Classification: Official

Publication reference: PR1998

To:
- GP practices
- Primary care network leads

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 September 2022

Dear Colleagues,

Supporting general practice, primary care networks and their teams through winter and beyond

To support the NHS during this period of sustained significant pressure, NHS England has taken action to boost capacity ahead of winter. Recognising the fundamental importance of primary care in underpinning NHS services, a critical part of this plan is to increase capacity outside of acute trusts, which includes the scaling up of additional roles in primary care, increasing the flexibility for primary care networks (PCNs) to do this, and taking further action to support general practice.

To enable this, we are taking several steps over the next few weeks to support the expansion of general practice capacity and reduce both workload and administrative burden. The measures will help general practice focus on access pressures and facilitate system collaboration, working with local providers to manage urgent demand and help address workload challenges.

These actions, listed below, will support both practical, rapid improvements for practices, as well as help the NHS move closer to our vision for integrated primary care. Dr Claire Fuller's Next Steps for Integrating Primary Care outlines our ambition for driving towards integrated neighbourhood teams (INTs) that move beyond PCNs as a fundamental building block of an integrated care system (ICS).

1. An ICB framework for supporting general practice

This framework will support ICS teams to rapidly assess the needs of their practices/PCNs, building on local knowledge, and identify the practical and supportive interventions that would be most appropriate in the short term to boost resilience and patient access. ICBs should prioritise resources where they are most needed.

We are also seeking to identify where additional capital – should it be made available via ICBs later in the year, alongside usual revenue funds (system development funding [SDF]) – could be used to make a difference to primary care delivery and resilience over winter. The annexes to this letter set out this framework and give more detail on scoping for how any capital could be used.

2. Immediate changes to the Network Contract DES

Following on from lessons learned through last winter and the pandemic to support practice capacity and PCN development, the following changes are being made, which are set out in more detail in annex 4:

- Issuing a variation to the Network Contract DES to make several changes:
  - Introducing further flexibility into the Additional Roles Reimbursement Scheme (ARRS) [see annex 4 for full list] including the addition of a GP assistant role to help reduce administrative burden for GP teams, and a digital and transformation lead role to support patients and practice teams to optimise digital tools and embed transformation.
  - Retiring or deferring to 2023/24 four investment and impact fund (IIF) indicators, worth £37m, and allocating this funding to PCNs via a monthly PCN capacity and access support payment, for the purchase of additional clinical services or workforce to increase access to core services this winter.
  - Reducing the thresholds of two IIF indicators and changing the definition of a further two IIF indicators to make them easier to achieve.
  - Removing the personalised care requirement for all clinical staff to undertake the Personalised Care Institute's e-learning refresher training for shared decision making (SDM) conversations.
  - Making changes to the anticipatory care requirements to support PCN capacity over the winter, and to reflect the revised national approach of phased implementation of this model of care from April 2023.

In line with the recommendations of Dr Fuller's stocktake report, NHS England is committed to supporting the long-term development of neighbourhood multi-disciplinary teams in primary care. Staff recruited via the ARRS are central to this ambition.

In 2020, NHS England advised that ARRS-recruited staff will be treated as part of the core general practice cost base beyond 2023/24 (Update to the GP Contract Agreement 2020/21-2023/24 para 1.20), and so permanent contracts where appropriate could be

offered by PCN employers. We encourage PCNs to continue to recruit, making full use of their ARRS entitlement to improve access to care and support for patients, with the knowledge that support for these staff will continue.

3. Reducing bureaucracy and primary/secondary care interface

As part of the public commitment made in *Update to the GP Contract Agreement,* the Department of Health and Social Care (DHSC) and NHS England have worked to jointly identify areas to reduce workload in primary care. On 23 August 2022, DHSC published the Bureaucracy Busting Concordat, with seven principles to reduce unnecessary burdens on general practice.

We now plan to go further. The Academy of Medical Royal Colleges (AoMRC) has been commissioned to identify actionable insights during the next three months where closer clinical collaboration at the interface would have most impact in managing upcoming winter pressures and beyond. There are already tools and support available to help systems, including:

- A briefing document for clinicians and managers on why managing the primary / secondary care interface is important.
- A practical toolkit with practical steps that ICSs can take to improve this interface.
- Supporting principles for effective professional behaviours and communications principles for working across the interface.

DHSC and NHS England will continue to engage with stakeholders to assess impact on GP teams' workload burden.

The measures outlined above represent the beginning of a longer journey to support transformation of place-based primary and community care services into integrated neighbourhood teams, while providing a supportive environment to practices and alleviating some capacity pressures to make a tangible difference to patients.

Yours sincerely,

Dr Amanda Doyle OBE MRCGP
National Director, Primary Care and Community Services

The annexes attached to this letter sets out the detail of these different initiatives and the requirements from systems, PCNs and practices to access the support being made available.

- Annex 1 – ICB framework for supporting general practice
- Annex 2 – SDF for primary care
- Annex 3 – Scoping for use of any additional capital funding for primary care
- Annex 4 – Further support for general practice and PCNs during winter 22/23

Annex 1 – ICB framework for supporting general practice

The purpose of this framework is to support integrated care boards (ICBs) and practices/ PCNs to determine where investment can be best targeted to enable rapid improvement in patient and staff experience in general practice, and to ensure that existing good practice is identified so that it can be built on and shared across the system.

Many ICBs will already have some local intelligence and data on the points covered and can use this existing knowledge to complete the framework.

The first part of the framework should be completed by ICS teams and will be used to inform scoping for how any additional capital funding which may be available later in the year for primary care could be used, as described below, and to help identify how other resources (eg SDF) should be targeted. ICS teams are encouraged to return submissions for possible areas of use for capital funding as soon as possible, and by 21 October at the latest.

Completion of this framework should also feed into ICB submissions against the Board Assurance Framework[1] as outlined within the Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter publication.

The second part of the framework covers areas where support may be needed to help improve patient access and staff experience over the longer term, with the aim of building an ongoing quality improvement support process within primary care, supported by ongoing SDF or other transformation funding.

Please note: ICBs will not be required to submit the detail on any specific practice or PCN to NHS England. ICBs will collect thematic feedback which will be used to inform

[1] assurance-framework.xlsx (live.com) Aligning Demand and Capacity 1.6 Primary Care

NHS England policy, procurement of resources and development of ongoing solutions to help primary care.

ICB framework: conversation between ICS teams and practice/PCN

Potential key lines of enquiry for ICS to assess where immediate investment and support may be required **Section 1**
i. Patient contact
• Is cloud-based telephony in place, over what proportion of your practices, for how long, and what functionality do you have? (To note, this data collection will support the development of a national framework for cloud-based telephony for general practice).
ii. Use of data for improvement
• What, if any, business intelligence (BI) tool(s) do your practices use? • How many practices have no access to a BI tool? • How do they use it to understand demand, activity and capacity?
iii. Operational efficiency
• What business functions have practices automated, if any? eg document workflow, certain pathology results, vaccine recall systems
iv. Clinical and administrative workspace
• Do your PCNs have the estates/facilities to optimise use of clinical/admin teams? • If not, what are the expected costs and realistic timelines – including business case approvals, procurement and building works completion – to resolve identified estates/facilities challenges
v. Enhanced access
• Have the PCNs' plans been signed off to deliver a minimum of 60 minutes of appointments per 1,000 PCN adjusted populations per week during the network standard hours? • Do your PCNs have interoperability capability to work as a PCN/enable EA? – If yes – are there any plans to support other hub type working eg respiratory winter hubs? – If no, interoperability of IT systems then escalates via return to regional team to consider support for capital / other funding.

Equipment

- Do general practice staff have sufficient equipment to carry out their roles effectively? (eg laptops, screens, headsets, webcams, phones, etc)
- Do PCN/ARRS staff have sufficient equipment to carry out their roles effectively?

General

- Have your PCNs implemented any other interventions to manage workload, optimise clinical capacity or improve patient access in general practice?
- If so, what were they and have you measured/quantified the improvement? eg establishing PCN hubs

Section 2: Support areas

i. Patient contact

- How is cloud based telephony being used to improve patient access, and how is good practice shared?

ii. Patient communication

- How does the ICS support practices to ensure patients can easily find and understand accessing the following on practice websites: (see checklist for 'highly usable websites' outlined in the Creating a highly usable and accessible GP website for patients' guidance)
  - The online consultation system
  - Opening times
  - Phone number for the practice
  - Self-care information and community pharmacy options
  - Online services via the NHS App or other similar service eg repeat prescriptions

iii. Use of data for improvement

- How does the data on use of 111 services during 8-6.30pm compare (using calls per 1000 patients) when benchmarked to local practices?

iv. Operational efficiency

- How does the ICS support spread and adoption of automation of business functions?
- How does the ICS support the sharing of good practice and the impact of automation?
- Does the ICS plan to support further automation of practice functions?

v. Appointment allocation

- Do practices have effective systems in place for care navigation?
- What support does the ICS provide to monitor and support this to ensure it is safe and effective (eg training)?
- How many practices and PCNs use a system of clinical triage for appointment requests?
- What ARRS staff are in place across PCNs?
- How could the ICS support PCNs to ensure ARRS roles are working as effectively as they could to help meet demand?
- Where there is a High Intensity User scheme locally in ED, consider where a PCN could utilise a SPLW (social prescribing link worker(s)) or Care coordinator(s) recruited through the ARRS scheme to support.

BP@Home and LTC remote monitoring

- Are PCNs able to make effective use of BP@Home/LTC remote monitoring to support patients to manage their blood pressure?
- Awareness of community pharmacy BP checks and promotion for patients?
- What support is required to make good use of this service?
- What improvements have been delivered as a result of BP@Home or LTC remote monitoring?

vi. Clinical and other capacity

- What are the vacancy levels across clinical/admin teams?
- How many of these have been open for more than two months?
- What strategies does the ICS team have in place to support workforce challenges?

Annex 2 – System development funding for primary care

The primary care SDF enables systems to continue to deliver critical primary care transformation and workforce projects that will strengthen services and deliver improvements. The funding should also be utilised to support the programmes of work identified via the framework process outlined in annex 1.

ICSs should prioritise resources where they are most needed. For example, practices/PCNs working in the most deprived areas, in areas with the highest health inequalities or with the most serious recruitment challenges.

Along with using SDF funding to support framework plan implementation, ICSs should support general practice and PCNs to continue with existing work-plans that:

a. identify the type and intensity of support needs of their general practices and distribute resource to where it is needed most

b. retain and expand staff capacity (eg making full use of ARRS roles and supporting retention of existing staff)

c. strengthen staff skills and capability to lead change and build high performing teams.

Full details of the Primary Care SDF can be found here

Annex 3 – scoping for any additional capital funding for primary care during 22/23

We are interested in urgently scoping where any additional capital investment in primary care would make a difference to front-line service delivery and support resilience over winter and beyond.

We have listed below some initial ideas around investment on areas/tools that would deliver change most quickly and easily, with a view to improving the experience of both patients and staff. Work to date and feedback from ICS and practice teams suggests that the following types of investment may be most valuable in the short term:

- Digital interoperability and other tools to support cross PCN working, including delivery of enhanced access services at PCN level.
- Rapid improvements in primary care estates, especially to support optimal use of ARRS roles eg creation of additional consulting rooms.
- Increasing use of automation of business/back office functions in general practice.

Collated returns of section 1 of the framework above and feedback from ICSs via regional teams will support the national team to identify where capital might be spent, should funding become available later in the year. For any identified areas for capital investment, systems will need to consider whether the revenue impact can be locally absorbed or be clear where that is not possible.

Annex 4 – Further support for general practice and PCNs during winter 22/23

Updates to the ARRS

1. Introduce a general practice assistant (GPA) role in the ARRS. The role will offer clinical and administrative support to GPs, freeing up clinical time to focus on patient care. The role will be subject to a maximum reimbursement equivalent of an Agenda for Change Band 4 level and the outline will be based on the HEE competency framework.

   PCNs can immediately start recruiting to the role, predominantly through trainee positions. Staff can be trained in-practice, with on-the-job training and development led by GPs, in line with the role outline. Trainee GPAs will also have the opportunity to complete HEE's structured, accredited training route, aligned to the competency framework, equipping them with formal certification of their learning.

2. Introduce a digital and transformation lead, to support increased access to care for patients, by supporting the adoption and/or optimisation of new technology and other initiatives to improve the care offer, and enabling PCN staff to work more effectively to support the sustainability of general practice services. The role will be capped at one per PCN and maximum reimbursement will be equivalent to an Agenda for Change band 8a. It will include delivery of a combination of the following responsibilities:

   a. Improve adoption and/or optimisation of new technology to enhance patient access and experience and increase PCN productivity

   b. Build relationships and facilitate collaboration between practices and the wider system to support the delivery of care to patients (including shared appointments between practices to aid delivery of enhanced access)

   c. Lead an improvement approach to change including building capability for quality improvement within the PCN and system wide approaches to problem solving

   d. Review and improve the PCN's digital maturity

   e. Use data, and improve data quality, to:

      i. understand demand, capacity and activity and drive improvements in:

         1. patient experience of access

2. operational efficiency including better matching capacity to need
3. staff experience at work.

ii. support population health management

iii. support understanding of the type and intensity of support/training needs of the PCN and coordinate this support, including through OD programmes

iv. facilitate clinically led innovation and the effective adoption of improvement initiatives, including integrated working at neighbourhood and/or place level to improve access to services for patients.

3. Increase the current cap on hiring advanced practitioners (APs) through the ARRS, from one per PCN to two (double for those with over 100,000 patients). APs are able to supervise members of the multidisciplinary team (MDT) and see undifferentiated patients, supporting workload reduction from GPs.

4. Reimburse training time for nursing associates to become registered nurses who work in general practice, enabling PCNs to develop their nursing workforce and providing a career path for nursing associates. For April 2023 onwards, we will also consider support for senior nurses within PCNs.

5. Increase the ARRS maximum reimbursement rates for 2022/23 to account for the Agenda for Change uplift.

6. Remove the minimum 0.5 FTE restriction on clinical pharmacists once they have completed their required 18-month training course or have been granted equivalence/exemption from the PCPEP pathway.

7. Contractually permit equivalent entry routes to PCPEP for clinical pharmacist role. This will formalise the exemptions that PCPEP apply to some clinical pharmacists who already have the requisite skills.

Updates to the PCN service specifications

8. Update the anticipatory care requirements to better reflect system-level work on anticipatory care. Replace the current specification with:
    a. 8.9.1. ICSs have responsibility to design and plan anticipatory care for their system, of which the following PCN requirements form a part.

b. 8.9.2. PCNs must contribute to ICS-led conversations on the local development and implementation of anticipatory care working with other providers with whom anticipatory care will be delivered jointly.

9. Remove the personalised care requirement for all clinical staff to undertake the Personalised Care Institute's 30-min e-learning refresher training for SDM conversations.

Updates to IIF incentives

10. Defer the following indicators to 2023/24:
    a. ACC-02: Number of online consultation submissions received by the PCN per registered patient.
    b. EHCH-06: Standardised number of emergency admissions on or after 1 October per care home resident aged >= 18.
    c. IIF ACC-08: Percentage of patients whose time from booking to appointment was two weeks or less.

11. Retire IIF ACC-05: By 31 March 2023, make use of GP Patient Survey results for practices in the PCN to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop, publish and implement a plan to improve patient experience and access for these patient groups, taking into account demographic information including levels of deprivation.

12. In total, the above equals £37m of funding to be released to PCNs as a PCN Support Payment. The PCN Support Payment will be paid on a monthly basis and will be based on the PCN's Adjusted Population. In line with the reinvestment commitment relating to IIF earnings, the PCN capacity and access support payment must be used to purchase additional workforce and increase clinical capacity to support additional appointments and access for patients.

13. Amend the thresholds of the following indicators to better reflect operational realities:
    a. IIF CVD-02: Increase in percentage of registered patients on the QOF Hypertension Register: This indicator is closely linked to IIF CVD-01 which recognises PCNs for following up elevated blood pressure readings to confirm or exclude hypertension. Reduce the 22/23 thresholds to from 0.6/1.2 to 0.4/0.8 percentage point increase.
    b. IIF PC-01: Percentage of registered patients referred to a social prescribing service. Reduce 22/23 thresholds from 1.2%/1.6% to 0.8%/1.2%.

14. Amend the wording of the following IIF indicators based on feedback from the first half of the year to make them easier to achieve:

    a. CAN-01, which recognises PCNs for ensuring that lower gastrointestinal fast-track referrals for suspected cancer are accompanied by a faecal immunochemical test or FIT – change permissible time between FIT result and referral from seven to twenty-one days.

    b. CVD-04, which recognises PCNs for referring patients with high cholesterol for assessment for familial hypercholesterolaemia – expand list of success criteria to include diagnoses of secondary hypercholesterolaemia, genetic diagnoses of familial hypercholesterolaemia, and assessments for familial hypercholesterolaemia, in addition to referral for assessment for familial hypercholesterolaemia.