

To: All GP practices in England
Primary Care Network Clinical
Directors
NHS England and NHS Improvement
Skipton House
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cc. CCG Clinical Leads and Accountable
Officers
ICS Primary Care Leads
ICS Chief Executive Designates
Regional Directors of Commissioning
Regional Directors of Primary Care
and Public Health
Regional Heads of Primary Care

1 March 2022

Dear colleagues

General practice contract arrangements in 2022/23

General practice teams responded swiftly and fully to the Government's request that they reprioritise their work to support the COVID booster programme. Thank you to all those working in general practice for the agility and responsiveness that was shown over these past few months. Your contribution is recognised, valued and appreciated.

As we look ahead, the needs of our populations and patients necessitates that the primary focus of general practice returns to addressing non-COVID needs. In particular this needs to be on long-term condition management and chronic disease control, ensuring timely access for patients with urgent care needs, and regaining momentum on the wider Long Term Plan prevention agenda. Responding to COVID, including COVID vaccinations, will continue to be an important subset of activity but on a smaller scale than in 2021/22. The British Medical Association (BMA) and the Royal College of General Practitioners (RCGP) set out guidance at the end of last year stating 'we must reassure the public that general practice remains open and that patients will be seen face to face where it is clinically appropriate', which remains in place.

2022/23 also sees the formal start of NHS Integrated Care Boards, subject to parliament. The success of Integrated Care Systems (ICSs) is dependent on successfully supporting and developing primary care, enabling it to be sustainable and more joined-up with other services. The stocktake led by Dr Claire Fuller will set

out what all ICSs need to do locally, with a particular focus on development of Primary Care Networks (PCNs) so that their potential benefits can be fully realised.

NHS England and NHS Improvement and the Government continue to remain committed to honouring the 5-year settlement that runs to 2023/24, negotiated and agreed with BMA General Practitioners Committee (GPC England) and subsequently enhanced. Through nationally guaranteed entitlements, this provides significant real terms growth in overall investment for general practice.

The GP contract regulations will be updated in 2022/23 with the intention to make the following changes:

- in light of the new models of access to general practice which have been developed during the pandemic, there will be a change to the existing contractual requirement that at least 25% of appointments are available for online booking. The existing requirement, currently drawn from the totality of a practice's appointments, is too crude. It will be replaced with a more targeted requirement that all appointments which do not require triage are able to be booked online, as well as in person or via the telephone. Guidance will be issued on what type of appointments practices are expected to be made available for online booking;
- to require GP practices to respond to Access to Health Records Act (AHRA) requests for deceased patients and to remove the requirement for practices to always print and send copies of the electronic record of deceased patients to Primary Care Support England (PCSE). It is expected that the savings from not having to print and send the electronic record will far outweigh the additional burden of managing a small number of AHRA requests;
- there will be some minor changes to vaccinations and immunisations in 2022/23 (set out at Annex A) which reflect forthcoming changes to the routine vaccination schedule recommended by the Joint Committee on Vaccination and Immunisation (JCVI), including:
 - human papillomavirus (HPV)
 - MMR including support for a national campaign
 - MenACWY Freshers programme;
- there will also be continuation of funding in Global Sum (£20 million) for one additional year (2022/23) to reflect workload for practices from Subject Access Requests (SARs). The original 5-year deal had assumed that this funding would cease beyond 2021/22; and

- to support the modernisation of GP registration there will be a clarification of the ability for patients to register digitally.

No new additional indicators will be added to QOF when the temporary income protection arrangements come to an end in March 2022. The Quality Improvement (QI) modules for 2022/23 will focus on optimising patients' access to general practice and prescription drug dependency. 97% of practices signed up to the Weight Management Enhanced Service in 2021/22 and the service will continue for 2022/23.

Expanding primary care capacity remains a top priority, and PCNs have made excellent progress in recruiting to roles under the Additional Roles Reimbursement Scheme (ARRS). The national target is 15,500 FTEs by the end of 2021/22. Based on NHS Digital (NHSD) data and NHS England and NHS Improvement ARRS financial returns we are confident that we are on track to achieving that target, and to achieving 21,000 FTE by 31 March 2023 and 26,000 FTE by 31 March 2024.

The amount available for PCNs to recruit additional staff will increase as promised by £280 million to just over £1 billion for 2022/23. PCNs will continue to have flexibility to hire into any of 15 different roles. We continue to encourage PCNs to make full use of their ARRS entitlements, including working with mental health providers to take advantage of the doubling of Mental Health Practitioners roles to support people with complex mental health needs, that can be employed on a 50:50 shared reimbursement model. Additional flexibility to help support recruitment to these roles will also be introduced, including a broadening of the role outline to include non-clinical support for patients and an inclusion of band 4 in the eligibility.

The PCN Clinical Director funding for 2022/23 has been agreed as £0.736 per head or £44M nationally as part of the five-year deal. We confirm that this funding will be boosted by a further £43 million. PCNs will continue to be able to draw down the £1.50 per head core PCN funding, meaning that a total of £178 million will be available for PCNs and their Clinical Directors to support core running, leadership and management in 2022/23.

As agreed in the 2019 deal and subsequent updates, we will bring together, under the Network Contract DES, the two funding streams currently supporting extended access to fund a single, combined and nationally consistent access offer with updated requirements, to be delivered by PCNs. This will bring together the current £1.44 per head Network Contract DES extended hours funding and the current £6 per head CCG-commissioned extended access services. This transfer to PCNs was

delayed as a result of the COVID-19 pandemic and delivery will now start from October 2022, with preparatory work from April 2022.

The new enhanced access arrangements aim to remove variability across the country and improve patient understanding of the service. The new offer is based on PCNs providing bookable appointments outside core hours within the Enhanced Access period of 6.30pm-8pm weekday evenings and 9am-5pm on Saturdays, utilising the full multi-disciplinary team, and offering a range of general practice services, including 'routine' services such as screening, vaccinations and health checks, in line with patient preference and need. PCNs will be able to provide a proportion of Enhanced Access outside of these hours, for example early morning or on a Sunday, where this is in line with patient need locally and it is agreed with the commissioner. A summary of the new Enhanced Access requirements is included at Annex B.

NHS England and NHS Improvement has already set out in August 2021 our plans for 2022/23 for PCN service specifications and the PCN Investment and Impact Fund (IIF). There will be a limited expansion of the Cardiovascular Disease Prevention and Diagnosis service, and the Anticipatory Care and Personalised Care services will be introduced in a phased approach from April 2022.

We are now further re-phasing published plans in two ways. First, PCNs will have an additional year to implement digitally enabled personalised care and support planning for care home residents. 2022/23 will now become a preparatory year, with implementation of the requirement required by 31 March 2024. Second, there will be an extension of the period that PCNs have to develop their anticipatory care plans until December 2022. The Anticipatory Care service itself, which will be ICS led, will start in 2023/24.

The Early Cancer Diagnosis service requirements will be streamlined and refocussed in 2022/23 in response to clinicians' feedback. The proposed new requirements are simpler and clearer, while also focusing PCNs on national diagnosis priorities arising from evidence around lower than expected referral rates for prostate cancer. The new requirements are set out in Annex C.

Three new Investment and Impact Fund (IIF) indicators focused on Direct Oral Anticoagulants (DOAC) prescribing and FIT testing for cancer referrals will be introduced in 2022/23. These changes will help to ensure that a greater number of patients with Atrial Fibrillation receive anticoagulation therapy where clinically

appropriate and that more patients with suspected lower gastrointestinal cancer will have their two week wait referral accompanied by a FIT test result. Funding for these indicators amounts to £34.6 million and is wholly additional to the existing £225 million funding envelope for the scheme. The detail of the three new indicators are included at Annex D along with the thresholds for two indicators previously announced.

The current five-year framework of GMS contract changes, agreed by GPC England concludes at the end of 2023/24. The default position is that the existing GMS contract will automatically roll forwards unless it is changed.

In considering options for any future potential changes to the national GMS contract, NHS England and NHS Improvement and DHSC will engage with a range of NHS organisations including the new Integrated Care Boards who will be responsible for commissioning primary care services; and patient and professional representative groups. This will be to understand views and perspectives, including the extent to which further changes to national contractual arrangements, as opposed to additional local support and commissioning, are required to support high quality and accessible general practice services, support the general practice workforce, and enable primary care to work at the heart of ICSs. Taking account of Dr Claire Fuller's stocktake, this will include looking at how PCNs will further develop and support both practices and the wider systems in which they operate.

GPC England has explicitly 'called on the Government to support negotiations in a refreshed fit for purpose contract agreement beyond the 5-year agreement ending in 2023/24'. NHS England and NHS Improvement confirms that it remains fully committed to discussing any proposals for potential future national changes from 2024/25 with GPC England.

Further details on the 2022/23 changes will be published ahead of April including a revised Network Contract DES Contract specification which will set out the PCN changes including the Enhanced Access arrangements.

We will separately communicate with commissioners to advise them of updates to allocations. The detail of the 2022/23 changes are set out in further detail in the annexes below.

We believe that these updates will maintain stability and limit change for general practice, while bolstering investment for the workforce and leadership, supporting our

communities to recover, and ensuring patients continue to receive timely, high quality care. Thank you for your hard work in supporting your populations.

Yours sincerely,



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NHS England and NHS Improvement



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Medical Director of Primary Care
NHS England and NHS Improvement

Annex A - Vaccinations and immunisations

1. There will be some minor changes to Vaccinations and Immunisations in 2022/23 which simply reflect forthcoming changes to the routine vaccination schedule recommended by JCVI, including:
 - human papillomavirus (HPV)
 - MMR including support for a national campaign
 - MenACWY Freshers programme.
2. For HPV there will be a transition from Gardasil 4 to Gardasil 9 during 2022/23. Additionally, the JCVI has advised a move from a three-dose schedule to a two-dose schedule (with doses given at least six months apart), for both those aged 15 and over, and for the national HPV MSM vaccination programme. This change will align HPV vaccine doses across age groups, as well as aligning school, sexual health and general practice provision, thus minimising the risk of conflicting or missing doses.
3. This change will not apply to those who are HIV positive or those who are immunocompromised for whom the three-dose schedule will remain. As such, practices will deliver just two doses of the HPV vaccine in most cases from April 2022. Where a three-dose schedule has been started prior to April 2022 this schedule should be adhered to and three doses given. Eligibility for girls is up to the age of 25 years. Eligibility for boys is based on age for those born on or after September 2006.
4. There will be changes to the Measles, Mumps and Rubella (MMR) vaccination programme which will include the cessation of the 10 and 11-year-old catch-up programme along with practice participation in a national MMR campaign as per the current contractual requirement for practices to take part in one catch up campaign per year. The Men ACWY Freshers programme will come to an end on 31 March 2022.
5. There will also be a wider childhood immunisation campaign taking place during the early part of 2022 to support recovery of these programmes. This will primarily be aimed at capturing children that have missed these immunisations due to the COVID-19 pandemic and the reduction in uptake over the last two years. Practices will be asked to support uptake of routine childhood

immunisations for 0 to 5-year olds and will receive the IOS payment of £10.06 per dose.

Annex B - Summary of Enhanced Access offer

The following sets out a summary of the Enhanced Access model and the associated preparatory requirements which will be included in the 2022/23 Network Contract DES.

Preparatory arrangements – from April 2022 to October 2022

1. From 1 October 2022, PCNs will be required to provide Enhanced Access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays.
2. To prepare for delivery of Enhanced Access from 1 October 2022, PCNs must work with their commissioner to produce and agree an Enhanced Access Plan. This Plan will need to set out how the PCN is planning to deliver Enhanced Access from October, including:
 - i. how the PCN will engage or has engaged with its patient population and will or has considered patient preferences, including consideration of levels of capacity and demand
 - ii. what mix of services will be provided during the Enhanced Access period
 - iii. what appointment types and channels will be available to patients in Enhanced Access, including how the PCN will meet the requirement to ensure a reasonable number of appointments for in person face-to-face consultations are available
 - iv. what the proposed staffing or skill mix will be to deliver services
 - v. where the PCN intends the site location(s) to be situated for patients to access in person face-to-face services, taking account of reasonable travel times for local patients as agreed with the commissioner
 - vi. proposals for how the PCN will deliver the necessary system interoperability to support delivery of Enhanced Access; and
 - vii. any planned sub-contracting arrangements in respect of the Enhanced Access.

3. PCNs must submit their draft Enhanced Access Plan to their commissioner by 31 July, with a final iteration agreed by 31 August. Commissioners will need to ensure the PCN Enhanced Access Plans form part of a cohesive ICS approach.

Service offer from October 2022

4. PCNs will be required to provide enhanced access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays (known as “Network Standard Hours”).
5. PCNs will be required to provide bookable appointments during the Network Standard Hours which are:
 - i. available to the PCN’s registered patients
 - ii. are for any general practice services
 - iii. for bookable appointments, that may be made in advance or on the same day, regardless of the access route via which patients contact their practice, and the PCN must:
 - a) make the appointments available a minimum of two weeks in advance, with the PCN’s Core Network Practices utilising appropriate triage and/or navigation as required to book and/or offer patients available appointments
 - b) make the Network Standard Hours appointment book accessible to its practices to enable efficient patient bookings into slots following patient contact
 - c) make same day online booking for available routine appointments where no triage is required up until as close to the slot time as possible
 - d) operate a system of enhanced access appointment reminders
 - e) provide patients with a simple way of cancelling enhanced access appointments at all times
 - f) in line with published guidance, make available to NHS111 any unused on the day slots during the Network Standard Hours from

6.30pm on weekday evenings and between 9am-5pm on Saturdays, unless it is agreed with the commissioner that the timing for when these unused slots are made available is outside of these hours; and

- g) have in place appropriate data sharing and, where required data processing arrangements to support the delivery of Enhanced Access between the PCN's Core Network Practices and where applicable a sub-contractor.
- iv. delivered by a multi-disciplinary team of healthcare professionals, including GPs, nurses and Additional Roles Reimbursement Scheme workforce
- v. within Network Standard Hours and are:
- a) a mixture of in person face to face and remote (telephone, video or online) appointments, provided that the PCN ensures a reasonable number of appointments are available for in person face-to-face consultations to meet the needs of their patient population, ensuring that the mixture of appointments seeks to minimise inequalities in access across the patient population;
 - b) in locations that are convenient for the PCN's patients to access in person face-to-face services; and
 - c) delivered from premises which are is as a minimum equivalent to the number of sites within the PCN's geographical area from which the CCG Extended Access Service was delivered
- vi. providing a minimum of 60 minutes of appointments per 1,000 PCN adjusted patients per week during the Network Standard Hours, calculated using the following formula:

additional minutes* = the PCN adjusted population** ÷ 1,000 x 60

*convert to hours and minutes and round, either up or down, to the nearest quarter hour

**PCN adjusted population is based on the CCG Primary Medical Care weighted population as at 1 January 2022

6. If agreed with the commissioner, a proportion of the Enhanced Access minutes may be provided outside of the Network Standard Hours, where it is evidenced by the PCN that such appointments would better meet the needs of the PCN's patients. For example, this could be through the provision of a morning clinic between 7am to 8am, or by exception a proportion of capacity may be used to support management of demand during core hours, where this is regularly high.
7. PCNs must ensure GP cover during the Network Standard Hours, providing in person face-to-face consultations, remote consultations, leadership, clinical oversight and supervision of the MDT.
8. PCNs must actively communicate availability of these enhanced access appointments to their patients, including informing patients how they can be accessed, what and when specific services are available (for example vaccinations and immunisations, screening, health checks, PCN services etc) and what and when different members of the multi-disciplinary team (MDT) are available, through promotion and publication through multiple routes. This may include the NHS website (nhs.uk), the practice leaflet, the practice website, on a waiting room poster, by writing to patients and active offers by staff booking appointments.
9. PCNs must ensure, when available, appropriate telephony and IT interoperability will operate between the practices of the PCN, as well as any other parties involved, such as sub-contracted providers. This must include the ability, once consistently available, to view, book into, and cancel appointments, make referrals and request tests, to view and update patients' records, and for all relevant staff to have the ability to access medical records within the PCN, and to cover other points in the core digital offer provided by member practices as part of their primary medical services contract . Further guidance on IT interoperability will be made available.
10. Following from the above, when available PCNs will utilise core digital capabilities consistently across the PCN, including to:
 - i. enable practice and PCN staff to book appointments in Standard Network Hours; and

- ii. enable patients to book appointments online where appropriate, including up until as close to the slot time as possible.

Annex C – Updated Early Cancer Diagnosis service requirements 2022/23

The following sets out what will be the updated requirements in the 2022/23 Network Contract DES:

A PCN will be required to:

1. Review referral practice for suspected and recurrent cancers, and work with their community of practices to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas where early diagnosis rates are lower.
2. Work with local system partners – including the NHS England and NHS Improvement Regional Public Health Commissioning team and Cancer Alliance – to agree the PCN’s contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations. This must build on any existing actions across the PCN’s Core Network Practices and include at least one specific action to engage a group with low participation locally.
3. Work with its Core Network Practices to adopt and embed:
 - i. the requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer; and,
 - ii. where available and appropriate, the use of teledermatology to support skin cancer referrals (teledermatology is not mandatory for all referrals).
4. Focusing on prostate cancer, and informed by data provided by the local Cancer Alliance, develop and implement a plan to increase the proactive and opportunistic assessment of patients for a potential cancer diagnosis in population cohorts where referral rates have not recovered to their pre-pandemic baseline.
5. Review use of their non-specific symptoms’ pathways, identifying opportunities and taking appropriate actions to increase referral activity.

Annex D - Three new Investment and Impact Fund (IIF) indicators focused on DOAC prescribing and FIT testing for cancer referrals will be introduced in 2022/23. Funding for these indicators is additional to the existing £225m funding envelope for the scheme.

<i>Area</i>	<i>Indicator</i>	<i>Thresholds</i>	<i>Valuation</i>
CVD	CVD-12: Percentage of patients on the QOF Atrial Fibrillation register and with a CHA ₂ DS ₂ -VASc score of 2 or more (1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist.	UT: 95% LT: 70%	£14.8m / 66 points
	CVD-15: Number of patients that were prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register and with a CHA ₂ DS ₂ -VASc score of 1 or more for men or 2 or more for women and who were prescribed a direct-acting oral anticoagulant (DOAC).	UT: 60% LT: 40%	£14.8m / 66 points
Cancer	CAN-10: Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral.	UT: 80% LT:40% (22/23), 65% (23/24)	£5.0m/ 22 points

The previous announcement of the IIF plans for 2022/23¹ did not include thresholds for ACC-02 and SMR-01. The thresholds for these indicators will be as follows:

<i>Area</i>	<i>Indicator</i>	<i>Thresholds</i>	<i>Valuation</i>
Access	ACC-02: Number of online consultation submissions received by the PCN per 1000 registered patients	5 per 1000 per week	£4.1m / 18 points
SMR	SMR-01: Percentage of patients eligible to receive a Structured Medication Review who received a Structured Medication Review	UT: 62% LT: 44%	£12.0m / 53 points

¹ <https://www.england.nhs.uk/wp-content/uploads/2021/08/B0828-iii-annex-b-investment-and-impact-fund-21-22-22-23.pdf>