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Primary Care Networks: Frequently Asked Questions

Updated July 2019

PCN set up and structures

1. **Are PCNs statutory bodies, will they be able to hold other contracts?**
   No, a primary care network is not a statutory body. They consist of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. Members of a PCN may in due course wish to form a legal entity (perhaps a limited company or a limited liability partnership) through which they may (if commissioned to do so) jointly provide healthcare services beyond core primary medical services.

   Commissioners can contract for other services either from PCN member practices (i.e. through a LIS) or from the PCN direct **but only** if they are formed as a legal entity. The award by commissioners of any contract to a member of a PCN, or to a legal entity created by PCN members, will be subject to those commissioners' duties under procurement law.

2. **Can a PCN clinical director also cover a CCG role?**
   The two roles have distinct remits and responsibilities but there is nothing within the Network Contract DES preventing a single person holding both roles. Section 4.4.2 of the Network Contract DES Specification sets out the requirements linked to the Clinical Director. Within this section, paragraph 4.4.2.d sets out the key role responsibilities. Existing principles in the conflict of interest guidance on the NHS England website would apply to primary care networks and the employment of clinical directors as it would do to any other CCG post.

3. **Could PCNs be asked to pool their budget with ICSs?**
   There is no requirement for PCNs to pool their budgets. Locally, networks and commissioners may wish to consider how they work collaboratively to deliver services within the ICSs overall strategic aims.

4. **Will existing primary care homes (PCHs) need to adjust to meet the new PCN contract requirements?**
   Primary Care Home is one model for working as a PCN that has been adopted in a number of areas. Alongside others, PCH sites have played a role in informing national PCN policy. Existing PCH sites can continue with their current approach, providing it is consistent with the requirements set out in the Network Contract DES (in order to receive the associated funding) and local CCG/STP/ICS primary care strategies. It may be that some other PCNs forming across the country decide to use the PCH model to support them as they develop; others will adopt different approaches.

5. **Will Primary Care Homes (PCH) need to appoint a clinical director?**
   Existing PCH sites can continue with their current approach, providing it is consistent with the Network Contract DES and local CCG/STP/ICS primary care strategies. For contracting purposes, practices within a PCH model will need to meet the requirements of the Network Contract DES to draw down the available PCN resources. This includes having a clinical director.

PCN development programme

6. **When will the development offer and budgets come out to networks?**
   Based on feedback from the engagement events, a decision has been made not to procure a national development offer. This recognises that 'one size' does not fit all given PCNs are at different stages of maturity and enables local flexibility. Instead, it has been agreed to co-develop a PCN development support prospectus with systems, PCNs and stakeholders that sets out a consensus view and description of 'good' development support. The prospectus will therefore set out an agreed consistent view for regional and local teams to use and build upon to ensure any support put in place meets local needs.

   Development support funding is expected to flow through ICS/STPs. Regions will want to work with their systems and PCNs to agree the most effective way to ensure PCNs can easily access good development support.

   Seven modules of support are described in the draft prospectus:

   Module 1: PCN set-up
   Module 2: Organisational development support
   Module 3: Change management quality and culture
   Module 4: Leadership development
   Module 5: Collaborative working (MDTs)
   Module 6: Asset based community development and social prescribing
   Module 7: Population health management

   Additionally, it has been agreed to co-develop a support offer specifically aimed at Clinical Directors which sets out a description of 'good' development support for this particular cohort.

   The PCN development support prospectus will be issued to regions in July 2019 to inform local specification development.

GP Contract

7. **My understanding is that in 2019/20 each PCN is entitled to claim for 1 WTE clinical pharmacist and 1 WTE social prescribing link worker. Please can you explain what the funding changes will be in 2020/21?**

See reply to question 8.

8. **What will the funding changes be in 2020/21 under the Additional Roles Reimbursement Sum?**
   As outlined in the Network Contract DES guidance (section 4.3 page 8) the Additional Roles Reimbursement Scheme in 2019/20 will be an introductory year and transition to a weighted capitated sum from April 2020.

   From April 2020/21, each PCN will be allocated a single combined maximum sum under the Additional Roles Reimbursement Scheme. This sum will be calculated on a weighted capitation basis PCNs will be able to claim up to this maximum sum each year, in line with the rules set out in the Network Contract DES Specification.

9. **Will smaller primary care networks taking on a full-time clinical pharmacist and social prescriber in 2019/20 have sufficient funding to cover the posts going forwards.**
   From April 2020/21 each PCN will be allocated an Additional Roles Reimbursement Sum based on the PCNs weighted population. This sum will grow year on year.
10. **A number of PCN areas based on practice boundaries are likely to overlap and cross into other CCG boundaries, is this ok?**
    Information has been included in the updated Network Contract DES guidance regarding PCNs that cross CCG boundaries. Please refer to section 7.2 on page 25.

    7.2 PCNs that span two CCGs

    Typically, PCNs will not cross CCG boundaries. However, there may be circumstances where this occurs, and commissioners will be required to agree locally if this is appropriate.

    The GP practice members of the PCN will have their individual contracts varied to include the Network Contract DES by their respective commissioners. Commissioners will also need to agree the appropriate proportion of Network Contract DES funding relating to their respective registered populations to be paid to the PCN's nominated payee and work collaboratively, as required, to monitor delivery of the Network Contract DES requirements.

11. **If practices set up a separate bank account for their PCN, is this subject to VAT as it is a non-clinical service?**
    NHS England has published a VAT information note which can be found here.

12. **Is the PCN payment based on weighted population figures? For a university practice with a fluctuating patient list this could impact dramatically.**

All PCN payments are based on registered population, other than the Network Participation Payment which is based on weighted population. Please see the table below for further clarity.

	Payment	Weighted or actual?
1. Core PCN funding	£1.50 per registered patient per year (equating to £0.125 per patient per month)	Per actual registered patients as at 1 January immediately preceding the financial year (i.e. 1 January 2019 for 2019/20).
2. Clinical Director contribution	£0.514 per registered patient to cover July 2019 to March 2020 (equating to £0.057 per patient per month)	Per actual registered patients as at 1 January immediately preceding the financial year (i.e. 1 January 2019 for 2019/20).
3. Staff reimbursements	Actual salary plus employer on-costs up to the maximum amounts as set out in the Network Contract DES Specification, paid from July 2019 following employment	From April 2020/21, each PCN will be allocated a single combined maximum sum under the Additional Roles Reimbursement Scheme. This sum will be calculated on a weighted capitation basis (to be confirmed during 2019).
4. Extended hours access	£1.099 per registered patient to cover period July 2019 to March 2020 (i.e. equating to £0.122 per patient per month)	Per actual registered patients as at 1 January immediately preceding the financial year (i.e. 1 January 2019 for 2019/20).
Network Participation Payment (practice-level payment)	Monthly - £0.147 multiplied by number of the Contractor Weighted Population	Per weighted contractor population taken as at quarter 4 immediately preceding the financial year (i.e. at 1 January in the preceding financial year).

13. **Where it makes sense geographically, can a single practice with a branch surgery be split across two PCNs? For example, a practice in a single core location but also has branch surgeries that fit better geographically in a different PCN?**
Information has been included in the updated Network Contract DES guidance regarding practices that cross CCG boundaries. Please refer to section 7.1 on pages 24 and 25.

14. **For 2019/20 the Network Contract DES allows for flexibility to substitute between the social prescribing link worker and clinical pharmacist roles with agreement from the commissioner. Is there any flexibility to substitute for any of the other roles in 2019/20?**

In 2019/20, the only flexibility is to substitute between clinical pharmacists and social prescribing link workers. From 2020/21, PCNs have the flexibility to use their Additional Roles Reimbursement Sum for clinical pharmacists, social prescribing link workers, physician associates and physiotherapists. Paramedics will be introduced in 2021/22.

15. **The Network Contract DES includes requirements around the supervision for clinical pharmacists. What happens if a PCN does not have a senior clinical pharmacist to provide supervision to a clinical pharmacist and will there be funding to cover this?**
The clinical supervision does not need to be from someone who is a Clinical Pharmacist in the same network, it can be within a wider professional network that the clinical pharmacist has connections with, including acute and community service pharmacists. PCNs will need to meet any costs from within the overall funding provided as part of the Network Contract DES.

16. **When will the workforce survey be made available?**
The workforce survey was shared with regional leads on 7 June 2019.

17. **The Data Protection Officer (DPO) role is required to be offered out to practices and CCGs but we are not clear on where the funding will come from for that role.**
See section 3.10 on page 18 of the GMS Guidance - CCGs are expected to fund this from their general allocation.

18. **Do the extended hours access appointments in the Network Contact DES need to be provided face-to-face or can access be provided over the phone or virtually?**
The extended hours requirement is to offer a reasonable mix of face to face appointments and other modes of access (e.g. telephone, video or online consultations. As such, PCNs member practices cannot solely offer telephone or virtual extended hours appointments and would need to provide a number of face to face extended hours appointments as well.

19. **What is happening to the Extended Hours DES between April and July prior to being transferred into the Network Contract DES?**
The current Extended Hours DES remains unchanged until the end of June at individual practice level. The normal commissioning process for this should be followed for the first quarter.

20. **If practices currently close half a day, to be part of the PCN would they need a practice to cover the full core hours or potentially sub contract the hours that they currently close?**
Yes, that is correct. The extended hours requirements in the Network Contract DES are clear that PCN member practices should not close for half a day on a weekly basis unless they have prior written approval from the commissioner.

21. **What should a CCG do if they have an existing long-term (3-5 year contract) in place to deliver wider extended access? Will it have to cease**

the contract in the next two years as the service becomes a PCN responsibility?
Many CCGs will have entered into multi-year contracts with providers to deliver wider extended access services. These will typically be APMS contracts with break clauses and it will be for the CCG, working with the chosen provider and the PCN to look at the best time to cease current arrangements and move to this becoming a PCN responsibility. A PCN could deliver the extended access service itself or sub contract to another provider.

The review of access will be undertaken this year and ready for implementation from April 2020 onwards.

22. **What should a CCG do if it has only a short-term contract with a provider to deliver extended access services?**
NHS England and NHS Improvement will be undertaking a review of extended access services this year. In the interim, it would make sense to only contract at £6 per head (or less) for the duration of the 2019/20 financial year, so as not to pre-empt the outcomes of the review.

CQC compliance

23. **What does CQC regulate?**
Legal entities that provide 'regulated activities' are required to register with CQC, and are responsible in law for the quality of care (the legislation uses the term 'carrying on' - 'carrying on' means to have ongoing direction and control of the regulated activity).
Regulated activities are defined in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and are also explained in the CQC publication: 'The Scope of registration'.
CQC registers providers in respect of the 'regulated activities' they provide, It does not register them to operate particular 'services' or to provide services to particular groups or lists of patients. It imposes a condition on their registration, restricting providers to carrying on regulated activities at or from specified places, which it calls 'locations'. You can find further guidance about locations on our website at www.cqc.org.uk/locations.

24. **Will PCNs need to register with the CQC and do practices need to modify their current registration when they become a part of a PCN?**
It is important to remember that only legal entities can register with CQC. If a provider collaborative, such as a PCN, is not a legal entity then it cannot carry on regulated activities and therefore it cannot be registered with CQC.

As such, in a situation where a PCN is not a legal entity, and the constituent providers are already registered with CQC for the regulated activities they will provide as part of the network (which will also include extended access services), they will not need to register again or separately in respect of being a constituent member of a PCN. However, it is advised that providers amend

their 'statements of purpose' to accurately reflect the additional role(s) in service delivery they will assume as a participant member of a PCN.

However, in a situation where a new or currently unregistered provider organisation is to be formed and that organisation will have ongoing direction and control of any regulated activity as a part of a PCN, then this provider organisation would be required, as a legal entity, to register with CQC. New applications for registration can take up to 10 weeks to complete from when CQC accept the application to when CQC issue a notice of their decision to register or a proposal to refuse. The timeframe will depend on the complexity of the application, the level of assessment and scrutiny required, and the availability of key information requested by the registration inspector.

25. How should providers within a PCN arrange themselves to ensure appropriate accountability?

Where PCNs have organised themselves so that one of the constituent parties (who is already registered) becomes responsible for all of the regulated activity provided by the network on behalf of all of the network's organisations, then no new application is required if that party is already registered to provide regulated activity(ies) at this location.

If all of the participating parties in the PCN provide regulated activities on behalf of the network, then any of those parties who are not already registered will need to apply for registration. If they are only going to be providing regulated activity to patients from their own patient list, then they will normally only need to list one location as part of their registration (any other places where they see their patients will be regarded as 'satellites' or 'branches' of their location). However, if they provide regulated activity to patients from the list of any of the network's other members then, because of the way that locations are currently defined, they may need to add all of those practices as locations.

To avoid this, and to ensure there is clarity about accountability, PCNs that have not formed a legal entity should always ensure that their network agreements clearly reflect who is responsible for the regulated activity being provided on behalf of the network.

PCNs could consider the following options to clarify accountability:

Option A – ('patient led') The constituent providers enter into a written agreement between themselves, which states that whenever care is provided under the network agreement, this care will be delivered under the direction and control of the practice from whose list the patient comes. Under this arrangement, the patient's regular practice is ALWAYS responsible for the regulated activity provided – no matter who sees the patient or in which premises they are seen. In this case, none of the PCN participants would need to add any locations to their registration, because each provider would only ever be responsible for the regulated activity delivered to their own patients. The participants would use each other's locations as satellites or

branches of their own location – they'd simply need to list them in their statements of purpose.

Option B: ('premises led option') The constituent providers enter into a written agreement which states that it is always the provider in whose premises the patients are seen, who is responsible for the regulated activity delivered there.

Providing that the PCN only delivered regulated activities in the premises of its constituent members, then as with Option A, none of the members would need to add any locations to their registration.

CQC has no preference about how PCNs should make their contracting / operational arrangements, but the identity of the party or parties, carrying on the regulated activity must be made clear. Contracts, sub-contracts and other arrangements should be explicit about this. This is so that everyone knows who has statutory responsibility under the Act and CQC can hold them to account for compliance with the requirements of registration.

Role of primary care in an Integrated Care System (ICS)

26. How are PCNs expected to operate at the different levels of an ICS? What services might be provided at neighbourhood, place and system levels?

Working alongside the ICSs we have learnt that integrated care has a common 'architecture', with primary care playing a key role across all tiers of the system:

Neighbourhood

At the neighbourhood level primary care networks will collaborate around natural geographies to improve general practice resilience, share staff and assets, and provide proactive, multidisciplinary care to populations of 30,000-50,000. This is widely recognised as the scale to integrate community-based services and to provide multidisciplinary care for people with enduring, complex health and care needs, who require close collaboration between service providers and long-term care coordination. As such, a key focus for PCNs should be on the development and implementation of network-level care models that improve access for episodic care, encourage self-care and support greater patient activation and wellbeing, as well as providing improved anticipatory care for those patient groups with rising risk profiles.

Examples of services that could be delivered at neighbourhood level:	
Extended Access	Health trainers / peer coaches
Proactive planned MDT care for complex needs, e.g. frailty	Primary Care Diagnostics

Care Navigators	Minor operations
Mental Health LTC IAPT workers	Community Paediatrics
Social Prescribing	First contact practitioners for MSK conditions
Substance Misuse	Podiatry
Urgent home visiting service	Optometrist for eye health triage
Care home outreach services	

Place

At the place level, often coterminous with district/borough councils, primary care is frequently represented by large-scale general practice organisations (e.g. Federations, super-practices). These organisations make shared operational systems possible, whilst also enabling support in areas such as training, workforce development and quality improvement. This is also the level at which primary care should seek to work with acute providers, mental health and local government to affect the development of place-based strategies and wider integrated care models. Engaging in this way with wider health and care partners will help to ensure that PCNs are embedded in the wider transformation of hospital-based services (e.g. U&EC and planned care), as well as being effectively positioned to influence and facilitate the shift towards more community-based models of care delivery.

Examples of services that could be delivered at place level:	
LTCs: - Quarterly MDT Educational Meetings (Diabetes, Respiratory) - Respiratory Specialist Outreach Support Team (Specialist GP, Consultant, Respiratory Specialist Nurse) - MSK - Advance Care Planning - Access to Crisis and Recovery Teams	**Other:** - Extended and Urgent GP Access - Direct 111 - Out of Hours - Clinical/Virtual Hubs - Ambulance non-conveyancing - Direct A&E booking - Specialist clinics - Intermediate care beds - UTC

System
At system level primary care functions are the foundation of a wider integrated care system, which works in partnership with other health and care providers to collaboratively manage population health, implement strategic change, take on added responsibility for operational and financial performance, and hold system accountability. There will be a strong focus on monitoring and evaluating PCN implementation/maturity with regional colleagues, and close working with constituent CCGs on the commissioning strategy for primary care, including design of future local business models and market development opportunities for PCNs.

Services in scope for delivery at 'System' level:
All health and social care for the population, via local providers working with commissioners.

Relationship between PCNs and primary care providers at scale

27. Is there a role for federations and primary care providers at scale in the new system?
Networks and federations are not mutually exclusive and can co-exist to deliver a broader set of integrated out of hospital services for their local communities. CCGs may commission some services from federations. Federations may also deliver some services on behalf of a PCN/several PCNs such as extended access or play a supporting role to help them deliver their responsibilities in an effective and efficient way.

Models in London have larger scale GP organisations (Federations) built into their operational model between networks and ICSs as a platform to provide the scale to develop and train a broad workforce, create shared operational systems and quality improvement approaches, support the delivery of collective back office functions, develop integrated unscheduled and elective care services for the whole population, and provide professional leadership and the "voice" for general practice in the local health economy.

28. Can a GP federation be the nominated payee to receive funding on behalf of the PCN?
Unlike the requirements over who can hold the Network Contract DES, the nominated payee does not have to hold a registered list and be delivering an essential primary medical services contract. The nominated payee must, however, hold a primary medical services contract (GMS, PMS or APMS) and be party to the Network Agreement.

An APMS provider (including a provider who holds a hybrid NHS Standard Contract that is delivering primary care services under a Schedule 2L arrangement) can therefore be a nominated payee, even if they do not hold the Network Contract DES. As such, it is possible for a GP federation holding an APMS contract for extended access or improved access (or another reason), to be nominated as the payee if all the core PCN GP practices agree.

It also means that the same GP Federation could be nominated to be the payee for more than one PCN.

From April 2020, we plan for National Health Application and Infrastructure Services (NHAIS) to be amended so that networks can nominate for automated payment any organisation that can receive funds on their behalf under the Network Contract DES, whether or not they hold a primary care contract. However, if it subsequently emerges that this is not possible, commissioners may need to continue using local manual payment arrangements to pay these nominated payees.

29. Can a PCN sub-contract elements of the network DES?

A GP practice's primary medical services contract will contain provisions expressly dealing with sub-contracting arrangements. This may include a requirement to obtain commissioner consent for any activity that is proposed to be sub-contracted. The Network Contract DES operates as a variation to a GP practice's primary medical services contract. It provides further rights (for the GP practice to receive payments) and obligations (for the GP practice to carry our specified activities). Any provisions in a GP practice's primary medical services contract will therefore apply to the sub-contracting of any Network Contract DES related activity.

30. What are the VAT issues for PCNs contracting with primary care providers at scale?

Information on the contract network DES and VAT has been published by NHS England.

31. What are the current NHS Pension access rules and how do they relate to federations?

For healthcare staff to have access to the NHS pension scheme, the employing body must qualify as an 'employing authority' under the scheme. Employing authority (EA) status to access the NHS pensions scheme can be acquired through different routes depending on organisation type:

- NHS statutory bodies have automatic status
- GP practices holding GMS / PMS contracts have automatic status
- Non-NHS statutory bodies are subject to pension rules which determine eligibility based on holding a qualifying contract i.e. APMS/ICP/NHS Standard contract

Where the PCN is planning to set up or utilise an existing limited liability vehicle, such as a GP federation, the staff employed by that body under the Network Contract DES may not be able to access the NHS pension scheme unless the body itself holds a qualifying contract (NHS Standard Contract or APMS Contract).

32. What are the potential benefits of working with primary care providers at scale?

There are a number of potential benefits, some are identified below by way of example:

- Can be effective in reducing unplanned attendances and admissions to hospital.
- Have developed good working relationships with health commissioners and create more efficient use of existing resources.
- Are experienced in delivery of services at scale across larger populations, diversifying and growing the size of the primary care workforce and testing new employment models whilst redesigning the nature and scope of primary care.
- Are ensuring greater consistency of primary care offer through at scale coordination of individual delivery units whether practices or PCNs
- Can carry the risk of employing a diverse range of staff that can be mobilised at individual practice level, neighbourhood (30-50K) or locality (150K) level.
- Can improve governance and reduce duplication allowing Practices and PCNs to focus on delivering outcomes not developing form.
- Are already directly contributing to the successful implementation of local STPs/ICSs.
- Can make change happen at scale from their experience of understanding and overcoming the barriers to change, knowing and putting in place the key enablers of change, and having the size and capacity to deliver change quickly and efficiently.

33. Do you have any example case studies of primary care providers at scale and what they do?

Yes, these will be published on the NHS England webpage shortly: www.england.nhs.uk/pcn or please email england.pcn@nhs.net for a copy.

Extended access review

34. What is the extended access review?

As set out in *"Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan"* NHS England and Improvement will undertake a review of current extended access to general practice services commencing 2019 for full implementation by 2021/22. The review will enable the development and implementation of a single coherent "extended access" offer that primary care networks will make, for both physical and digital services as an integral part of the Network Contract DES to 100% of patients.

35. What are the access review timescales?

Work is currently underway on data gathering and hypotheses testing to be completed by summer when we will take to take stock of the scope and review timetable. Current expectation is delivery of a report in winter.

Please email england.pcn@nhs.net with any additional questions and a member of the team will be in touch.