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NHS England and NHS Improvement
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To:

- GP practices
- Primary care network clinical directors

17 June 2021

Dear Colleagues,

Update to GP contract arrangements for 2021/22

1. Thank you for all the work that you and your teams are continuing to do for your patients.

2. **In January 2021, NHS England and the BMA GPC England agreed an initial set of funding and contractual arrangements for 2021/22**, recognising that the uncertainty of the pandemic meant it was not the time to agree details for the whole of 2021/22. **This was supplemented by £120m additional funding for the period April to September 2021 to support general practice capacity, as well as up to £32.5m additional funding for PCN clinical director support** from April to June 2021 (where at least one PCN Core Network Practice was signed up to the COVID-19 Vaccination Programme Enhanced Service).

3. **NHS England can now confirm that it will provide further funding for PCN Clinical Director support for the period from July to September 2021**. This funding is temporary and time limited. It will be equivalent – as previously – to an increase from 0.25WTE to 1WTE. As before, PCNs are eligible for this further support payment where at least one Core Network Practice is signed up to the COVID-19 Vaccination Programme Enhanced Service. This funding is to support the leadership and management of the COVID-19 response and may be used by PCNs to enhance the management or support capacity for their clinical leadership.

4. We have previously confirmed that no new PCN services or further Investment and Impact Fund indicators will be introduced until 1 October at the earliest. In advance of this, **NHS England is offering practices the voluntary opportunity to participate in two new enhanced services from 1 July, backed by up to £50m of wholly additional funding for 2021/22**. These focus on two areas

which are a priority to support recovery from the pandemic: long COVID and weight management.

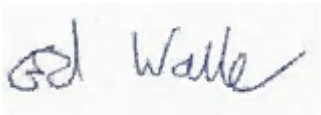
5. **The Weight Management Enhanced Service encourages practices to develop a supportive environment for clinicians to engage with patients living with obesity about their weight, and provides up to £20m funding for referrals to weight management services**. This enhanced service goes alongside a broader expansion of weight management services, including the launch of the NHS Digital Weight Management Service for those with hypertension and diabetes, and further investment into local authority tier 2 services.

6. Long COVID is an increasingly widespread condition, which can have a substantive impact on the quality of life of those affected by it. According to estimates by ONS, around 932,000 people were living with long COVID in England in the four weeks to the beginning of March. We know that general practice is playing a key role in managing patients with long COVID. **Therefore, to support general practice in managing this new and complex condition, NHS England will provide up to £30m from 1 July via a Long COVID Enhanced Service**. This will support professional education, training and pathway development that will enable management in primary care where appropriate and more consistent referrals to clinics for specialist assessment. It will also support accurate coding and planning to ensure equity of access.

7. Details about the new enhanced services are set out at Annexes A and B.

8. Further arrangements for 2021/22 will be developed and communicated in due course, providing as much notice to practices as possible.

Yours sincerely,



Ed Waller
Director of Primary Care

NHS England and NHS Improvement

Annex A – summary of Weight Management Enhanced Service

Aims

1. Despite obesity being a recognised risk factor for the development of several long-term conditions and serious illness with COVID-19, there is evidence that the numbers of people identified by general practice as living with obesity have fallen during the pandemic. The aim of this enhanced service is therefore twofold:

    a. To support practices to develop and implement a proactive approach to the identification of patients living with obesity both within the practice and with wider system partners which is fit for purpose in a world of virtual consultations and empowers patients to actively provide and update their records with this information. For the purpose of this enhanced service obesity is defined as a BMI ≥ 30 or ≥ 27.5 for those of Black, Asian and other minority ethnic groups.

    b. To incentivise practices to engage with individual patients living with obesity on weight management and to support patients who are ready to make behavioural changes to do so through referral to appropriate weight management programmes.

Who can make these referrals?

2. All referrals to Weight Management Services must be made by suitably trained and competent GP practice or PCN healthcare professionals.

Requirements

Component 1: developing a supportive environment

Education and training

3. Practices should assure themselves that those practice and PCN staff involved in referral conversations have the necessary skills and training on conversational approaches to lifestyle and weight management. Example resources will be signposted as part of the enhanced service.

4. Protected learning time for practice staff is important and commissioners should support this as part of routine learning activity.

Development of a practice-based approach to the identification and support of people living with obesity

5. The practice should develop and implement a protocol for the identification and support of patients living with obesity which seeks to:
    a. normalise conversations about weight and weight management in all consultations, not just those for long-term condition management;

    b. recognise that these conversations need to be handled sensitively, using shared decision making principles, to understand if a patient would want to be referred;

    c. ensure that all opportunities for the identification of people living with obesity are maximised including how this can be achieved during telephone, virtual and face to face consultations;

    d. empower patients to provide the practice with information on their weight, BMI and other self-reportable health information;

    e. ensure that, where a patient has a BMI recorded in their record that indicates they are living with obesity, an updated BMI is recorded annually;

    f. detail available weight management services and how to refer to them;

    g. utilise healthy weight coaches to identify and support patients as appropriate.

Review and maintenance of the obesity register

6. Commitment to restore the practice obesity register to, at a minimum, pre-pandemic levels of recording.

Component 2: patient support and referral

7. For individual patients recorded on the QOF obesity register as of 31 March 2021 and those identified as living with obesity during the service period the practice should make an individual assessment of patient readiness to engage with weight management services and record the outcome of this assessment in the patient record. This should include ensuring a recent (within 12 months) BMI is recorded (unless clinically inappropriate to do so) and an offer of a referral to an appropriate weight management or specialist service. This individual assessment of willingness to engage with weight management services is an integral part of the referral process; there is no minimum volume requirement for these assessments.

8. All patients identified as being ready and able to engage with weight management services should be referred to the most clinically appropriate service, recognising that some of these patients may have additional risk factors

making them eligible for more specialist services e.g. non-diabetic hyperglycaemia, diabetes or hypertension. Acceptable referrals will include:

a. NHS Digital Weight Management services for those with hypertension and/or diabetes. This should be the default option for this cohort of patients. This service will come on stream in July 2021, and has capacity for up 270,000 patients in the current financial year;

b. Local Authority funded tier 2 weight management services. Self referrals continue to be available for patients to these services, though these self referrals will not attract the referral payment for practices;

c. NHS Diabetes Prevention Programme for those with non-diabetic hyperglycaemia;

d. Tier 3 and Tier 4 services.

9. None of the above activity needs to be undertaken as part of a discrete or standalone consultation. Practices may, and in many cases will, carry out the assessment of readiness and the referral itself opportunistically, as part of a broader consultation or patient contact. Many of the patients that practices will wish to refer will have co-morbidities that mean that they are already in regular contact with health care professionals in the practice.

Payment

10. Practices will be paid £11.50 per patient living with obesity who is referred to eligible weight management services.

11. Individual practice earnings under the enhanced service will be capped. Notional practice shares of the available £20m national funding will be determined based on the practice obesity register at 31 March 2020.

12. These practice-level caps on payments will be kept under review. Commissioners will be entitled to increase caps where practices have reached their payment cap, and are entitled to reduce caps for practices from 1 January 2022 if their data shows that, by 30 November (or the closest data collection date), a practice has earned less than 40% of their total payment cap. This reallocation of funding entitlements between practices will help to maximise referrals through the scheme.

13. Local commissioners may waive the capping mechanism entirely, with any excess referral payments beyond their share of the available £20m national funding to be met from existing local commissioner funding allocations.

14. Payments under the scheme will be made quarterly by commissioners, via a manual payment.

Annex B – summary of Long COVID Enhanced Service

Context

1. As per NICE/SIGN/RCGP guidance,[1] 'Long COVID' is a commonly used term to describe:

    - ongoing symptomatic COVID-19: signs and symptoms of COVID-19 from 4 to 12 weeks;
    - post-COVID-19 syndrome: signs and symptoms that develop during or after COVID-19 and continue for more than 12 weeks and are not explained by an alternative diagnosis

2. General practice plays a key role in supporting patients, both adults and children, with long term symptoms of COVID-19. This includes assessing, diagnosing, referring where necessary and longer term holistic support of patients. These are all part of the essential services provided by practices to their patients. Further details on the clinical pathway and the role of general practice can be found in the NICE guidance and national commissioning guidance: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/11/C1248-national-guidance-post-covid-syndrome-assessment-clinics-v2.pdf

3. This is a new and complex condition and will require professional education, consistent coding of patients, planning of practice clinical pathways to assess and support patients as appropriate and consideration of measures to reduce the risk of inequity of access to support. Therefore, we will offer a one year Enhanced Service until 31 March 2022 to all GP practices to support this.

Requirements

Professional education

4. Practice staff are required to have the knowledge, as appropriate to their role, to identify, assess, refer and support patients with Long COVID. This includes:

    a. Education about the condition: This is a new condition and ongoing education will be required as learning evolves. Depending on the identified learning needs, this may involve:
        i. Learning at different levels of expertise within the team;

[1] NICE/SIGN/RCGP guidance: https://www.nice.org.uk/guidance/ng188

ii. Learning tailored to the needs of different professionals in the team (for example, the role of the GP is likely to differ from the role of the social prescriber or health and wellbeing coach);
iii. Sharing of learning with system partners (such as between specialist clinics and primary care);
iv. Sharing of learning on national online platforms (such as the Long COVID network on the FutureNHS platform)

Useful educational materials will be published as part of the enhanced service.

b. Knowledge of local pathways: Understanding local clinical pathways will be required to enable signposting or referring into appropriate pathways. This includes:
    i. Your COVID Recovery website;
    ii. Post COVID Assessment Clinics;
    iii. Other local rehabilitation or support services

Coding

5. Coding within the clinical record is required to support the development of consistent and accurate data.

6. Coding includes the following elements:

    a. SNOMED codes:
        i. Diagnosis codes:
        1. *Ongoing symptomatic COVID-19* (4-12 weeks after infection)
        2. *Post-COVID-19 syndrome* (12 weeks plus)

        ii. Signposting and referral codes
        3. *Signposting to Your COVID Recovery*: when signposting patients to the publicly available Your COVID Recovery website (phase 1)
        4. *Referral to post-COVID assessment clinic*

        iii. Resolution code:
        5. *Post-COVID-19 syndrome resolved*: to be used at the patient and clinician discretion when all symptoms are fully resolved and there is no evidence of persisting organ impairment or if an alternative diagnosis has been made to account for all symptoms

    b. Coding of key clinical information in letters from post-COVID assessment clinics or other specialist services

Measures to reduce inequity of access

7. Practices are required to consider how to reduce potential inequity of access to Long COVID services. This may include using existing infrastructure, such as working with the practice Patient Participation Group (PPG) and system partners to help raise awareness of support (such as Your COVID Recovery website) and to understand any potential barriers to support.

Assurance

8. General practices participating in the enhanced service will be required to undertake a self-assessment and submit a declaration confirming the following is in place:

    a. Workforce training on how to identify, assess and manage Long COVID; this learning may differ depending on the role and learning need of each professional

    b. Development of own practice/primary care network clinical pathway to enable supported self-management; this might include referral to a social prescriber or health and wellbeing coach

    c. Knowledge of local clinical pathways including how to signpost to support or refer to a specialist clinic where necessary

    d. Comprehensive data coding for Long COVID from the start date of the enhanced service (but retrospective coding opportunistically where practical)

    e. Equity of access plan, working with system partners, to help raise awareness of support and to understand potential barriers

Payment

9. Up to £30m is available nationally for the Long COVID Enhanced Service, with practice payment based on registered list sizes as at 1 January 2021, unless a later date has been agreed with the commissioner. Practices will be entitlement to 75% of their total entitlement upon sign up to the service, payable monthly; the remaining 25% will be paid upon commissioner confirmation that the declaration set out above has been completed by 31 March 2022.