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An electronic copy of this letter, and all other relevant guidance from NHS England and NHS Improvement can be found here:
https://www.england.nhs.uk/coronavirus/primary-care/.

Dear GPs and their commissioners,

UPDATE TO GP CONTRACTS

1. We continue to be very grateful for the care you are delivering to your patients as the Covid-19 pandemic continues. This letter confirms contractual arrangements and income protection arrangements.

2. Over the coming weeks, we expect the level of demand on general practice to continue to grow, reflecting your critical role in the NHS in keeping the population well.

3. We need general practice to continue its vital role in supporting high-risk patients with ongoing care needs, including those who have been in the 'shielding' cohort, those who may need to shield in future, care home residents, as well as the increasing need for Covid-19 aftercare and support. But we also need practices to resume as soon as possible services which may have been paused, managing pre-existing conditions and urgent demand.

4. To support general practice to deliver this, we are:
    - Continuing to support an expansion of the workforce
    - Focussing in on cutting bureaucracy
    - Refocusing QOF
    - Making more funding available – a separate letter will be shared shortly on the Covid Support Fund for general practice

5. Practices have made great progress over the past few months in delivering remote total triage and online consultations – and we want to encourage this to continue. All practices must now also deliver face to face care, where clinically appropriate. It should be clear to patients that all practice premises are open to provide care, with adjustments to the mode of delivery. No practice should be communicating to patients that their premises are closed. Nor should they be redirecting patients to other parts of the system, except where clinically assessed as appropriate.

6. Our success as a health system will rest not only on our management of patients with Covid-19, but also how we maintain wider healthcare provision. Recent reports by PHE show that the virus itself has had a disproportionate effect on certain sections of the population - including older people, men, people living in deprived areas, people from Black, Asian and Minority Ethnic (BAME) groups, those who are obese and who have other long term health conditions mirroring and reinforcing existing health inequalities. We therefore need to ensure that patients are able to access comprehensive primary care. Further, the long-term economic impact of the pandemic may exacerbate health inequalities among these and other population groups. For these reasons, there is an urgent need to prioritise key aspects of primary care not directly related to Covid-19 itself. We are asking that practices and networks do this in a way which is both proactive and sensitive to the range of needs in each practice population.

7. The best way to successfully manage the combined demands of on-going care for patients with, or at risk, of Covid-19 and non Covid-19 services will be by sustaining many of the transformations in ways of working adopted during the height of the pandemic. This includes local system working; strong clinical leadership; a continuation of total triage; a continuation of hot hubs where these have been established and make sense in a longer term offer; flexible and remote working where possible; and rapid scaling of technology-enabled service delivery options.

8. Digital consultation should be offered as standard unless there are good clinical reasons otherwise.

Expanding the workforce

9. Expanding the workforce is a top priority for PCNs this year. It is critical to relieving the workforce pressures felt by many in general practice, enabling primary care to be sustainable into the future.

10. Over 98% of practices are now signed up as members of a PCN, with access to up to £430m of investment that will be made available in primary care where PCNs employ new staff across 10 workforce roles (with at least a further two roles to follow in 2021/22). The DES reimburses 100% of actual salary costs plus employer on-costs (up to the maximum levels set out in the scheme), thereby significantly reducing the financial investment being asked of practices and PCNs from their core funding. We urge all PCNs to take immediate steps to plan to expand capacity now, by using this funding rather than it being lost to primary care in 2020/21. Support for staff recruitment and deployment is available from CCGs and other community services partners; the PCN development funding for 2020/21 will enable support for staff induction and retention.

11. PCNs concerned about employment liabilities should be assured that NHSE/I is committed to the continued funding of these roles. Additionally, if all the practices

in a PCN were to withdraw from the DES in future, commissioners would seek to support the transfer of relevant staff from the outgoing practices to the new provider of network services as part of the appointment process, unless there were exceptional circumstances not to do so.

12. We are committed to increasing the number of GPs. We are asking systems, working with training hubs, to implement GP recruitment and retention initiatives in their area. Guidance will be published on each of the initiatives through the summer. The New to Partnership Payment has recently been launched. Systems should deploy PCN development funding, which will be provided in August, in line with guidance to support their PCNs.

Cutting bureaucracy

13. We are reviewing bureaucratic burdens in general practice in order to free up valuable time for patient care – a new Bureaucracy Review is being jointly led by DHSC and NHS England and NHS Improvement, involving the GPC and RCGP. We will engage with GPs and practice staff to inform the approach taken and to shape the outcome.

14. A priority area for action is to re-purpose the appraisals process in the context of the pandemic. We are working with partner organisations to redesign the current process. We intend to take a flexible approach to its re-introduction and accommodate doctors who are prepared for appraisal, perhaps prior to their revalidation date, and want to press ahead. We want to anchor the new approach around professional development and support, focusing on well-being as well as minimise the supporting information requirements. We do not plan to require doctors to use different documentation for their appraisal, many will have a lot information already recorded in various on-line platforms, though we would be keen to signal flexibility in what is required this year.

15. Whilst this work is underway, we continue to recommend that appraisals are suspended, unless there are exceptional circumstances agreed by both the appraisee and appraiser. The GMC has also announced that doctors who were due to revalidate between 17 March 2020 and 16 March 2021 have had their revalidation submission dates moved back by one year. Read more here.

Quality and Outcomes Framework

16. We recognise that practices will need to reprioritise aspects of care not related to Covid-19 and we intend to modify the QOF requirements for 2020/21 to support this.

17. In 2020/21, we are proposing that practices will be:

- Asked to gear up for a major expansion of the winter flu programme. We are discussing this with the GPC and further information will follow in the coming weeks;
- Asked to focus on early cancer diagnosis and care of people with a learning disability in the quality improvement domain but that the requirements will be recast to focus upon restoring care delivery in these two key areas. Payment of this domain will be conditional on practices working to these revised requirements. We are still working through the detail of this with GPC England and will publish full details shortly;
- Asked to maintain accurate disease registers, prescribing indicators and the delivery of cervical screening indicators, where we expect the rate of delivery to be as close as possible to normal performance. We acknowledge that practices will have to make extra efforts to encourage patients to attend;
- Offered income protection on other indicators, subject to the delivery of revised and simplified requirements focused upon care delivery to those patients at greatest risk of harm from Covid-19, uncontrolled long term condition parameters and those with a history of missing reviews. These are being discussed with GPC and published shortly. Practices will need to agree their approach to patient prioritisation and service delivery with their CCG.

18. By guaranteeing financial support and temporarily reducing the current QOF requirements, we are releasing capacity in general practice to focus on COVID recovery – and support those patients most in need of long-term condition management support.

19. Absent to national agreement to the contrary, QOF will be reintroduced fully from April 2021.

Investment and Impact Fund

20. The Investment and Impact Fund will commence from 1 October 2020. The first six months of IIF monies have been recycled into the Network Contract DES as a PCN support payment without conditions attached. The remaining monies will be used to reward PCNs for performance in relation to the IIF indicators set out in the GP contract deal 2020/21 over the second half of the financial year – with the detail subject to further discussions with GPC England.

Dispensary Services Quality Scheme (DSQS) – for dispensing practices only

21. The Dispensary Services Quality Scheme will be reinstated from the 1 August 2020. We are talking to GPC about the details and further information will follow. Practices intending to participate in the scheme should provide a written undertaking to their commissioner in line with Section 24.4 of the Statement of Financial Entitlements.

GP contractual position

22. On 14 April, we wrote to practices setting out activities that could be deprioritised if necessary to free up capacity[1]. This was enabled using the powers granted by the National Health Service (Amendments Relating to the Provision of Primary Care Services During a Pandemic etc.) Regulations 2020.

23. From 1 July 2020 practices should resume the following services if these have been deprioritised:
    - *New patient reviews (including alcohol dependency)*
    - *Routine medication reviews*
    - *Over-75 health checks*
    - *Clinical reviews of frailty*

24. We recognise that practices will likely have a backlog of reviews and checks to undertake and they will need to sequence these using their clinical judgement and a risk-based approach. Healthcare professionals should discuss with the patient, their carer or their advocate the most suitable and safe way to conduct reviews and checks. Where they can be delivered safely on a face to face basis this should be offered. Where this care cannot be delivered safely face to face or where the patient has other medical conditions which still require them to shield or socially isolate the review could be conducted remotely, with as much of the physical review completed as is practicable in these circumstances - or in exceptional cases by home visit.

25. PHE colleagues have also recommended that the routine call for shingles vaccination programme is re-instated from 1 July 2020. Some individuals who were eligible for the Shingles (catch-up) vaccination programme may have turned 80 years during the COVID-19 pandemic. PHE advises that, if someone who has previously not been vaccinated for shingles and has turned 80 years since 1 February 2020, they could still benefit from the vaccine and should be offered this on an opportunistic basis (unless contraindicated) between now and 31 December 2020. Payment for this should be at the same rate as other shingles vaccines and will be managed by local commissioners.

26. From 1 July the requirement for practices to engage with and review feedback from Patient Participation Groups (PPG) is also reinstated as it is important that practices continue to engage patients and citizens in the development and transformation of services over the rest of the year. It is particularly important that practices engage with their PPGs to help understand and shape the changes in access to services to ensure that no one is inadvertently excluded. We encourage practices to conduct PPGs remotely.

[1] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0264-GP-preparedness-letter-14-April-2020.pdf

27. We will keep the situation under review and may reinstate some flexibilities under the GP Contract nationally using the powers of the Pandemic Regs, if necessary to help manage subsequent outbreaks. See below.

28. The following provisions will continue under the National Health Service (Amendments Relating to the Provision of Primary Care Services During a Pandemic etc.) Regulations 2020 **until 30 September 2020** for GP practices in England at the earliest:

- ***A suspension of the requirement that practices report to commissioners about the Friends and Family Test returns;***

- ***A temporary suspension of the requirement for individual patient consent in certain circumstances, in order to encourage increased use of electronic repeat dispensing (eRD)***[2]***.*** Use of eRD has many benefits for patients, practices and wider systems and this temporary provision aims to make it easier for practices to transfer patients to e-RD in defined circumstances, where this is clinically appropriate.

- ***A continuation of the temporary increase in the minimum number of appointment slots that practices must make available for direct booking by 111 to a minimum of 1 slot per 500 patients***. This is because they remain necessary to support phase 2 of the NHS response, in particular the important role NHS 111 is playing in reducing the face-to-face transmission risk for patients and NHS staff. Under this model, the slots, which will be booked following clinical triage, are not appointments in a traditional sense; instead practices should clinically assess the patients remotely and arrange their ongoing management. This ensures that only those who need further care (in-person or via telephone / video consultation) are presenting to services, and they are managed as appropriate for their clinical condition.

Flexibilities to respond to local outbreaks

29. Local commissioners may be able to offer some flexibilities in a specific location if local general practices services are compromised as a result of a new local Covid 19 outbreak. For example, this could be because:
    - The impact on an individual practice triggers an adverse incident;
    - There are high sickness absence levels across practices in an area which means demand cannot be fully met;

30. In these extreme circumstances where services are compromised CCGs may agree changes to planned services as follows:

    a) Business continuity and practice resilience measures

[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0546-electronic-repeat-dispensing-letter-4-june-2020.pdf

- The local commissioner should engage with the practice to understand the pressures identified by the practice, and consider solutions.
- Practices to enact business continuity plans. It may be necessary to enter into temporary buddying arrangements with other providers.
- The impact of the outbreak will need to be monitored through daily situation reporting.

b) Locally managed suspension of activities

- In extreme circumstances, CCGs may need to coordinate a suspension of activities across practices in local outbreak areas. This could include, in addition:
    - submitting a request to NHSE/I to suspend the following GP contract requirements:
        - New patient reviews (including alcohol dependency)
        - Routine medical reviews
        - Over 75 health checks
        - Clinical reviews of frailty
        - Engagement with and review of Patient Participation Groups
        - As well as a suspension of LESs/LISs

  If approved, NHSE/I will write to the practices concerned to notify them of the new contractual arrangements in place. Further details on the process will be communicated to CCGs and regions soon.

31. Other than in exceptional cases where support and financial assistance (Section 96) may be appropriate (e.g. adverse incident), CCGs would need to apply to the national NHSE/I GP contracts team, via the NHSE/I regional team, to request income protection on any schemes e.g., QOF, Childhood Immunisation DES etc.

LESs/LISs and local pilots

32. We encourage local commissioners to reintroduce local enhanced services, local incentive schemes and local pilots as part of their wider plans to step up routine and non-urgent services. Local audit and local assurance activities that support the delivery of high quality services should also be reintroduced as soon as practicable.

33. Commissioners are asked to consider which local data collections are essential to re-introduce and how they can minimise administrative demands on general practice.

Further updates

Complaints

34. Practices are asked to resume normal complaints management activities from 1 July 2020.

List accuracy and updating

35. Primary Care Support England (PCSE) will resume routine list reconciliation and data quality checks from June 2020. Some practices have undertaken list cleansing activities during the pandemic and we ask that practices continue to ensure their lists are accurate and up-to-date in the interests of patient safety and clinical care. This is particularly important to support the transition of the GP payment system from NHAIS to PCSE online later this year. Dispensing practices are also asked to resume dispensing list cleansing activities from 1 July 2020.

Covid-19 PCR Swab Testing

36. We are advised by NHS Test and Trace that test results from national COVID-19 PCR swab testing will soon be sent to GP systems and appear in patients' records as laboratory test results. Results from tests undertaken in the past will also be sent to GP systems, whenever they are able to identify the patient's NHS number. Patients will have received the results by text and email together with guidance and advice, so there will be no action necessary from GP practices on receipt of these results. There will also be no requirement to communicate these results to Public Health England, as communication to PHE should have already taken place by NHS Test and Trace.

Funding

37. Annex A sets out further details of income protection arrangements for general practice in 2020/21. Given our commitments to maintain GP practice income during the outbreak, we want to remind practices that GP practice staff who are shielding because they are at highest clinical risk from Covid-19 or have completed a risk assessment and been advised not to deliver face to face care, should continue to receive full pay. They should also be encouraged and supported to work remotely while they are doing so, in light of the home working solutions we are facilitating.

38. In conjunction with the Department of Health and Social Care, further details will be issued soon on the Covid Support Fund for general practice to assist with the legitimate additional costs of the response, borne by practices.

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Annex A: Income protection arrangements for general practice

39. The income protection arrangements seek to ensure that practices do not lose significant income as a result of the outbreak, supporting the deployment of general practice staff to activities of the highest clinical priority.

40. The income protection arrangements described below apply to GMS, PMS and APMS contractors with a registered list.

41. All payments made under the income protection arrangements will be made to GP practices under Section 96 of the NHS Act 2006 (as amended) "Assistance and support: Primary Medical Services". GP practices will receive the payments via the usual mechanisms. Local commissioners may be required to request manual adjustments to payment systems to implement the arrangements set out in this letter.

42. These arrangements apply to practices that continue to deliver services. Income protection arrangements are intended to support all practices, including those who were redeploying core practice staff to work in "hot sites" etc. Income protection arrangements are provided on the basis that practices will co-operate with their local CCGs and deliver care to their local patients, with due regard to guidance issued by NHS England and NHS Improvement.

43. Income protection arrangements are intended to support practices with fixed practice costs including staffing costs. As such GP practices must not also use the Government's Coronavirus Job Retention Scheme to claim for the pay of publicly funded staff, including those who are shielding. In exceptional circumstances where practices find that practice staff cannot be fully utilised in their normal place of work, consideration should be given to whether they could be temporarily redeployed to support the Covid-19 response in another part of the NHS.

44. The income protection arrangement is not a new or additional source of funding. CCGs must be assured that support provided under these income protection arrangements to a practice is appropriate.

45. In recognition of the impact of Covid-19 on practice activity, income protection will be offered in relation to the following in 2020/21 up until 30 June 2020 unless otherwise indicated:

Core practice contract

- **Global sum** will continue to be paid at the agreed rates for the whole of 2020/21.
- **QOF:** we will share further details soon on arrangements for QOF in 2020/21, further to the advice in this letter.

- **Dispensary Services Quality Scheme (DSQS)**: Local commissioners must continue to make the same monthly payments for DSQS from 1 April 2020 until 31 July 2020. The DSQS will be re-introduced from 1 August 2020. We are talking to GPC about the details and further information will follow.

Directed Enhanced Services

- **Network Contract DES:** The Network Participation Payment will continue to be paid to individual practices that have signed up to the DES and meet the requirements set out in the Statement of Financial Entitlements (SFE). The Clinical Director funding will also continue to be paid. Practices will be able to continue to seek reimbursement for any Additional Roles Reimbursement Scheme roles recruited to on the basis of the current Scheme rules, and can undertake further recruitment in line with the Scheme. A workforce planning template to support this process is available as part of contract documentation.

- **Investment and Impact Fund (IIF) has been deferred until 1 October 2020.** The first six months of IIF monies (£16.25m) have been recycled into the Network Contract DES as a PCN support payment, worth £0.27 per weighted patient. This supports further work by PCNs and their Clinical Directors on the pandemic.

- **Minor Surgery DES:** Local commissioners should make the same monthly payments to practices for the Minor Surgery DES in line with the previous year's achievements – from 1 April 2020 up until 30 June 2020.

- **Violent Patients Scheme DES:** Local commissioners should make the same monthly payments to practices for the Violent Patients Scheme DES in line with the previous year's achievements – from 1 April 2020 up until 30 June 2020.

- **Childhood Immunisation Scheme DES:** Local commissioners may offer income protection to practices for Q4 of 2019/20 and Q1 of 2020/21 only. To be eligible for income protection practices will need to demonstrate that they have submitted data through Open Exeter by the required dates, that their planned performance had been negatively impacted by Covid-19 related activities and that this had a material impact upon payment i.e. it resulted in them dropping a payment bracket.

Local enhanced services

- **Enhanced Services/Local Incentive Schemes in Q1 of 2020/21:** Recognising the importance of this local funding, it should be maintained where services were being fully delivered. Where services were unavoidably impacted by COVID, commissioners will set a fair payment arrangement.

Temporary closure of services as a result of Covid-19

46. Income will also be protected for those few practices who were forced to close to patients because their services and staff were consolidated onto another site, to work as part of another practice team, in order to provide a full service.

47. Practices must secure prior permission from the commissioner to temporarily close in these circumstances and any practice staff still able to work must be offered to other practice sites, and must do so to maximise clinical capacity.

48. We recognise that in exceptional circumstances some practices e.g., single handed practices may have had to close temporarily if their GPs or most practice staff were unable to work through illness. Where it has not been possible to identify alternative staffing arrangements for these practices and it has been agreed by the local commissioner those practices should temporarily close, income protection should be provided, as long as all available staff are actually redeployed to another NHS role over that period.

49. As closures should be very short term, commissioners should normally look at what the practice was paid in total in the month prior to closure and pay the same pro rata. Where the previous month's funding was not typical, commissioners should look at funding levels for the previous three months and consider applying an average. Practices may continue to claim reimbursement of premises costs via the Premises Costs Directions.