined legal entitlement in 2021/22 in return for implementing the revised and more joined-up access requirements that will arise from the access review; and
- (iv) **the new Investment and Impact Fund.** If agreed with GPC England, access to the fund becomes an entitlement, in line with national rules. The level of funding will relate to the level of achievement.

TABLE 5: NETWORK FUNDING

| £millions | 2019/20 | 2020/21 | 2021/22 | 2022/23 | 2023/24 |
|---|------------|------------|--------------|--------------|--------------|
| 1. Additional Roles Scheme | 110 | 257 | 415 | 634 | 891 |
| 2. Network Support | | | | | |
| <i>£1.50 per head from CCG general allocation</i> | 90 | 90 | 91 | 91 | 92 |
| <i>GP PCN leadership (0.25 WTE per PCN, starts July 2019)</i> | 31 | 42 | 43 | 44 | 45 |
| Subtotal | 121 | 132 | 134 | 135 | 137 |
| 3. Access | | | | | |
| <i>Extended Hours Access DES</i> | 66 | 87 | 87 | 87 | 87 |
| <i>Improving Access to General Practice at £6 per head</i> | | | 367 | 376 | 385 |
| Subtotal | 66 | 87 | 454 | 463 | 472 |
| 4. Investment and Impact Fund | 0 | 75 | 150 | 225 | 300 |
| TOTAL PCN FUNDING | 296 | 552 | 1,153 | 1,457 | 1,799 |

7.11 **GPC England and NHS England have agreed that we do not expect additional national money for practice or network contract entitlements, taken together, until 2024/25.**

7.12 **The Premises Review will be published by March 2019. The NHS Long Term Plan** committed to its implementation.

Local enhanced services

7.13 This national agreement covers national contract funding. It does not cover additional CCG funding for primary medical care. CCGs in discussion with LMC(s), will need to review their local enhanced services in the light of the new Network Contract DES, so that their additional local funding for general practice secures services that go beyond national contractual requirements. Most local contracts for enhanced services will normally be added to the Network Contract DES. The total funding for primary medical and community services will rise by £4.5 billion by 2023/24. This is a floor level that is being nationally guaranteed, that local CCGs and ICSs are likely to supplement further.

Centrally-funded programmes

7.14 Primary care also benefits from support provided free to practices and networks, because they are met from within a separate NHS England central budget allocation. Some of these funds are devolved to regions or ICSs. They include a range of *GP Forward View* programmes such as practice nurse development, international GP recruitment, as well as estates and technology transformation, practice resilience, the *Time for Care* programme, the online consultations programme, and the GP mental health service.

7.15 This agreement also commits NHS England to new centrally-funded support:

- (i) the new framework to offer digital-first platforms to all Primary Care Networks, on top of the existing *GP IT futures* programme which replaces *GP Systems of Choice*;
- (ii) a significant national Primary Care Network development and support programme;
- (iii) the new primary care fellowship programme and training hubs;
- (iv) provision for expected indemnity costs; and
- (v) support for the new testbeds programme.

8. Supporting research and testing future contract changes

Research

- 8.1 *The NHS Long Term Plan* emphasises the importance of research. NHS England will work to increase the number of people registering to participate in health research to 1 million by 2023/24, and Primary Care Networks will be able to help with this goal.
- 8.2 Research participation within general practice has many additional benefits: quality improvement, professional development, and generating income, amongst others. Working with the Royal College of General Practitioners, the National Institute of Health Research and the Clinical Practice Research Datalink, **we will use the opportunity created by Primary Care Networks to increase general practice research participation levels.** During 2019, we will develop a way of helping networks to do this, embedding approaches such as the RCGP *Research Ready* quality assurance model⁵⁹. We welcome also the National Institute of Health Research's intention to prioritise an expansion in academic research capacity into primary care.

A new national development and testing programme

- 8.3 In addition to traditional academic research and evaluation, *The NHS Long Term plan* committed to expanding the current NHS England 'Test beds'. Expanding this commitment and translating it into primary care, **NHS England will create a dedicated development and testing programme in 2019 for specific planned contract changes.**
- 8.4 This five year framework enables us to construct a clearer pipeline of future potential contract changes. We will work out which would benefit from a more formal development and testing process, in advance on contract implementation, to improve the quality of implementation.
- 8.5 Rather than commission a fixed number of ongoing test bed practices or networks, NHS England envisages the test sites being selected purely on a topic by topic basis.
- 8.6 Each topic will have a cluster of distinct test bed sites, whether practices, or PCNs, or whole Integrated Care Systems. We will aim for a representative sample of different practices or PCNs drawn from different parts of the country, Test bed sites would be funded by topic, rather than to pursue their own local interests. The programme will be nationally managed and is likely to involve rapid-cycle development and evaluation.
- 8.7 It will develop and test the seven new sets of network requirements, QI modules and QOF indicators. The programme could extend to developing other specific changes such as a practice-level version of *Helpforce*, which is developing NHS

volunteering at scale and has hitherto focused on hospitals. Another example would be to test general practice demand management initiatives such as the pharmacy connect scheme outlined in *The NHS Long Term Plan*. We will consider the precise scope and design of the programme in 2019.

9. Schedule of future contract changes and development work

9.1 This agreement marks the expansion of a major programme of development work by NHS England with GPC England and other stakeholders over the next five years. This chapter summarises the major changes and future work between 2019/20 and 2021/22.

2019/20

| Key changes and development work | |
|----------------------------------|--|
| Network | <ul style="list-style-type: none"> • Network Contract DES goes live • Network participation practice payment starts • Design of new national network service specifications starts |
| Workforce | <ul style="list-style-type: none"> • Additional Roles Reimbursement Scheme launched, starting with clinical pharmacists and social prescribing link workers • Design of primary care fellowship programme |
| Indemnity | <ul style="list-style-type: none"> • New centrally, funded Clinical Negligence Scheme for General Practice starts |
| QOF reform | <ul style="list-style-type: none"> • 28 indicators retired; 15 new indicators; introduction of personalised care adjustment and Quality Improvement domain • Review of heart failure, asthma and chronic obstructive pulmonary disease QOF domains |
| Testbeds | <ul style="list-style-type: none"> • New primary care testbed programme launched |
| Digital | <ul style="list-style-type: none"> • New digital improvement requirements introduced including access by patients online to full record • Revisions to rurality index payment and London adjustment • Review of premium for registering new patients • Review of out of area registration and choice of digital-first registration • Requirement for Electronic ordering of repeat prescriptions and using electronic repeat dispensing for all patients for whom it is clinically appropriate as a default from April 2019 • All practices will ensure at least 25% of appointments are available for online booking by July 2019 |
| Advertising | <ul style="list-style-type: none"> • Ban on GP providers advertising or hosting paid-for GP services that fall within the scope of NHS funded primary medical services |
| Access | <ul style="list-style-type: none"> • Extended Hours Access DES requirements introduced across all practices in every network (until March 2021) • NHS111 direct appointment booking into practices introduced nationally • Review of wider access arrangements |

| | |
|----------------------|--|
| Vacs and Imms | <ul style="list-style-type: none"> • Review of Vaccination and Immunisation arrangements, including screening |
| Premises | <ul style="list-style-type: none"> • Implementation of Premises Review starts |

2020/21

Key changes and development work

| | |
|---------------------------------|---|
| Networks | <ul style="list-style-type: none"> • New Dashboard to monitor progress on network metrics • National Network Investment and Impact Fund launched • Anticipatory care requirements (with community services) start • Enhanced health in care home requirements start • Structured Medication review requirements start for priority groups • Personalised care requirements start • Early cancer diagnosis support requirements start |
| Workforce | <ul style="list-style-type: none"> • Additional Roles Reimbursement Scheme extended to include physician associates and first contact physiotherapists • Primary care training hubs established |
| QOF reform | <ul style="list-style-type: none"> • Further changes introduced - post review of heart failure, asthma, and COPD domains • Review of mental health domain • New QI modules |
| Digital | <ul style="list-style-type: none"> • Requirement for online presence, to give patients access online to correspondence and to no longer be using facsimile machines for either NHS or patient communications; |
| Out of area registration | <ul style="list-style-type: none"> • Potential out of area registration reform – post review |
| Vacs and Imms | <ul style="list-style-type: none"> • Changes to vaccination and immunisation arrangements – post review |
| Access | <ul style="list-style-type: none"> • Start of transition to new access arrangements – post review |

2021/22

Key changes and development work

| | |
|------------------|---|
| Networks | <ul style="list-style-type: none"> • Cardio-vascular disease case finding requirements start • Prevention and inequalities requirements start |
| Workforce | <ul style="list-style-type: none"> • Additional Roles Reimbursement Scheme extended to include community paramedics |
| QOF | <ul style="list-style-type: none"> • Further changes introduced, including new QI modules |
| Digital | <ul style="list-style-type: none"> • New digital-first support offer |

Access

- All patients will have the right to online and video consultations by April 2021
- New access arrangements fully implemented - post review
- Patient reported access & waiting times data published monthly

Engagement in 19/20

9.2 NHS England and GPC England will hold a series of roadshows and webinars to communicate the new contract. Further details about these events will be communicated in due course. In addition, both GPC England and NHS England will publish supporting guidance on their websites.

Annex A: QOF indicator changes

Indicators to be retired in 19/20

1. 28 indicators worth 175 points in total will be retired from April 2019 as detailed in table 1.

Table 1: Indicators to be retired

| Indicator ID | Indicator wording | Points | Rationale for retirement |
|----------------|---|--------|--|
| CHD002 | The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less | 17 | Replacement with more clinically appropriate targets |
| CON001 | The contractor establishes and maintains a register of women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or other clinically appropriate interval e.g. last 5 years for an IUS | 4 | Simple collection of prescribing data. No link to any other indicators |
| CON003 | The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible contraception at the time or within one month of the prescription | 3 | Small numbers of patients at practice level leading to reliability issues. Achievement has plateaued. |
| COPD004 | The percentage of patients with COPD with a record of FEV ₁ in the preceding 12 months | 7 | Not required on an annual basis to guide care coupled with issues with access to annual spirometry in general practice |
| COPD005 | The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥ 3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months | 5 | Not in line with NICE guidance |
| CS001 | The contractor has a protocol that is in line with national guidance agreed with the NHS CB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates | 7 | Core professional responsibility |
| CS002 | The percentage of women aged 25 or over and who have not attained the age | 11 | Replacement with indicators in line |

| | | | |
|---------------|---|----|---|
| | of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years | | with screening recommendations |
| CS004 | The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample takers at least every 2 years | 2 | Core professional responsibility |
| DEM005 | The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 12 months before or 6 months after entering on to the register | 6 | Small numbers at a practice level leading to reliability issues. |
| DM002 | The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less | 8 | Replacement with indicators in which treatment targets are stratified according to whether the patient has moderate or severe frailty |
| DM003 | The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less | 10 | |
| DM004 | The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less | 6 | |
| DM007 | The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months | 17 | |
| DM008 | The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months | 8 | |
| DM009 | The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months | 10 | |
| HYP006 | The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less | 20 | Replacement with more clinically appropriate targets |
| MH007 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months | 4 | Replacement with an indicator focused upon BMI recording |
| MH008 | The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective | 5 | Small numbers at a practice level leading to |

| | | | |
|----------------|--|---|---|
| | disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years | | reliability issues. Also double payment of CS002. |
| MH009 | The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months | 1 | Small numbers at a practice level leading to indicator reliability issues. |
| MH010 | The percentage of patients on lithium therapy with lithium levels in the therapeutic range in the preceding 4 months | 2 | Small numbers at a practice level leading to reliability issues. Indicator timing not in line with clinical guidance. |
| OST002 | The percentage of patients aged 50 or over, and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone sparing agent | 3 | Small number s at a practice level leading to reliability issues. Concerns about over-treatment. |
| OST005 | The percentage of patients aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis, who are currently treated with a bone sparing agent | 3 | Small number s at a practice level leading to reliability issues. Concerns about over-treatment. |
| PAD002 | The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less | 2 | Significant overlap with other CVD areas therefore not a priority for ongoing incentivisation. |
| PAD003 | The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken | 2 | |
| PC002 | The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed | 3 | Issues with indicator assurance. Greater potential gain through a QI approach. |
| SMOK003 | The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy | 2 | Core professional practice |
| STIA003 | The percentage of patients with a history of a stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less | 5 | Replacement with more clinically appropriate targets |

| | | | |
|----------------|---|---|--|
| STIA008 | The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or the first TIA | 2 | Time for referral clinically inappropriate |
|----------------|---|---|--|

New indicators in 19/20

- We are introducing 15 more clinically appropriate indicators from April 2019 as detailed in Table 2.

Table 2: New Indicators

| Indicator ID | Indicator wording | Points | Payment thresholds | Rationale for inclusion |
|--------------------------------|--|---------------|---------------------------|--|
| CS005 (NICE ID NM154) | The proportion of women eligible for screening and aged 25-49 years at the end of reporting period whose notes record that an adequate cervical screening test has been performed in the preceding 3 years and 6 months | 7 | 45-80% | To achieve alignment with screening committee guidelines |
| CS006 (NICE ID NM155) | The proportion of women eligible for screening and aged 50-64 years at the end of reporting period whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months | 4 | 45-80% | |
| COPD 008 (NICE ID NM47) | The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥ 3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme | 2 | 40-90% | High impact intervention for patients with COPD |
| DM019 (NICE ID NM159) | The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less. | 10 | 38-78% | Suite of changes to reduce the potential for over-treatment and iatrogenic harm to patients with moderate or severe frailty and to |
| DM020 (NICE ID NM157) | The percentage of patients with diabetes without moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months. | 17 | 35-75% | |

| | | | | |
|---|---|----|--------|---|
| DM021 (NICE ID NM158) | The percentage of patients with diabetes with moderate or severe frailty, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months. | 10 | 52-92% | reduce the potential for under-treatment of patients without moderate or severe frailty. |
| DM022 (NICE ID NM162) | The percentage of patients with diabetes aged 40 years and over, with no history of CVD and without moderate or severe frailty, who are currently treated with a statin. (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years) | 4 | 50-90% | |
| DM023 (NICE ID NM163) | The percentage of patients with diabetes and a history of CVD (excluding haemorrhagic stroke) who are currently treated with a statin. | 2 | 50-90% | |
| HYP003 (NICE ID NM53) | The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90mmHg or less. | 14 | Tbc | To achieve alignment with NICE guidance and introduce more clinically appropriate targets |
| HYP007 (NICE ID NM54) | The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90mmHg or less | 5 | Tbc | |
| MH006 (NICE ID NM16) | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months | 4 | 50-90% | To maintain focus upon weight management in this patient group |
| CHD008 (NICE ID NM68) | The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90mmHg or less | 12 | Tbc | To achieve alignment with NICE guidance and introduce more clinically appropriate targets |
| CHD009 (based on NICE ID NM86) | The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90mmHg or less | 5 | Tbc | |
| STIA010 (NICE ID NM69) | The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the last blood pressure reading | 3 | Tbc | |

| | | | | |
|--|--|---|-----|--|
| | (measured in the preceding 12 months) is 140/90 mmHg or less | | | |
| STIA011 (based on NICE ID NM93) | The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less | 2 | Tbc | |

3. We will also be introducing a new QOF Quality Improvement domain from 19/20. For 19/20, the two Quality Improvement Modules will be end of life care and prescribing safety. Further detail on the modules will be included in the QOF implementation guidance.

Changes to the Indicators No Longer incentivised in QOF (INLIQ) extraction

4. Minor changes are proposed to the INLIQ extraction as a result of the current retirements and indicators reintroduced from INLIQ described above. These are detailed in Table 3 and 4.
5. These changes represent a net decrease in the number of indicators supported through INLIQ from 25 to 23.

Table 3: Indicators to be added to INLIQ

| Indicator ID | Indicator wording |
|---------------------|---|
| MH007 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months. ¹ |
| MH008 | The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years. |
| PAD002 | The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less. |
| PAD003 | The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken. |

Table 4: INLIQ indicators where data collection may cease

| Indicator ID | Indicator wording |
|---------------------|---|
| CON002 | The percentage of patients, on the register, prescribed an oral or patch contraceptive method in the preceding 12 months who have also received information from the contractor about long acting reversible methods of contraception in the preceding 12 months. |
| DEP001 | The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have had a |

¹ Swapped with INLIQ indicator MH006

| | |
|----------------|--|
| | biopsychosocial assessment by the point of diagnosis. The completion of the assessment is to be recorded on the same day as the diagnosis is recorded. |
| DM016 | The percentage of male patients with diabetes, on the register, who have a record of erectile dysfunction with a record of advice and assessment of contributory factors and treatment options in the preceding 12 months. |
| HYP004 | The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 in whom there is an assessment of physical activity, using GPPAQ, in the preceding 12 months. |
| HYP005 | The percentage of patients with hypertension aged 16 or over and who have not attained the age of 75 who score 'less than active' on GPPAQ in the preceding 12 months who also have a record of a brief intervention in the preceding 12 months. |
| STIA004 | The percentage of patients with a stroke or TIA who have a record of total cholesterol in the preceding 12 months. |

Annex B: QOF Quality Improvement

Prescribing safety

| Indicator | Points | Achievement thresholds |
|---|--------|------------------------|
| QI001. The contractor can demonstrate continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance. | 27 | NA |
| QI002. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings. | 10 | NA |

End of life care

| Indicator | Points | Achievement thresholds |
|---|--------|------------------------|
| QI003: The contractor can demonstrate continuous quality improvement activity focused on end of life care as specified in the QOF guidance | 27 | NA |
| QI004: The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings. | 10 | NA |

Rationale for inclusion of a QI domain

This is a new domain which seeks to fulfil the recommendation in the Report of the Review of QOF² to introduce a quality improvement domain. The aim of this domain is to provide support for contractors and their staff to recognise areas of care which require improvement, and take steps to address this through the development and implementation of a quality improvement plan and sharing of learning across their network. Being skilled in quality improvement has been recognised as a key role for healthcare professionals in the Shared View of Quality³.

NHS England and GPC (England) have worked with the Royal College of General Practitioners, NICE and the Health Foundation to develop the topic specific guidance included here. This guidance sets specific objectives for each topic which contractors are expected to work towards and provides advice on potential quality improvement actions. Within the parameters set out in this guidance, contractors are encouraged to understand where they have the potential to make quality improvements and then to design and implement bespoke quality improvement plans, including improvement targets to address these. There are no deadlines given for the completion of the

² QOF Review

³ Shared View of Quality

diagnostic activities, the subsequent plan or the network meetings. However, contractors are advised that they are expected to be working on these improvement activities throughout the QOF year.

The two topic areas identified for 2019/20 are prescribing safety and end of life care. These topics will change on an annual basis. Through practice engagement with these and future modules we expect to see measurable improvement in the quality of care and patient experience at a national level against the areas of focus described in the individual modules.

The focus of the indicators and associated points is on contractor engagement and participation in the quality improvement activity both in the practice and through sharing of learning across their network. This is to recognise that not all quality improvement activity will be successful in terms of its immediate impact upon patient care. If a contractor does not achieve the targets which they have set themselves this would not in itself be a reason to withhold QOF points and associated payments, unless they have also failed to participate in the activities described in the guidance.

All the supporting information and resources referred to in this guidance will be made available on NHS England's website by end of March 2019. Further information as to how to undertake quality improvement activities is available from a number of sources including:

NHS England Sustainable Improvement Team

(<https://www.england.nhs.uk/sustainableimprovement/>) - this is a national resource to support quality improvement activity in primary care and includes training, practical advice and support from quality improvement specialists.

NHS Improvement (<https://improvement.nhs.uk/improvement-hub>) - resources including improvement tools and case studies.

RCGP QI resources (www.rcgp.org.uk/qi) - resources including the RCGP QI Guide for General Practice and other quick guides to the use of quality improvement tools and techniques. These are available to both members and non-members.

Health Foundation (<https://www.health.org.uk/publications/quality-improvement-made-simple>) - an easy to read and practical guide to undertaking QI

NICE Practical Steps [<https://intopractice.nice.org.uk/practical-steps-improving-quality-of-care-services-using-nice-guidance/index.html>] – online guide to putting NICE guidance into practice and tools to support this.

Institute for Health Improvement [<http://www.ihl.org/>] – a US site with a range of resources to support QI activity.

Prescribing safety

| Indicator | Points | Achievement thresholds |
|---|--------|------------------------|
| QI001. The contractor can demonstrate continuous quality improvement activity focused upon prescribing safety as specified in the QOF guidance. | 27 | NA |
| QI002. The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings. | 10 | NA |

Rationale

Medicines prevent, treat or manage many illnesses or conditions and are the most common intervention in healthcare ([NICE, 2015](#)). The number of prescribed medicines supplied in primary care in England has been increasing year on year. The Health Survey for England 2016 ([NHS Digital, 2017](#)) reported that 1,104 million prescription items were dispensed in 2016, an increase of 1.9% (20.5 million additional items) on the number dispensed in 2015. The average number of prescription items per head of the population in 2016 was 20.0, compared with 19.8 items in the previous year.

As primary care staff will be aware, the number of people with multiple conditions is increasing; 25% of all people in England live with 2+ conditions and 8% live with 4+ conditions ([Health Foundation, 2018](#)). Over a 2-year period, people with 4+ conditions visited their GP almost 25 times for face to face consultations and were prescribed over 20 different medications.

In May 2012, the GMC published its report *Investigating the prevalence and causes of prescribing errors in general practice* which found that 1 in 20 prescriptions contained an error in terms of medication or monitoring. Most were graded as mild or moderate severity but 1 in 550 was a severe error. Many such errors relate not just to a prescriber's clinical knowledge but also to communication between primary and secondary care, communication with patients and carers, and safety monitoring systems in practices.

Through these QOF indicators practices are being encouraged to help meet the WHO challenge to reduce medication-related harm by 50% by December 2022 (*Medication Without Harm*, Third Global Patient Safety Challenge, WHO, 2017) and recently announced five year action plan to reduce antimicrobial resistance (Tackling antimicrobial resistance 2019-2024, HM Government 2019).

Overview of the QI module

The overarching aim of these QI indicators is to lead to improvements in the following aspects of prescribing safety:

- Reduce the rate of potentially hazardous prescribing, with a focus upon the safer use of non-steroidal anti-inflammatory drugs (NSAIDs) in patients at significant risk of complications such as gastro-intestinal bleeding.

- Better monitoring of potentially toxic medications and the creation of safe systems to support drug monitoring through a focus upon lithium prescribing (or another agreed medication if no patients on the registered list are currently being prescribed lithium).
- Better engagement of patients with their medication through a focus upon valproate and pregnancy prevention.
- Improve collaboration between practices, networks and community pharmacists to share learning and improve systems to reduce harm and improve safety.

Practices will need to:

- i. Evaluate the current quality of their prescribing safety and identify areas for improvement – this would usually include an baseline assessment of current prescribing (QI001)
- ii. Identify quality improvement activities and set improvement goals to improve performance in the three identified areas – see below (QI001)
- iii. Implement the improvement plan (QI001)
- iv. Participate in a minimum of 2 network peer review meetings (QI002)
- v. Complete the QI monitoring template in relation to this module (QI001 + QI002)

The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

Detailed contractor guidance

1. Identifying areas for improvement

All practices should undertake an audit of the current quality of their prescribing in relation to the following measures:

- Patients at significant risk of gastrointestinal adverse effects who have been prescribed a nonselective nonsteroidal anti-inflammatory drug (NSAID) without co-prescription of a proton-pump inhibitor (PPI) in the preceding 6 months.
- Patients receiving lithium and being monitored in primary care who have not had a recorded check of their lithium concentrations, estimated glomerular filtration rate, urea and electrolytes, serum calcium and thyroid function in the previous 6 months.
- Girls and women of childbearing potential currently being prescribed valproate have had an annual specialist medication review and are taking this in compliance with the pregnancy prevention programme as documented by a specialist in the annual risk acknowledgement form. This standard applies equally to unlicensed use for pain, migraine and other conditions.

Where practices do not have any patients being prescribed lithium they may select an alternative medication to focus on based on their prescribing data and professional judgement. It is recommended that the medication chosen reflects similar issues to lithium prescribing e.g. a requirement for systematic toxicity monitoring. Suggested alternatives include the appropriate monitoring of amiodarone, phenobarbital or methotrexate. As this is a quality improvement exercise, this should not lead to the removal of locally agreed shared care protocols, including any

associated funding to deliver the activity. Any alternative to lithium should be agreed between the contractor and the commissioner.

Even if a practice does not have any girls of any age or women of childbearing potential who are currently prescribed valproate, they should ensure their practice has a robust system in place to identify and refer for annual specialist review any new at-risk patients being prescribed valproate and should ensure continuous measurement of this measure. The inclusion of valproate prescribing and monitoring seeks to further promote health care professional awareness of the appropriate monitoring actions whilst awaiting the report of the Independent Medicines and Medical Devices Safety Review, chaired by Baroness Cumberlege.

These medications have been selected as they are linked to significant potential harm if prescribed and managed inappropriately. At a national level, progress against these measures will be monitored and used to inform any evaluation of this QI module.

BOX 1. How to do a prescribing audit

A prescribing audit is considered to have five steps:

1. Choose a relevant topic (such as NSAID prescribing)
2. Derive some standards from good quality guidelines (eg NICE)
3. Measure your prescribing practice (through searches in the clinical system) and compare how you do against your chosen standards
4. Plan any actions needed to make improvements or sustain good practice and implement them, setting clear goals to achieve
5. Repeat the measurement of your prescribing practice against the standards to assess the impact of the changes you have made.

Continue repeated cycles of these steps as you judge necessary.

An audit function is available on all GP software systems to identify and recall all women and girls being prescribed valproate who may be of child bearing potential. Contractors should use this tool in preference to developing their own bespoke searches.

Practices may also find it useful to undertake a reflective group meeting and complete a SWOT (strengths, weaknesses, opportunities, threats) analysis. Guidance as to how to do this can be found in the RCGP guide *How to get started in QI* ([link](#)). Understanding and sharing individual learning experiences and promoting reflective practice as individuals and in groups helps in the creation of a culture of learning and continuous improvement and the ultimate success of any quality improvement activity.

2. Identifying quality improvement activities and setting improvement goals

Following the initial baseline assessment, practices should develop a quality improvement plan which describes the actions they are going to take to address the prescribing safety improvements they are going to make. Evidence based improvement quality activities include:

- Audit of current prescribing against validated measures
- Review of patients identified as potentially at risk through the audit

- Review of practice systems to address organisational factors which contribute to medication related harm
- Ongoing measurement to demonstrate the impact of any changes [ref – PINCER, BG work]

Objectives to support these plans should be SMART (Specific, Measurable, Achievable, Relevant and Time-bound). See Box 2 for examples. Practices should set their own targets for improvement based upon their baseline audit results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting.

Factors to consider when setting these targets include:

- The severity level of identified clinical risk to patients
- The urgency of the timescale to review patients and reduce the risk
- The availability and training of appropriate practice staff to review patients

Quality improvement activities can involve the whole practice team and specialist advice as necessary. In relation to prescribing safety, practices are encouraged to work with clinical and community pharmacists to consider potential improvements and how these may be realised.

There are many aspects of prescribing safety which would be suitable for quality improvement work, but practices should as a minimum address the aspects listed above. A number of external resources are available to support practices with improving prescribing safety such as the [RCGP Patient Safety toolkit](#). In addition, the Academic Health Sciences Network (AHSNs) are implementing the PINCER intervention between now and 2020. Practices are encouraged to engage with their AHSN to access this support.

Box 2: Examples of SMART objectives

Objective 1:

Baseline practice prescribing analysis identifies patients on regular NSAID prescriptions with a recorded contraindication.

SMART outcome: Repeat analysis after 3 months (and repeated at 3monthly interval thereafter) shows NO PATIENTS with a recorded contraindication have been prescribed NSAIDS.

Objective 2:

Baseline practice prescribing analysis shows only 5% of patients obtaining a regular (repeat) NSAID have had a clinical safety risk assessment clearly documented within the last 12months.

SMART outcome: Increase from 5% to X% over the next 6 months (practice to decide) and X-Y% over the 6-12 months (practice to decide) of people prescribed NSAIDs regularly have a documented clinical safety risk assessment (as part of their medication review) as per NICE advice within the preceding 12months.

Objective 3:

Baseline practice prescribing analysis shows 50% of patients prescribed lithium for more than one year and suitable (as per NICE guidance) for 6 monthly checks had had a recorded serum lithium level checked within the last 6 months.

SMART outcome: At a repeat analysis 6 months after the baseline analysis there is an increase from 50% to X% (practice to decide) of patients prescribed lithium for greater than a year who are suitable for 6 monthly checks who have a recorded serum lithium level within the last 6 months.

Objective 4

Baseline practice prescribing analysis shows no girls or women of childbearing potential are currently prescribed valproate without a highly effective pregnancy prevention plan in place as per MHRA guidelines. However no practice system is in place to routinely identify new potential at risk patients.

SMART outcome: Within one month the practice can demonstrate an appropriate repeated monthly search of the clinical system to identify all girls or women of childbearing potential who have been recommended to start valproate medication have had a clinical review to ensure compliance with the pregnancy prevention programme as recommended by the MHRA.

Guidance on specific elements of the quality improvement activity

NSAID prescribing

[NICE Clinical Knowledge Summary \(CKS\) on NSAID prescribing](#) (revised August 2018) provides advice on this topic including how to reduce harm from gastrointestinal side effects such as ulcer, perforation, obstruction or bleeding. Nonsteroidal anti-inflammatory drugs (NSAIDs) must not be prescribed to people with:

- active gastrointestinal (GI) bleeding, or active GI ulcer
- history of GI bleeding related to previous NSAID therapy, or history of GI perforation related to previous NSAID therapy
- history of recurrent GI haemorrhage (two or more distinct episodes), or history of recurrent GI ulceration (two or more distinct episodes).

The CKS advice also sets out how to assess risk of harm from NSAIDS in patients and then what appropriate prescribing decisions to take. This advice can be used as evidence-based standards against which to assess a practice's current prescribing.

Examples of the audit standards which practices could adopt are:

- No patients with a current clinical contraindication are currently being prescribed an NSAID medication.
- 100% of patients with an NSAID medication on regularly receiving a repeat prescription have had a documented clinical safety risk review in the last 12 months.
- 100% of patients identified as high risk and requiring ongoing treatment have been prescribed a selective NSAID.
- 100% of patients identified as moderate risk and requiring ongoing treatment have been prescribed an appropriate NSAID with proton pump inhibitor unless contraindicated.

Practices should then demonstrate the action they have taken to reduce risk to these patients, and the system or process they will continue to use to maintain safe NSAID prescribing.

Monitoring or potentially toxic medications – Lithium - [NICE guidance Bipolar disorder: assessment and management](#), NICE (2014) clearly sets out the requirements for monitoring lithium once a patient has been returned from secondary to primary care.

Analysis of the practice's prescribing data and searches within the practice's electronic clinical system will be able to identify individual patients prescribed lithium who are not being managed in line with NICE guidance. Practices are encouraged to review their process for following up a person who has not responded to invitations for monitoring or fails to order or collect prescriptions to ensure concordance with treatment plans and avoid clinical deterioration and crisis.

Practices can use the QI approach to ensure their processes for lithium monitoring are robust and comply with NICE guidance and take action to identify and reduce any risks to individual patients.

Valproate and pregnancy prevention programme – [MRHA alert April 2018, updated October 2018](#)

(see also *Drug Safety Update* volume 11 issue 10; May 2018)

During 2018, all practices and individual GPs will have been sent a pack of information advising them of the need to identify any girl or woman of childbearing potential (this is defined as a pre-menopausal woman who is capable of becoming pregnant) currently being prescribed valproate and setting out a series of actions for health professionals including GPs. Valproate use in pregnancy is associated with an increased risk of children with congenital abnormalities and developmental delay. Valproate is contraindicated in women of childbearing potential unless the conditions of the valproate pregnancy prevention programme are fulfilled. Whilst the rates of prescribing of valproate continue to decline slowly there are wide geographical variations in prescribing.

Clear actions have been set for general practices to identify and recall existing patients, provide them with a copy of the Patient Guide, to check they have had a specialist review in the last year and to have systems in place to identify and appropriately manage new patients who are prescribed valproate and are of child bearing potential.

The pregnancy prevention programme requires GPs to:

- Ensure continuous use of highly effective contraception* in all women of childbearing potential (consider the need for pregnancy testing if not a highly effective method).
- Check that all patients have an up to date, signed, Annual Risk Acknowledgment Form each time a repeat prescription is issued.
- Ensure the patient is referred back to the specialist for review, annually.
- Refer back to the specialist urgently (within days) in case of unplanned pregnancy or

where a patient wants to plan a pregnancy.

* The Summary of Product Characteristics for valproate states that 'Women of childbearing potential who are prescribed valproate must use effective contraception without interruption during the entire duration of treatment with valproate. These patients must be provided with comprehensive information on pregnancy prevention and should be referred for contraceptive advice if they are not using effective contraception. At least one effective method of contraception (preferably a user independent form such as an intra-uterine device or implant) or two complementary forms of contraception including a barrier method should be used. Individual circumstances should be evaluated in each case when choosing the contraception method, involving the patient in the discussion to guarantee her engagement and compliance with the chosen measures. Even if she has amenorrhea she must follow all the advice on effective contraception.'

For children or for patients without the capacity to make an informed decision, provide the information and advice on highly effective methods of contraception and on the use of valproate during pregnancy to their parents/ caregiver/ responsible person and make sure they clearly understand the content.

The practice should regularly use the audit function on their clinical system to identify at risk patients and ensure timely recall for clinical review in line with the MHRA alert. Such continuous measurement can be used to demonstrate compliance with the MHRA alert.

This improvement programme offers general practice a further opportunity to ensure these actions have been completed and that ongoing systems to protect patients from harm have been put in place.

3. Implementing the plan

Practices should implement the improvement plan developed to support their objectives. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues in community pharmacy where practicable.

Practices should undertake continuous improvement cycles to achieve the outcomes they have set themselves. These should focus upon necessary changes to practice systems and processes, staff roles, methods of recording and sharing information as well as reviewing care for individual patients.

Continuous measurement is recommended to demonstrate the impact of the changes being tested. The audit cycle should be closed by repeating the audit and clarifying the outcomes achieved.

Example case studies will be made available on the NHS England at the end of March 2019.

4. Network Peer review meetings

A key objective of the network peer review meetings is the establishment of a system to enable shared learning across Primary Care Networks. The aim of this is to share best practice in prescribing safety.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings.

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner. Suggested discussion points for these meetings are made in Box 3.

The network clinical lead or their nominated deputy should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of these meetings but we would recommend that the first meeting takes place early in the QI activity and the second towards the end.

Box 3. Suggested peer review meeting discussion points

The first peer review meeting should take place early in the QI process and focus upon:

- Sharing of the outputs of diagnostic work to understand the issues associated with prescribing safety
- Validation of practice improvement targets

Discussion points could include:

1. What relevant evidence-based guidance / quality standards can the group use?
2. What data has each practice used to inform its review of current performance?
3. Has the right focus been chosen by each practice based on their current performance?
4. Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
5. What ideas for changes is each practice planning to try in an improvement cycle?
6. How are practices ensuring the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?

The second peer review meeting should take place towards the end of the QI process and should focus upon:

- Celebrating successes and sharing of key changes made in practice.
- How these changes can be embedded into practice.

Discussion points could include:

1. What results have each practice seen in their QI activity testing?
2. What changes have been adopted in each practice?
3. How will these changes be sustained in the future?
4. What new skills have staff developed and how can they be used next?
5. What further QI activity prescribing safety is planned in each practice?
6. What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?

5. Reporting and verification

The contractor will complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings as described above, unless there are exceptional and unforeseen circumstances which impact a contractor's ability to participate. In these circumstances contractors are expected to make efforts to ensure alternative participation in peer review.

Verification – Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exception and unforeseen circumstances then they will need to demonstrate other active engagement in peer learning as review.

The reporting template is available below.

QI module documentation: Safe prescribing

It is anticipated that the responses noted here should total 1 A4 sides in Arial font size 11.

| |
|---|
| Practice name and ODS code |
| |
| Diagnosing the issues |
| <i>What issues did the practice identify with prescribing safety?</i> |
| |
| <i>What changes did the practice make to try to address issues identified with prescribing safety?</i> |
| |
| Results |
| <i>What did the practice achieve?</i> |
| |
| <i>What changes will/ have been embedded into practice systems to ensure prescribing safety in the future?</i> |
| |
| <i>How did the network peer support meetings influence the practice's QI plans and understanding of prescribing safety?</i> |
| |
| Please attach the results of both prescribing audits (as appendices) |

End of life care

| Indicator | Points | Achievement thresholds |
|---|--------|------------------------|
| QI003: The contractor can demonstrate continuous quality improvement activity focused on end of life care as specified in the QOF guidance | 27 | NA |
| QI004: The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings. | 10 | NA |

Rationale

In 2015 the National Palliative and End of Life Care Partnership published [*Ambitions for palliative and end of life care: a national framework for local action 2015-2020*](#).

This quality improvement activity is designed to support practices to respond to those ambitions and to build the foundations needed to provide excellent, holistic and individualised care for all.

Identifying patients in need of end of life care, assessing their needs and preferences, and proactively planning their care with them are key steps in the provision of high quality care at the end of life in general practice. There is evidence to suggest that there is the potential for the quality of this care to be improved⁴. Increased use of healthcare services during this time also occurs often with limited clinical effectiveness and poor experiences for people. Better identification of people in the last year of their life followed by appropriate care planning and support for them are recognised as key elements of good medical practice as set out by the General Medical Council ([*Treatment and care towards the end of life: good practice in decision making*](#), 2010).

Involving, supporting and caring for all those important to the dying person is also recognised as a key foundation of good end of life care. As well as being individuals facing impending loss and grief, they often provide a key caring role for the dying person.

Overview of the QI module

The overarching aim of these QI indicators is to lead to improvements in relation to the following aspects of care:

1. **Early identification and support for people** with advanced progressive illness who might die within the next twelve months.
2. **Well-planned and coordinated care** that is responsive to the patient's changing needs with the aim of improving the experience of care.

⁴ National Audit Office. End of Life Care: Report by the Comptroller and Auditor General. 2008; available from <https://www.nao.org.uk/wp-content/uploads/2008/11/07081043.pdf>

3. **Identification and support for family / informal care-givers**, both as part of the core care team around the patient and as individuals facing impending bereavement.

Practices will need to:

- vi. Evaluate the current quality of their end of life care and identify areas for improvement – this would usually include a retrospective death audit (QI003)
- vii. Identify quality improvement activities and set improvement goals to improve performance (QI003)
- viii. Implement the improvement plan (QI003)
- ix. Participate in a minimum of 2 GP network peer review meetings (QI004)
- x. Complete the QI monitoring template in relation to this module (QI003 + QI004)

The following section includes further detail on the types of things practices could do to deliver this module. These are suggestions only and the decision about what to include in the QI plan and which QI methodologies to use should be made by practices and shared with their peers through the network meetings.

Detailed contractor guidance

1. Identifying areas for improvement

All practices should start with an assessment of the current quality of care they provide for patients and their families at the end of life. This would usually include the completion of a retrospective baseline audit analysis of deaths unless this has been completed in the previous 3 months. Box 1 provides further information about how to do this. The purpose of this is to understand firstly, the numbers of people who had been identified on the palliative care register and therefore deaths which had been anticipated and secondly, how many patients had care plans in place. If the practice already has well-established end of life care process then this baseline audit analysis could focus upon other aspects of care such as:

- Priority care goals achieved e.g. is preferred place of death recorded and achieved?
- Quality of care plans including treatment escalation and advance care plans e.g. legal status of Power of Attorney and advance Directives, and emergency treatment preferences such as recording of decision on cardiopulmonary resuscitation (note evidence suggests that this should be part of the care planning process and not done in isolation).
- Main carer is identified with offer of assessment and support
- Anticipatory medicines are available in the place of care

We encourage practices, particularly those with well-established end of life care processes to seek the views of family members / informal carers which for example could be done through a **survey of carers** or a **structured interview with one carer or patient every six months** to evaluate how well the practice meets their needs and what improvements could be made.

Box 1: How to do a retrospective death baseline analysis (audit)

Practices should review a sample of X deaths over the previous 12 months to establish baseline performance on the areas of care listed above and to calculate their expected palliative care register size. A suggested template to support data collection for the audit will be made available on the NHS England website by end of March 2019.

The number of deaths each year will vary between individual practices due to differences in the demographics of the practice population. Practices could use the number of deaths reported in their practice populations in the previous year to assess how well they are identifying patients who would benefit from end of life care. An audit standard against which to assess current practice would be that the practice was successfully anticipating approximately 60% of deaths.

Practices may also find it useful to undertake a reflective group meeting and complete a SWOT (strengths, weaknesses, opportunities, threats) analysis. Guidance as to how to do this can be found in the accompanying RCGP guide *How to get started in QI* (link). Understanding and sharing individual learning experiences and promoting reflective practice as individuals and in groups helps in the creation of a culture of learning and continuous improvement and the ultimate success of any quality improvement activity.

2. Identifying quality improvement activities and setting improvement goals

The identification of quality improvement activities should be informed by the results of the retrospective death baseline audit and analysis. Practices should focus their QI activities on delivering improvement across the following four **measures**:

1. An increase in the proportion of people who die from advanced serious illness who had been **identified** in a timely manner on a practice 'supportive care register', in order to enable improved end of life care, reliably and early enough for all those who may benefit from support.
2. An increase in the proportion of people who died from advanced serious illness who were sensitively **offered timely and relevant personalised care and support plan discussions; documented and shared electronically** (with appropriate data sharing agreements in place) to support the delivery of coordinated, responsive care in and out of hours with key cross-sector stakeholders.
3. An increase in the proportion of people who died from advanced serious illness where a family member / informal care-giver/ next-of-kin had been **identified**; with an increase in those who were **offered holistic support before and after death**, reliably and early enough for all those who may benefit from support.
4. A reliable system in place to monitor and enable improvement based on timely feedback of the **experience of care** from staff, patients and carer perspectives.

These measures will be used at a national level to assess the impact of the module. Identification and care planning should be addressed in parallel. Improvement activity should focus on impact., and may include a dedicated focus on specific areas or patient groups e.g. the practice may perform well in relation to supporting patients

with cancer at the end of life, but could improve in relation to other patient groups e.g. those with respiratory disease, children with life limiting illnesses or people with learning disabilities.

Practices may also wish to review the RCGP and Marie-Curie Daffodil standards: core Standards for advanced serious illness and end of life care in general practice (www.rcgp.org.uk/daffodilstandards_in_Spring_2009) and the NICE Quality Standards for End of Life Care in Adults (QS13) and Care of dying adults in the last days of life (QS144) for further suggestions of appropriate quality improvement activities.

For each of the measures, practices should identify and agree their own objectives which are *SMART* (Specific, Measurable, Achievable, Relevant and Time-bound). See Box 2 for examples of SMART outcomes. Practices should set their own targets for improvement based upon their baseline audit results. These should be challenging but realistic and recognise that it may be easier to make larger improvements when starting from a modest baseline. These should be validated by network peers as part of the initial network review meeting.

Box 2: Examples of SMART outcomes for each measure

Measure 1:

Baseline analysis from retrospective audit – 20% of people affected by serious illness and end of life care who died, had already been identified on a practice 'supportive care register'.

SMART outcome: Increase from 20% to X% of people **affected by serious illness and end of life care who died, to be identified** on a practice 'supportive care register', over the next 6 months.

Measure 2:

Baseline analysis from retrospective audit – 10% of people **affected by serious illness and end of life care who died**, had been sensitively offered timely and relevant personalised care and support plan discussions and these were **documented and shared electronically**.

SMART outcome: Increase from 10% to X% over the next 6 months (practice to decide) and X-Y% over the 6-12 months (practice to decide) of people **affected by serious illness and end of life care who died, to be** sensitively offered timely and relevant personalised care and support plan discussions and have these **documented and shared electronically**.

Measure 3:

Baseline analysis from retrospective audit – 10% **of family members / informal care-givers/ next-of-kin** identified on a practice 'supportive care register' were contacted and offered information on dealing with grief and bereavement within 1 month of the person on the register dying.

SMART outcome: Increase from 10% to X% (practice to decide) of **family members / informal care-givers/ next-of-kin** identified on the practice 'supportive care register' to be contacted and offered information on dealing with grief and bereavement within X weeks /months (practice to decide) of the person on the register dying – within a 12-month period.

Measure 4:

SMART outcomes:

To support and reflect on retrospective death audit and practice-relevant QI planning within the 12-month period, achieving a minimum of:

- a) 2-5 family/care-giver or patient interviews (See Appendix 1) e.g. semi-structured discussion, using an agreed template or annual carer survey relevant to EOLC needs.

Optional and additional SMART OUTCOMES could include:

3. Implementing the plan

Practices should implement the improvement plan they have developed to support the objectives they have identified. It is recommended that these plans and associated improvement activities should involve the whole practice team and practices are encouraged to engage with colleagues in community and related services (such as district nurses, hospice services, and community pharmacy) where practicable. Where possible, patients and their family members and informal care givers should be involved in continuous quality improvement around people affected by advanced serious illness and end of life care. This is especially the case in relation to measures 3 and 4.

Practices should undertake continuous improvement cycles to achieve the outcomes they have set for themselves in relation to the measures they are focusing on. Example case studies will be made available on the NHS England website by end of March 2019.

4. GP Network peer review meetings

A key objective of the network peer review meetings is to enable shared learning across the network. The aim of this is to improve learning from deaths and the provision of best practice end of life care. It is also intended to provide a forum for practices to identify wider system issues impacting upon care quality which may require a collective response.

Contractors should participate in a minimum of two network peer review discussions unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. Whilst these meetings would usually be face to face, networks are able to explore other mechanisms to facilitate real time peer learning and sharing including virtual meetings.

The peer review group will usually be the Primary Care Network of which the practice is a member. Where the practice is not part of a network their peer review group should be agreed with the commissioner. Suggested discussion points for these meetings are made in Box 3.

The network clinical lead or their nominated deputy should facilitate these meetings and maintain a record of attendance. It is for the network to determine the timing of these meetings but it is recommended that the first meeting takes place early in the QI activity and the second towards the end.

Box 3: Suggested peer review meeting discussion points

The first peer review meeting should take place early in the QI activity and focus on:

- Sharing the outputs of the diagnostic work to understand the issues for each practice about end of life care.
- Validation of practice improvement targets.

Discussion points could include:

1. What relevant evidence-based guidance / quality standards can the group use?
2. What data has each practice used to inform its review of current performance?
3. Has the right focus been chosen by each practice based on their current performance?
4. Has each practice set a clear aim with a challenging but realistic local target, and agreed an appropriate measurement to monitor impact?
5. What ideas for changes is each practice planning to try in an improvement cycle?
6. How are practices ensuring that the whole practice team (including other clinical colleagues and patients and carers) are engaged in the proposed QI activity?

The second peer review meeting should take place towards the end of the QI activity and focus on:

- Celebrating success and sharing of key changes made in practice.
- Encouraging a compassionate, no-blame and active learning culture.
- How these changes have been embedded and will be sustained.

Discussion points could include:

1. What results have each practice seen in their QI activity testing?
2. What changes have been adopted in each practice?
3. How will these changes be sustained in the future?
4. What new skills have staff developed and how can they be used next?
5. What further QI activity in end of life care is planned in each practice?
6. What further actions may need to take place (e.g. at network or CCG level) to support the changes in practices?

5. Reporting and verification

The contractor will need to complete the QI monitoring template in relation to this module and self-declare that they have completed the activity described in their QI plan. The contractor will also self-declare that they have attended a minimum of two peer review meetings as described above, unless there are exceptional and unforeseen circumstances which impact upon a contractor's ability to participate. In these circumstances contractors are expected to make efforts to ensure alternative participation in peer review.

Verification - Commissioners may require contractors to provide a copy of the QI monitoring template as written evidence that the quality improvement activity has been undertaken. Commissioners may require the network clinical lead to provide written evidence of attendance at the peer review meetings. If a contractor has been unable to attend a meeting due to exceptional circumstances then they will need to demonstrate other active engagement in network peer learning and review.

The reporting template is below.

QI module documentation: End of life care

It is anticipated that the responses noted here should total approx. 1 A4 side in Arial font size 11.

| |
|--|
| Practice name and ODS code |
| |
| Diagnosing the issues |
| <i>What issues did the practice identify with current end of life care?</i> |
| |
| <i>What SMART outcomes did the practice set for each measure?</i> |
| |
| Results |
| <i>What did the practice achieve?</i> |
| |
| <i>What changes will/ have been embedded into practice systems to ensure improved quality end of life care in the future?</i> |
| |
| <i>How did the GP network peer support meetings influence the practice's QI plans and understanding of end of life care?</i> |
| |
| Please attach the results of both end of life care audits (as appendices), including identified SMART outcomes for each objective. |

Annex C: Network Contract DES Registration Form

This registration form sets out the information required by the commissioner for any Primary Care Networks (member practices) signing-up to the Network Contract Directed Enhanced Service.

The completed form is to be returned to [add name] by no later than the 15 May 2019.

PCN members and ODS code

| Network Member Practices | ODS code | Practice's registered list size (as at 1 January 2019) |
|--------------------------|----------|--|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Network list size

| |
|--|
| [This is the sum of member practice's list sizes as at 1 January 2019] |
|--|

Name of Clinical Director

| Name | Job Title | Practice/organisation | Contact Email Address |
|------|-----------|-----------------------|-----------------------|
| | | | |

Details for network's nominated payee

| | | |
|--|----------------|-----------|
| Name of single nominated practice or provider ('nominated payee'): | | |
| | | |
| Name of bank account (if different to above) | Account number | Sort code |
| | | |

Map of network area



Appendix A: Initial Network Agreement

Note: A revised version of the Network Agreement may be required immediately prior to the contract variation to provide information that may not have been confirmed on initial registration.

Annex D: Additional detail on main 2019/20 contract changes

Main Contractual changes

Additional Services

1. From April 2019, contraception services will no longer be an Additional Service under the Regulations but will become part of Essential Services. There will be no opt-out or reduction of global sum payments as a result.

Network Practice Participation Payment

2. From April 2019 practices will be able to claim a Network Participation Practice Payment for being an active member of a Primary Care Network through signing up to the Network Contract DES, which will be introduced from 1 July 2019.

Ban on advertising and hosting of private GP services

3. To safeguard the model of comprehensive NHS primary medical care, from 2019 it will no longer be possible for any GP provider either directly or via proxy to advertise or host private paid-for GP services that fall within the scope of NHS-funded primary medical services. NHS England will consult in 2019 on expanding this ban on private GP services to other providers of mainly NHS services.

Changes to the FP10 form

4. For all future prescriptions, where the medication is for a Sexually Transmitted Infection (STI), the prescriber will write SH as an endorsement on the FP10 form. The requirement for the endorsement will be added to the GMS Regulations to make the requirement explicit as it is with other endorsements (Regulation 61). This will only be a temporary solution until EPS4 functionality is available.

Data Requirements

5. Practices will be required to provide data in support of delivering the contract requirements set out in this document through new contract requirements, including on any practice not participating in the Network DES providing data to facilitate the provision of network services to their list.

Digital

6. All patients will have online access to their full record, as the default position from April 2020, with new registrants having full online access to prospective data from April 2019.
7. All practices will be offering and promoting electronic ordering of repeat prescriptions and using electronic repeat dispensing for all patients for whom it is clinically appropriate, as a default from April 2019.
8. All practices will ensure at least 25% of appointments are available for online booking by July 2019.

9. Practice funding will be revised to avoid unwarranted redistribution to digital-first models from other practices. In 19/20:
 - i. the rurality index payment will be amended to apply to patients living within a practice catchment area only, rather than to all patients; and
 - ii. the London adjustment will be amended to apply to patients' resident in London, rather than registered in a London-based practice.

Direct booking from NHS111

10. From 2019/20, where the functionality exists, practices will allow the direct booking of clinician-assessed patient appointments from the NHS111 service into the practice.
11. NHS England and GPC England have agreed that practices will make available one appointment per whole 3,000 patients per day for direct booking from NHS111. If a practice has a registered list of less than 3,000 patients, the practice will make one appointment available per day for direct booking from NHS111. If those appointments are not taken up, they will be available to the practice to use in good time.
12. When the appointment is offered and made, it will be made clear to the patient that they are not being booked into automatically seeing a GP at that time. They must plan to attend the practice at that time. But they may be contacted by the practice prior to the appointment time, to confirm if:
 - they will see the GP at the practice; or
 - they will have a telephone appointment with the GP; or
 - they will see another healthcare professional at the practice.If they do not hear from the practice they must attend at the appointed time.
13. Clear post-event information will be automatically added to the patient record along with the appointment, so that the practice can easily see the reason for the appointment and any relevant clinical summary or why the practice decided the appointment was inappropriate. NHS England will provide guidance for practices and NHS 111 outlining how system configuration can be optimised to make this information as clear and accessible as possible.
14. Practices can then decide (as above) whether to accept a GP appointment at the appointed time, contact the patient to arrange a phone appointment with a GP, or contact the patient to arrange an appointment with another healthcare professional.
15. Commissioners will work with practices [and LMCs] to review the efficacy of direct booking arrangements both from a clinical audit and a logistical perspective.

Duty of Co-operation

16. The existing Duty of Co-operation requirements will be amended to facilitate data sharing between providers to support integrated provision of services.

Marketing campaigns

17. From 2019-20 NHS England and GPC England have agreed that GP practices will be required to support six national NHS marketing campaigns on an annual

basis, where the GP contractor will be required to put up and display in their premises, campaign display materials six times every 12 months. NHS England will produce the campaign materials and will share with each practice for them to display.

18. NHS England and GPC England will develop a formal process for agreeing which campaigns GP Practices will be asked to support.

MHRA Central Alerting System (CAS)

19. The Central Alerting System (CAS) which is the national system for issuing patient safety alerts, important public health messages and other safety critical information to all providers, including GP practices, is being updated. NHS England will be able to send alerts directly to practices by email or mobile phone (when functionality is available) which will improve public safety.
20. From October 2019, there will be a contractual requirement for practices to:
- register a practice email address with 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.
 - 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 e-mail systems are down.

QOF changes

21. See Chapter 3 and Annex A and B for further details of the QOF changes in 2019/20.

Payment to reflect changes to medical records movement

22. As part of the 2017/18 contract settlement, £2m was included in global sum to recognise the additional work arising from a change to medical records movement. We agreed that the funding would remain in global sum until this additional payment is no longer required. This funding continued to be included in global sum for 2018/19 and we have agreed that this £2m should remain in global sum as a non-recurrent element for 2019/20. However, we expect that this funding will not be included next year, subject to review at the time. The £2m released will be available for reinvestment in the contract.

Use of the NHS Logo

23. From October 2019, where GPs choose to apply the NHS primary care logo in relation to their NHS provided services, they will be required to adhere to the NHS Identity guidelines and apply the NHS primary care logo to all information and materials about their NHS services.

Shared parental leave

24. Legislation now allows parents to share parental leave on the birth of a child. To support GPs who wish to do this, NHS England will reimburse the cost of locum cover for GPs taking shared parental leave in the same way that is done for those taking maternity leave.

Transparency

25. GPs with total NHS earnings above £150,000 per annum – including salaried GPs - will be listed by name and earnings in a national publication, starting with 2019/20 income. The Government will look to introduce the same pay transparency across other independent contractors in the NHS at the same time.

Vaccinations and Immunisations

26. The item of service (IoS) fees for the following three programmes will be uplifted to £10.06 from April 2019:

- childhood seasonal influenza
- pertussis
- seasonal influenza and pneumococcal polysaccharide

27. IoS uplifts for future years to be included in the wider review of vaccinations and immunisations.

Influenza vaccine

28. From April 2019, care home and social care staff will be added to the categories of people entitled to a flu vaccine on the NHS under the Influenza and Pneumococcal Immunisation Scheme at an IoS fee of £10.06.

29. The Influenza and Pneumococcal Immunisation Scheme DES specification will be revised to explicitly underline that in order for practices to receive payment for the vaccination and reimbursement for the vaccine, they need to use the flu vaccine recommended in NHSE guidance.

HPV vaccine

30. The current Human Papillomavirus (HPV) programme is provided in schools and is for girls aged 14-18. Contractors can already vaccinate women above age 18, based on clinical judgement. We have agreed to amend the SFE from April 2019 so that any vaccination of women aged over 18 and up to 25 years will be paid at an IoS rate of £10.06.

31. The HPV for boys programme will begin as part of the HPV vaccine programme (including girls and boys going forward) from September 2019. NHS England, GPC England and PHE have agreed that the catch-up element for boys will not need to be delivered through GP practices in 2019/20. Any boys who miss the initial doses from September 2019 to March 31, 2020 will be offered another appointment via the school based programme. We anticipate that boys will be added to the HPV catch-up scheme in general practice from April 2020.

MMR catch up for 10 and 11 year olds

32. From April 2019 NHS England and GPC England have agreed an item of service payment of £5 per patient for the extra cost of a catch-up campaign for the Measles, Mumps and Rubella (MMR) vaccine for 10 and 11-year olds in the light of the current measles outbreaks. Payment will be made for each child recorded as unvaccinated.

33. In return for receiving payment practices will be expected to:

- i. Check patient paper/electronic records (Electronic Patient Record) and if necessary correct computerised record
- ii. Confirm that patient is still in the area - if not, remove from list and inform the local Child Health Information Service (CHIS)
- iii. Actively invite all those missing one or both doses of MMR to have the MMR vaccine at a vaccination clinic held in the practice or to make an appointment – priority should be given to patients missing both doses as this is where most clinical value /value for money can be gained
- iv. Invites should be by letter, email, phone call, text or digital personal child health record 'red book' as appropriate. NHS England expect as a minimum three invites per payment per patient and a record of practice activity to go local teams:
 - First invite can simply offer appointment
 - Second invite - offer appointment, confirm receipt and/or check if parent/guardian has record of vaccination already e.g. Personal Child Health Record
 - Third contact should be a practice healthcare professional discussion, either face-to-face or via telephone, with the parent or guardian - with the expectation that all staff participating are adequately trained. Practices to make use of the Public Health England (PHE) designed resources to aid call/recall discussions if required to support informed choice and improved uptake and coverage.
([https://www.gov.uk/government/collections/immunisation#measles,-mumps-and-rubella-\(mmr\)](https://www.gov.uk/government/collections/immunisation#measles,-mumps-and-rubella-(mmr))) At this point also check – offer/update any other childhood immunisations missing.
- v. Ensure that those parents/guardians of patients who need second dose are invited and attend for the second dose (three invites);
- vi. Continue to follow-up, recall and update computerised records for patients who do not respond or fail to attend scheduled clinics or appointments and offer opportunistically as and when
- vii. If there is no response after the following the process outlined above, practices to notify school nursing service to follow up/offer at school
- viii. Inform local team of outcome.

Non-contractual changes

Digital

34. NHS England and GPC England expect practices to make progress in 2019-20 towards the digital changes that will become contractual requirements from April 2020 and April 2021. These are:
- i. all practices will be offering online consultations by April 2020 at the latest;
 - ii. all patients will have online access to their full record, as the default position from April 2020, subject to existing safeguards for vulnerable groups and third party confidentiality and system functionality;
 - iii. all practices will need by April 2020 to have an up-to-date and informative online presence, with key information being available as metadata for other platforms to use;

- iv. all practices will be giving all patients access online to correspondence by April 2020, as the system moves to digital by default (with patients required to opt-out rather than in);
- v. by April 2020, practices will no longer use facsimile machines for either NHS or patient communications;
- vi. all practices will be offering consultations via video by April 2021 at the latest.

Freedom to Speak Up Guardian

35. The National Guardian's office will begin developing a proposal for 'Freedom To Speak Up' guardianship in primary care during 2019, taking account of emerging PCNs. We will keep under review any potential contract implications.

Over the Counter Medicine

36. NHSE has agreed to provide a letter to provide assurance that practices they will not be at risk of breaching their contract when following OTC prescribing guidance. The letter can be read here:

<https://www.england.nhs.uk/publication/letter-to-gp-practices-routine-prescribing-of-medicines-which-are-available-over-the-counter/>

Temporary residents

37. NHS England and GPC to issue guidance to CCGs and practices to facilitate local solutions around temporary residents. This guidance will set out the flexibilities that exist to support practices who have faced a significant increase or decrease in the numbers of unregistered patients requiring treatment and how to apply appropriate temporary patient adjustment funding accordingly.

Debt and mental health conditions

38. NHS England, GPC England and Government have a shared concern about the impact that financial debt has on the mental health of many people. Following a Government review, the credit sector has amended its code of practice to minimise the instances in which it is deemed necessary to seek input from GPs via the Debt and Mental Health Evidence Form. NHS England, GPC England and Government will continue to work with relevant groups to maximise use of self-certification and alternative evidence by patients with mental health conditions or carers/families of patients, with the patient's consent, when seeking debt relief. In exceptional situations where a self-certificated declaration requires validation or when patients are not in a position to self-certify, we will explore how this could be done by any appropriate health and social care professional or support worker known to the patient, reducing as far as possible the need for GP practice involvement. In the remaining circumstances where GP practice input is needed, we believe that this should be done without charge to the patient. NHS England and GPC England will therefore work with Government to amend regulations so that GP certification of a Debt and Mental Health Evidence Form much simplified from the version produced in 2012 is free of charges. Should banks or other lenders require further medical evidence in addition to the simplified initial validated statement of diagnosis, this would need to be sought directly from the practice for an appropriate fee which should be paid by the company not the patient.

Annex E: Network Contract DES Workforce Role Descriptions and Outputs

This Annex provides information on the core role requirements for the five workforce roles for which investment is being made via the new Network Contract DES. It is not a comprehensive list and Primary Care Networks will determine the job description for their staff ensuring they reflect these core requirements and enable delivery of the Network Service Specifications.

1. Workforce roles beginning from 2019/20

1.1. Network Clinical Director

Description of role/core responsibilities

Each network will have a named accountable Clinical Director, responsible for delivery. They provide leadership for networks strategic plans, through working with member practices and the wider Primary Care Network to improve the quality and effectiveness of the network services.

Together, the Clinical Directors will play a critical role in shaping and supporting their Integrated Care System (ICS), helping to ensure full engagement of primary care in developing and implementing local system plans to implement the *NHS Long Term Plan*. These local plans will go much further than the national parts of the Network Contract DES in addressing how each ICS will integrate care.

The role of the clinical lead will vary according to the particular characteristics of the network, including its maturity and local context, but the key responsibilities may include:

- providing strategic and clinical leadership to the network, developing and implementing strategic plans, leading and supporting quality improvement and performance across member practices (including professional leadership of the Quality and Outcomes Framework Quality Improvement activity across the network).
- Influencing, leading and supporting the development of excellent relationships across the network to enable collaboration for better patient outcomes
- providing strategic leadership for workforce development, through assessment of clinical skill-mix and development of network workforce strategy.
- supporting network implementation of agreed service changes and pathways, working closely with member practices, the wider PCN and the commissioner to develop, support and deliver local improvement programmes aligned to national and local priorities.
- developing relationships and working closely with other network Clinical Directors, clinical leaders of other health and social care providers, local commissioners and Local Medical Committees (LMCs).
- facilitating practices within the network to take part in research studies and will act as a link between the network and local primary care research networks and research institutions.

- representing the network at CCG-level clinical meetings and the ICS/STP, contributing to the strategy and wider work of the ICS.

The Clinical Director would not be solely responsible for the operational delivery of services. This will also be a collective responsibility of the network.

As outlined in section 4, each Network will receive an additional ongoing entitlement to the equivalent of 0.25⁵ WTE funding per 50,000 population size. This entitlement is a contribution towards the costs and not a reflection of the time commitment required to undertake the role.

1.2. Clinical pharmacists

Description of role/core responsibilities

- Indicative Agenda for Change Band 7-8a

Clinical pharmacists will have a key role in supporting delivery of the new Network Contract DES Service specifications. For the new *Structured Medications Review and Optimisation* requirements this will include tackling over-medication of patients, including inappropriate use of antibiotics, withdrawing medicines no longer needed through NHS-led programmes such as low priority prescribing and medicines optimisation more widely. For *Enhanced Health in Care Homes* residents will benefit from regular clinical-pharmacy led medicines reviews.

The following sets out the key role responsibilities⁶ for clinical pharmacists:

- a. Clinical pharmacists will work as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas.
- b. They will be prescribers, or training to become prescribers, and will work with and alongside the multi-disciplinary team across a Primary Care Network. They will take responsibility for the care management of patients with chronic diseases and undertake clinical medication reviews to proactively manage people with complex polypharmacy, especially the elderly, people in care homes, those with multiple long term conditions (in particular COPD and asthma) and people with learning disabilities or autism (through STOMP - Stop Over Medication Programme).
- c. They will provide specialist expertise in the use of medicines while helping to address both the public health and social care needs of patients in the network⁷ and help in tackling inequalities.
- d. Clinical pharmacists will provide leadership on person centred medicines optimisation (including ensuring prescribers in the practice conserve antibiotics in line with local antimicrobial stewardship guidance) and quality improvement, while contributing to the quality and outcomes framework and enhanced

⁵ 0.15 WTE for network size of 30,000 or 0.2 WTE for network size of 40,000

⁶ See: [RPS – practice based pharmacists job specification](#)

⁷ 'Modernising Pharmacy Careers Programme: Review of pharmacist undergraduate education and pre-registration training and proposals for reform.' Report to the Medical Education England Board. April 2011 <https://hee.nhs.uk/sites/default/files/documents/Pharmacist-pre-registration-training-proposals-for-reform.pdf>

services. Through structured medication reviews, clinical pharmacists will support patients to take their medications to get the best from them, reduce waste and promote self-care.

- e. Clinical pharmacists will have a leadership role in supporting further integration of general practice with the wider healthcare teams (including community and hospital pharmacy) to help improve patient outcomes, ensure better access to healthcare and help manage general practice workload. The role has the potential to significantly improve quality of care and safety for patients.
- f. They will develop relationships and work closely with other pharmacists across networks and the wider health system.
- g. Clinical pharmacists will take a central role in the clinical aspects of shared care protocols, clinical research with medicines, liaison with specialist pharmacists (including mental health and reduction of inappropriate antipsychotic use in people with learning difficulties) and anticoagulation.

1.3. Social Prescribing Link Workers

Description of role/core responsibilities

- Up to indicative Agenda for Change Band 5

Social prescribing empowers people to take control of their health and wellbeing through referral to non-medical 'link workers' who give time, focus on 'what matters to me' and take a holistic approach, connecting people to community groups and statutory services for practical and emotional support. Link workers support existing groups to be accessible and sustainable and help people to start new community groups, working collaboratively with all local partners.

Social prescribing can help to strengthen community resilience and personal resilience, and reduces health inequalities by addressing the wider determinants of health, such as debt, poor housing and physical inactivity, by increasing people's active involvement with their local communities. It particularly works for people with long term conditions (including support for mental health), for people who are lonely or isolated, or have complex social needs which impact on wellbeing.

Social prescribing link workers will have a key role in supporting delivery of the Comprehensive Model of Personalised Care.

The following sets out the key role responsibilities for social prescribing links workers:

- a. They will in 2019/20 take referrals from the network's members, expanding from 2020/21 to take referrals from a wide range of agencies⁸. Primary Care Networks that already have social prescribing link workers in place, or who have access to social prescribing services may take referrals from other agencies prior to 2020/21
- b. They will:

⁸ These agencies include but are not limited to: the network's members, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations.

- provide personalised support to individuals, their families and carers to take control of their wellbeing, live independently and improve their health outcomes;
 - develop trusting relationships by giving people time and focus on 'what matters to them';
 - take a holistic approach, based on the person's priorities, and the wider determinants of health;
 - co-produce a simple personalised care and support plan to improve health and wellbeing, introducing or reconnecting people to community groups and statutory services; and
 - evaluate the individual impact of a person's wellness progress.
- c. The role will require social prescribing link workers to manage and prioritise their own caseload, in accordance with the needs, priorities and any urgent support required by individuals on the caseload. Where required and as appropriate, the social prescribing link workers will refer people back to other health professionals within the network.
- d. Social prescribing link workers will draw on and increase the strengths and capacities of local communities, enabling local VCSE organisations and community groups to receive social prescribing referrals. They will ensure those organisations and groups are supported, have basic safeguarding processes for vulnerable individuals and can provide opportunities for the person to develop friendships, a sense of belonging, and build knowledge, skills and confidence.
- e. Social prescribing link workers will work together with all local partners to collectively ensure that local VCSE organisations and community groups are sustainable and that community assets are nurtured, by making them aware of small grants or micro-commissioning if available, including providing support to set up new community groups and services, where gaps are identified in local provision.
- f. Social prescribing link workers will have a role in educating non-clinical and clinical staff within the network on what other services and support are available within the community and how and when patients can access them. This may include verbal or written advice and guidance.

2. Workforce roles beginning from 2020/21

2.1. Advanced Practice Physiotherapists

Description of role/core responsibilities

- Indicative Agenda for Change Band 7-8a

Advanced Practice Physiotherapist have advanced skills to assess, diagnose, treat and manage musculoskeletal (MSK) problems and undifferentiated conditions. This will involve seeing patients, without prior contact with their GP, to establish a rapid and accurate diagnosis and management plan, thus streamlining pathways of care. They can work independently and do not require supervision, thus helping to release workload currently undertaken by GPs. Patients can either self-refer or be referred by the network's members.

Advanced Practice Physiotherapists will have a key role in supporting delivery of the new Network Contract DES Service specifications.

The following sets out the key role responsibilities for FCP physiotherapists⁹:

- 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.
- b. They will assess, diagnosis, triage and treat patients either via patient self-referrals or referrals from a professional within network, and take responsibility for managing a complex caseload (including patients with long term conditions, co-morbidities and multi-factorial needs). Practice physiotherapists will progress and request investigations (such as x-rays and blood tests) to facilitate diagnosis and choice of treatment regime.
- c. They will develop integrated and tailored care programmes in partnership with patients and provide a range of treatment options, including self-management, exercise groups or individual treatment sessions. 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.
- d. They will develop and make use of their scope of practice and clinical skills, including those relating to independent prescribing, injection therapy and imaging referral rights (where qualified/experienced).
- e. They will provide learning opportunities for the whole multi-professional team within primary care. They will also work across the multi-disciplinary team to develop more effective and streamlined clinical pathways and services.
- f. They will liaise with secondary care MSK services, as required, to support the management of patients in primary care.
- g. Using their professional judgement, they will take responsibility for making and justifying decisions in unpredictable situations, including the in the context of incomplete/contradictory information.
- h. They will manage complex interactions, including working with patients with particular psychosocial and mental health needs and with colleagues across primary care teams, sectors and setting.
- i. 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.

2.2. Physician Associates

Description of role/core responsibilities

- Indicative Agenda for Change Band 7

A physician associate 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

⁹ Job descriptions should be in line with those provided by respective professional bodies (these key responsibilities are reflective of these job descriptions).

field. The responsibilities¹⁰ 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 the new Network Contract DES Service specifications.

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

- a. They provide first point of contact for patients presenting with undifferentiated, undiagnosed problems
- b. Taking comprehensive patient histories and providing physical examinations, they will establish a working diagnosis and management plan (in partnership with the patient).
- c. They will deliver integrated patient centred-care through appropriate working with the wider primary care and social care networks.
- d. They will undertake home visits and clinical audits.

3. Workforce roles beginning from 2021/22

3.1. Paramedics – Advanced Paramedic Practitioners

Description of role/core responsibilities

- Indicative Agenda for Change Band 6

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.

Advanced Paramedic Practitioners will have a key role in supporting delivery of the new Network Contract DES Service specifications.

The following sets out the key role responsibilities¹¹ for advanced paramedic practitioners:

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

¹⁰ <https://www.healthcareers.nhs.uk/explore-roles/medical-associate-professions/roles-medical-associate-professions/physician-associate> or <https://www.prospects.ac.uk/job-profiles/physician-associate>.

¹¹ Job descriptions should be in line with those provided by respective professional bodies (these key responsibilities are reflective of these job descriptions). See [here](#) for national job profile

- 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.
- 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 GP home visit for the network and undertake clinical audits.
 - f. They will communicate at all levels across organisations ensuring that an effective, patient-centered 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.
- 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.

Glossary of Terms

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| A2SI | Access to service information |
| A&E | Accident and Emergency |
| AfC | Agenda for Change |
| AHP | Allied Health Professional |
| AHSNs | Academic Health Science Networks |
| APMS | Alternative Provider of Medical Services |
| BMA | British Medical Association |
| CAS alert | Central Alerting System |
| CCG | Clinical Commissioning Group |
| COPD | Chronic Obstructive Pulmonary Disease |
| CPCF | Community Pharmacy Contractual Framework |
| CVD | Cardiovascular Disease |
| DDRB | Doctors' and Dentists' Review Body |
| DES | Directed Enhanced Service |
| DHSC | Department of Health and Social Care |
| DPO | Data Protection Officer |
| EEA | European Economic Area |
| FIT | Faecal Immunochemical Test |
| GMS | General Medical Services |
| GP | General Practitioner |
| GPC | General Practitioner's Committee in England |
| (England) | |
| GPSoc | GP System of Choice |
| IAPT | Increasing Access to Psychological Therapies |
| HPV | Human Papilloma Virus |
| ICS | Integrated Care System |
| JGPITC | Joint General Practice IT Committee |
| LHCR | Local Health and Care Record |
| LMC | Local Medical Committee |
| MHRA | Medicines and Healthcare Products Regulatory Agency |
| NHS | National Health Service |
| NICE | National Institute for Health and Care Excellence |
| ONS | Office for National Statistics |
| PCNs | Primary Care Networks |
| PINCER | Pharmacist-led information technology intervention for medication errors |
| PMS | Personal Medical Services |
| PSNC | Pharmaceutical Services Negotiating Committee |
| QI | Quality improvement |
| QOF | Quality and Outcomes Framework |
| RCGP | Royal College of General Practitioners |
| S7a | Section 7a |
| STOMP | Stopping Over Medication of People with a learning disability, autism or both |
| STP | Sustainability and Transformation Partnership |
| WTE | Whole Time Equivalent |

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