

# Network Contract Directed Enhanced Service

Guidance for 2020/21 in England

**17 September 2020**

NHS England and NHS Improvement



# Network Contract Directed Enhanced Service

## Guidance for 2020/21 in England

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### **Equalities and health inequalities statement**

"Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities."

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## 1. Introduction

- 1.1. The Network Contract Directed Enhanced Service (DES) was introduced during 2019 and will remain in place until at least 31 March 2024. For 2020/21, the [Network Contract DES Directions](#) come into force on 1 April 2020 and, following participation in the DES, the requirements on practices and Primary Care Networks (PCNs), as outlined in the [Network Contract DES specification](#), will apply from that date.
- 1.2. This guidance provides supporting information for commissioners and practices. It does not take precedence over the Network Contract DES Specification.
- 1.2.A This document, dated October 2020, is an updated version of the guidance and incorporates the amendments to the Network Contract DES Specification intended to take effect from 1 October 2020.
- 1.3. The ongoing COVID-19 situation is placing substantial pressures on general practice, and we are very grateful to all colleagues for the work they are doing to respond swiftly and professionally. Dr Nikki Kanani and Ed Waller's [letter of 19 March 2020](#) set out a number of activities which practices and PCNs may consider suspending or postponing in order to free up capacity. NHS England and NHS Improvement has agreed a number of changes to the Network Contract DES for 2020/21 with the British Medical Associations (BMA) General Practitioners Committee (GPC) England, compared to the proposals set out in the [Update to the GP Contract agreement 2020/21 – 2023/24](#), to support practices and Primary Care Networks (PCNs) to enhance their capacity and ability to respond to the outbreak. We have done so because PCNs will play a vital role in the response to COVID-19: providing a structure to support general practice resilience, a mechanism to secure additional capacity, and a framework to deliver some of the urgent responses needed to manage the outbreak. The Network Contract DES and this guidance reflect those agreed changes.

## 2. Eligibility for and participation in the Network Contract DES

### 2.1. Participation process

- 2.1.1 The vast majority of practices in England participated in the Network Contract DES in 2019/20. These practices are therefore defined as Core Network Practices of a Previously Approved PCN established in the period 1 July 2019 to 31 March 2020. From 2020/21 onwards, there will be a simple reconfirmation process for these Previously Approved PCNs to continue without changes. However, there is also the potential for these Previously Approved PCNs to continue with changes and for new PCNs to be formed.
- 2.1.2 A practice wishing to participate in the Network Contract DES from April 2020 will fall within one of six scenarios set out in the Network Contract DES Specification. To confirm participation in the Network Contract DES, the commissioner and practice must follow the steps set out in the Network

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Contract DES Specification depending on which of the six scenarios applies to each PCN. Practices are required to use the [Network Contract DES Participation Form](#) to provide the required information. This form should be submitted to the commissioner as soon as possible to support timely implementation on payment systems and to avoid any delay and disruption in DES payments, and to ensure a PCN can benefit from the increased Additional Roles Reimbursement Scheme funding as early as possible, and by the 31 May 2020 at the latest. A single Participation Form can be submitted for a PCN.

### 2.1.3 The six scenarios are:

- a. A practice that is a Core Network Practice of a Previously Approved PCN and there have been no changes to the following, the:
  - i. identity of the Core Network Practices,
  - ii. Nominated Payee,
  - iii. Clinical Director; and
  - iv. Network Area.
- b. A practice that is a Core Network Practice of a Previously Approved PCN and there have been changes to the information listed above.
- c. A practice that has not previously participated in a Network Contract DES but wishes to become a Core Network Practice of a Previously Approved PCN.
- d. A newly established practice wishing to become a Core Network Practice of a Previously Approved PCN.
- e. A practice that is either a new practice or an existing practice and wishes to become a Core Network Practice of a newly proposed PCN.
- f. A practice that cannot identify a PCN that is willing to allow the practice to become a Core Network Practice.

### 2.1.4 The practices within the PCN must have completed the process for participating in the Network Contract DES prior to the next local payment deadline to avoid any disruption in payment. Commissioners should liaise with the Core Network Practices to confirm timescales. Where a local payment date has been missed, the commissioner will make the relevant payment in the next month.

### 2.1.5 Commissioners are not required to await 100 per cent geographical coverage in order to approve Core Network Practice participation and PCN continuation or formation.

### 2.1.6 In order to simplify the participation process in future, a practice participating in the Network Contract DES in 2020/21 will automatically be enrolled in subsequent years. Practices retain the right to opt-out of the Network Contract DES in line with the opt-out process set out in the Network Contract DES Specification. From 2021/22, this opt-out process will apply during one calendar month each year from the date of publication by NHS England and NHS Improvement of the Network Contract DES Specification.

### 2.1.7 The auto-enrolment will also apply to in-year variations to the Network Contract DES taking effect prior to the 31 March of each year. Where the

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Network Contract DES is varied during any given year, practices will retain the right to opt-out in line with the one calendar month window in accordance with the Network Contract DES Specification.

### **2.2. PCN unwilling to accept a practice as a Core Network Practice**

- 2.2.1. From 1 April 2020, where a practice wishes to participate in the Network Contract DES but is unable to find a PCN to join, commissioners will have the ability as a last resort to allocate a practice to a PCN as a Core Network Practice. It is not anticipated that this will happen on a regular basis as it is expected that disagreements over joining a PCN should be managed through mediation, supported by the commissioner and the Local Medical Committee (LMC).
- 2.2.2. Where agreement cannot be reached through mediation, in order to ensure maximum population coverage through the Network Contract DES, a commissioner may allocate the practice to a PCN, with the full engagement of the LMC, in line with the process as set out in section 4.9 the [Network Contract DES Specification](#).

### **3. Role of Commissioners and LMCs in reconfirming PCN establishment**

- 3.1. Commissioners and LMCs will need to work together to ensure all practices who wish to join or continue their participation in the Network Contract DES are included within a PCN. Commissioners and LMCs will also need to work with PCNs to ensure that 100 per cent of registered patients are covered by network services, for example by commissioning a local incentive scheme (see section 4). This may require discussion and mediation between the relevant PCN grouping and practices(s).
- 3.2. Commissioners will:
  - a. Liaise with the relevant Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) to ensure each PCN Network Area continues to or does support delivery of services within the wider ICS/STP strategy.
  - b. Engage with LMCs and bring practices together to resolve issues to ensure 100 per cent population coverage is maintained.
  - c. Engage with LMCs to aid a practice's participation in the Network Contract DES where the practice is unable to find a PCN.
  - d. Reconfirm or approve practice participation in the Network Contract DES as part of a PCN, ensuring that the participation requirements have been met.
  - e. Have oversight of PCN footprints to ensure these make long term sense for service delivery and in the context of the GP contract framework.
  - f. Support PCN development via investment and development support outside of the Network Contract DES.

## **4. Establishing local agreements with a PCN for delivery of network services for patients of a practice not participating in the Network Contract DES**

### **4.1. Key considerations**

- 4.1.1. Commissioners are required to ensure that that any patients of a practice that is not participating in the Network Contract DES have access to network services.
- 4.1.2. In those instances where a practice has chosen not to sign up to the Network Contract DES and a commissioner is required to secure network services for the patients of that practice, a commissioner may contract with any suitable provider for the delivery of network services, such as another PCN or a community services provider. The guidance below applies to those instances where a commissioner is contracting with a PCN through a local agreement, such as a Local Incentive Scheme (LIS), to deliver network services to such patients.
- 4.1.3. Commissioners will need to work with PCNs to agree how any patients from a non-DES practice - a practice not signed up to the Network Contract DES - can be covered by a PCN. The local agreement would usually be with:
  - a. a single Core Network Practice (as a signatory on behalf of a PCN in a lead provider type of arrangement), or
  - b. with all the Core Network Practices in the PCN (as a multi-signatory agreement)<sup>1</sup>.
- 4.1.4. These local agreements will be managed locally and the patient population of a non-DES practice, for whom a PCN is providing network services, will not be accounted for within the PCN ODS reference data.
- 4.1.5. There may be circumstances where more than one GP practice in an area is not participating in the Network Contract DES. Where a single PCN will be providing cover for multiple non-DES practices, this can be via either a single or multiple local agreement(s).
- 4.1.6. Having agreed which PCN or provider will provide the cover, commissioners will need to ensure the following services/activities<sup>2</sup> are provided to patients of the non-DES practice in accordance with the timescales for these services/activities:
  - a. a social prescribing service;

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<sup>1</sup> Where the PCN has formed as a legal entity, the local agreement could be made directly with the PCN.

<sup>2</sup> The list outlines the 2020/21 requirements. Commissioners and PCNs will need to review local agreements in future years to ensure they remain aligned to any changes to the Network Contract DES Specification.



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- b. the extended hours access requirements as listed at section 7.1 of the Network Contract DES specification.
- c. the Structured Medication Review requirements as listed at section 7.2 of the Network Contract DES Specification;
- d. the Enhanced Health in Care Homes requirements as listed at section 7.3 of the Network Contract DES Specification; and
- e. the Early Cancer Diagnosis requirements as listed at section 7.4 of the Network Contract DES Specification.

4.1.7. These requirements could be included in the local agreement by cross-referring to the relevant sections of the Network Contract DES Specification document. For some of the service requirements, co-operation between the provider of the LIS and the non-DES practice(s) will be critical to delivery. Further information on the duty of co-operation on all practices is detailed below.

4.1.8. Other provisions that would be expected to be included in a local agreement are:

- a. A provision requiring the PCN to provide to the commissioner any details of non-co-operation by a non-DES practice with the PCN who is providing network services via the LIS to the non-DES practice's patients. This information will be used by the commissioner to consider whether to take any action under the non-DES practice's primary medical services contract;
- b. Breach – how breaches by the PCN providing cover are dealt with by the commissioner; and
- c. Boilerplate provisions – the usual contractual provisions about commencement, duration, extension, break-clause, termination, variation, dispute resolution, entire agreement, surviving provisions, governing law, etc.

4.1.9. Commissioners should make every effort to find suitable cover to provide network services for patients of a non-DES practice. Where a commissioner has not been able to secure cover to patients of a non-DES practice, this should be notified to the NHS England and NHS Improvement Regional Team.

4.1.10. In areas where the scale of non-participation in the Network Contract DES is significant, NHS England and NHS Improvement will consider the case for establishing a new APMS contract, in addition to existing GMS/PMS/APMS contracts, in order to establish additional primary medical care capacity (covering both essential services and network services) in those areas.

## **4.2. Payments under a local agreement**

4.2.1. For the purposes of the Network Contract DES, payments to a PCN for the provision of PCN services/activities are mostly calculated by reference to the sum of its Core Network Practices' registered lists as at 1 January each year. This sum will not therefore include patients from practices who are not participating in the Network Contract DES. Instead, the patients of practices not participating in the Network Contract DES would need to be accounted

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for under the local agreement put in place with the PCN that will be providing cover. These local agreements will not be supported by either the General Practice Extraction Service (GPES) or the Calculating Quality Reporting Service (CQRS) and commissioners will be required to managed these out-with of these systems.

- 4.2.2. In respect of payments under the local arrangement, the simplest approach would be for the commissioner to consider replicating or clearly referring to the relevant payment provisions in section 9 of the [Network Contract DES Specification](#) but calculated with reference, where appropriate, to the registered patient size of the non-DES practice. These could include payments that reflect:
  - a. Core PCN funding;
  - b. extended Hours Access; and
  - c. care homes premium (from 1 August 2020)
  - d. PCN support payment (from 1 April 2020 to 30 September 2020).
- 4.2.3. The commissioner and PCN may need to consider on a case by case basis the extent to which the total number of patients that the PCN provides services to (i.e. including the non-DES practice patients) would require additional workforce capacity, in order to support delivery of network services and therefore what, if any, workforce related payments should be reflected in the LIS arrangements.
- 4.2.4. There may also need to be consideration of whether the Clinical Director of the PCN acts on behalf of the non-DES practice. If so, then consideration would need to be given to whether a payment in respect of this (calculated with respect to the patient list size of the non-DES practice) is appropriate.
- 4.2.5. Commissioners will have local discretion as to whether or not any additional funding can be made available, in part or in full to the PCN providing the cover for the non-DES practice.
- 4.2.6. The non-DES practice will not be entitled to the Network Participation Payment if not participating in the Network Contract DES.

### **4.3. Duty of co-operation**

- 4.3.1. To support co-operation between all practices in delivering PCN related services to their patients, regardless of whether or not a practice is participating in the Network Contract DES, the GMS and PMS Regulations require all practices to:
  - a. co-operate with Core Network Practices of PCNs who are delivering the Network Contract DES services/activities to the collective registered population and as required engage in wider PCN meetings with other PCN providers;
  - b. inform their patients, as required, of changes to PCN services/activities;
  - c. support wider co-operation with other non-GP provider members of the PCN;

- d. as clinically required, support the delivery of PCN services/activities, be party to appropriate data sharing and data processing arrangements, that are compliant with data protection legislation; and
- e. share non-clinical data with members of the PCN to support delivery of PCN business and analysis, following a process that is compliant with data protection legislation.

4.3.2. Alongside the above, a practice's compliance with the GMC Good Medical Practice to act in the best interests of patients and not put them at risk of harm, should provide assurance that non-DES practices will co-operate with the delivery of PCN services/activities. In the event a non-DES practice does not co-operate, the commissioner will need to be made aware of, and address, the matter appropriately in line with normal contract management arrangements.

## 5. PCN Organisational Requirements

### 5.1 Membership of a Primary Care Network, network area and crossing commissioner boundaries

5.1.1. Under the Network Agreement, PCN membership is divided into two categories – Core Network Practices and all PCN members. Core Network Practices are the practices participating in the Network Contract DES<sup>3</sup>. Any other organisations party to the Network Agreement are known as PCN members and may include other providers, such as a GP Federation, community or secondary care trust, community pharmacy, community or voluntary sector provider, and GP practices who are not participating in the Network Contract DES or who are not Core Network Practices of the PCN.

5.1.2. The Core Network Practice membership of a PCN must cover a Network Area that aligns with a footprint that would best support delivery of services to patients in the context of the relevant Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) strategy. The Network Area must also:

- a. cover a boundary that makes sense to:
  - i. the Core Network Practices of the PCN;
  - ii. other community-based providers which configure their teams accordingly; and
  - iii. the local community;
- b. cover a geographically contiguous area;
- c. not cross Clinical Commissioning Group (CCG), STP or ICS boundaries except where:
  - i. a Core Network Practice's boundary or branch surgery crosses the relevant boundaries; or
  - ii. the Core Network Practices are situated in different CCGs.

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<sup>3</sup> Practices eligible to participate in the Network Contract DES must hold a primary medical services contract, have a registered list of patients and offer in-hours (essential services) primary medical services.

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- 5.1.3. From contractual perspective, a primary medical services provider who holds either:
- a. a single eligible primary medical services contract will only be able to hold one Network Contract DES and be a Core Network Practice of a single PCN, this applies regardless of whether or not the single primary medical care provider has multiple sites spanning large areas and/or commissioner boundaries; or
  - b. multiple eligible primary medical care contracts will be able to have each of those contracts varied to include the Network Contract DES and each practice will be a Core Network Practice of the relevant PCN(s).
- 5.1.4. A practice not participating in the Network Contract DES could be a PCN member (like any other non-practice provider, i.e. not a Core Network Practice) and therefore be party to a PCN's Network Agreement.
- 5.1.5. A practice may be a member of more than one PCN, for example where a practice provides services from a branch surgery and sub-contracts the delivery of PCN services and/or activities for that branch surgery to a different PCN, or where a practice is the nominated payee for two PCNs. In these examples, the practice would be a Core Network Practice of one PCN and a PCN member (i.e. non-Core Network Practice) of another PCN. Similarly, within the PCN ODS reference data, GPES and CQRS, practices will only be a Core Network Practice of one PCN.
- 5.1.6. A practice with one or more branch surgeries in different PCNs, acknowledges that its list of patients will be associated with the PCN of which the practice is a Core Network Practice. For PCNs/practices intending to have a different PCN provide PCN services/ activities to a branch surgery, see section 6 for information about sub-contracting arrangements.

## 5.2 PCN Core Network Practice membership changes

- 5.2.1. PCN Core Network Practice membership will be agreed and signed off as part of the process for practices confirming participation in the Network Contract DES, as outlined in section 2.1 of this guidance (and section 4.3 of the [Network Contract DES Specification](#)).
- 5.2.2. Changes to Core Network Practice membership of a PCN can only take place outside of this window in exceptional circumstances as set out in sections 5.13 to 5.16 of the [Network Contract DES Specification](#) and with the approval of the commissioner. Any changes to Core Network Practice membership within the opt-in/opt-out window must be made in line with the process for seeking commissioner approval as set out in the Network Contract DES Specification.
- 5.2.3. Commissioners should maintain accurate records of all PCN Core Network Practice membership approvals and rejections and will be required to demonstrate if requested, the rationale for their decision.

## 5.3 PCN Organisational Data Service (ODS) information and Change Instruction Notice Form

5.3.1. Where changes to PCN membership or nominated payee have been approved by the commissioner, the commissioner must complete and submit the ODS Change Instruction Notice Form<sup>4</sup>. This form must be completed and submitted at the earliest opportunity and by no later than the last working day on or before the 14<sup>th</sup> day of each month, in order for the change to be actioned by the end of that month in the payment systems. In so doing, commissioners should have due regard to local payment arrangements and the timings implications of this when submitting an ODS Change Instruction Notice. Where the ODS Change Instruction Notice Form is not submitted by the monthly deadline, commissioners may be required to follow a manual exception process (i.e. manual payment reconciliation) to ensure the correct payments are made – see section 10.3).

5.3.2. The PCN ODS reference data provides the following information:

Category	Detailed information included
Organisational data for the PCN	ODS code PCN name PCN address Start and end dates of PCN Status (active or inactive);
Core Network Practice(s) to PCN	IsPartnerTo relationship: ODS for Practice and PCN Start and end dates of relationship Relationship Status (active or inactive)
PCN to commissioner mapping	IsCommissionedBy relationship: ODS for PCN and commissioner Start and end dates of relationship Relationship Status (active or inactive)
Nominated payee (NP)	IsNominatedPayeeFor relationship: ODS Code for Nominated Payee and PCN NP Name NP address Start and end dates of relationship Relationship Status (active or inactive) NP Role (whether NP is a practice or not)  Note: A Nominated Payee can be payee for more than one PCN. This means some payee records will have multiple 'IsNominatedPayeeFor' relationships to different PCNs. A PCN can only have one Nominated Payee.

5.3.3. Each PCN will have a single commissioning relationship, regardless of whether the Core Network Practices of a PCN cross commissioner boundaries. In the event a PCN crosses commissioner boundaries, then the relevant commissioners must agree who will be the 'lead' commissioner for the PCN. The agreed 'lead' will be identified as such within both the PCN

<sup>4</sup> The PCN ODS Change Instruction Notice is available [here](#).

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ODS reference data and subsequently within the relevant GP IT systems for payment processing. The identified lead commissioner will make payments to the relevant Nominated Payee in relation to the Network Contract DES. The lead commissioner and any other relevant commissioner must reconcile any funding allocation discrepancies between themselves and not via national GP payment systems.

- 5.3.4. Only a PCN's 'lead' commissioner will be able to instruct changes to the ODS reference data and by someone from within the primary care commissioning team.
- 5.3.5. The NHS Digital ODS Team is not able to distinguish between a delegated or non-delegated CCG. Where a Regional Team submits an ODS Change Instruction Notice, the assumption will be that this is due to the CCG not having delegated authority and/or that this has been agreed locally between the Regional Team and CCG. As such, it is the responsibility of the commissioners (Regional Team and/or CCG) to ensure that they have the authority to submit the ODS Change Instruction Notice, as it will have implications for payment system calculations and processing. Where a submission is made by a Regional Team, it will also need to be done by someone from within the primary care commissioning team.

### 5.4 Network Agreement

- 5.4.1. The Network Agreement sets out the collective rights and obligations of a PCN's Core Network Practices and is required to enable PCN claims of the financial entitlements under the Network Contract DES. It also sets out how the Core Network Practices will collaborate with non-GP providers which make up the wider PCN.
- 5.4.2. From April 2020, PCNs will continue to be required to use the national mandatory [Network Agreement and its Schedules](#) to support the Network Contract DES. The mandatory sections of the Network Agreement cannot be amended, except in those instances where the Network Agreement states that wording in a specific clause may be replaced with wording to reflect agreement which the PCN has reached.
- 5.4.3. Core Network Practices are required to ensure that PCN arrangements and agreements reached in the Network Agreement are updated to take account of any changes to the Network Contract DES specification. This would include how new services will be delivered, and for any other changes such as when new workforce is recruited.
- 5.4.4. Where PCNs decide to seek advice related to the Network Agreement, these costs will not be covered under the Network Contract DES nor by commissioners at a local level.

### 5.5 Recording agreements reached with local providers

- 5.5.1. In 2020/21, each PCN must agree with local community services providers, mental health providers and community pharmacy providers how they will work together. The collaboration agreements reached with these local

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providers must be documented in Schedule 7 of the PCNs Network Agreement.

- 5.5.2. As set out in the [Network Contract DES Specification](#), PCNs must update Schedule 7 of their Network Agreement to set out:
- a. the specifics of how the appropriate service requirements (those which require joint working with community services providers, community mental health providers and community pharmacy) under the Network Contract DES or other services deemed appropriate will be delivered through integrated working arrangements between PCNs and other providers; and
  - b. how providers will collaborate, including agreed communication channels, agreed representatives, and how any joint decisions will be taken.
- 5.5.3. A PCN must detail the arrangements with its local community services provider(s) in Schedule 7 of the Network Agreement by 30 September 2020. The commissioner will use reasonable endeavours to facilitate the agreement of arrangements between the local community services provider(s) and the PCN.
- 5.5.4. A PCN must detail the arrangements with community mental health providers, and community pharmacy (via the community pharmacy nominated Pharmacy PCN Lead) in Schedule 7 of their Network Agreement by 31 March 2021.

## 5.6 Clinical Director

- 5.6.1. The Clinical Director should be a practicing clinician from one of the PCN's Core Network Practices and be able to undertake the responsibilities of the role, representing the PCN's collective interests. It is most likely to be a GP, but this is not a requirement. The post should be held by an individual (or individuals if they are job-sharing the role) from within the PCN and should not be a shared role between PCNs. The Clinical Director should not be employed by a commissioner and provided to the PCN.
- 5.6.2. PCNs may wish to consider rotating the Clinical Director role within a reasonable term.
- 5.6.3. A national outline of the key requirements is included in section 5.3 of the [Network Contract DES Specification](#). The Clinical Director has overall responsibility for their key requirements and may, where appropriate, engage others within the PCN to aid in their delivery.

### Appointment of Clinical Director

- 5.6.4. It will be the responsibility of the PCN to agree who their Clinical Director will be. The selection process will be for the PCN to determine but may include:
- a. Election - nomination and voting;
  - b. Mutual agreement between the members;

- c. Selection – via application and interview for example; or
- d. Rotation within a fixed term (this could equally apply against the above processes).

## Managing Conflicts of interest

- 5.6.5. PCNs and Clinical Directors will be responsible for managing any conflicts of interest, taking account of what is within the best interests of the PCN and their collective patients. They will need to consider how best to manage inappropriate behaviour which negatively impacts on PCN member relationships or delivery of care to patients.

## 5.7 Data and analytics

- 5.7.1. Each PCN is required to have in place appropriate data sharing and, where appropriate, data processing arrangements between members of the PCN. These arrangements must be in place prior to the start of the activity to which they relate. The [Data Sharing Agreements and Data Processing Agreement non-mandatory templates](#) are available for PCNs to use.
- 5.7.2. Where functionality is available, clinical data sharing for service delivery should be read/write access, so that a GP from any practice, and where required other PCN staff, can refer, order tests and prescribe electronically and maintain a contemporaneous record for every patient.
- 5.7.3. From 2020/21, PCNs should be routinely monitoring, sharing and aggregating relevant data across the Core Network Practices. This is to allow for benchmarking of activity and the identification of:
- a. opportunities for improvement;
  - b. variation in access and service delivery; and
  - c. capacity and demand across the PCN population in order to review and manage appropriately.
- 5.7.4. The Calculating Quality and Reporting Service (CQRS) will include new functionality during 2020/21 to enable practice-level data for PCN Core Network Practices to be summed to PCN-level. PCN Core Network Practices and the lead commissioner will be able to review both PCN and practice-level data.
- 5.7.5. With regards to cross-boundary PCNs identified through the PCN ODS mapping data, reporting within CQRS will not enable PCN related data to be available to multiple commissioners. The commissioners will therefore need to work together and the 'lead CCG' – identified by the PCN ODS reference data - will be required to share all relevant PCN level data with the 'non-lead CCG' to support monitoring and payment information linked to the Network Contract DES. Providing the data is not patient identifiable – which for the purposes of the Network Contract DES it will not be – General Data Protection Regulation (GDPR) does not require a data sharing agreement to be in place between controllers.



## 5.8 Network Dashboard

- 5.8.1. The Network Dashboard will be introduced during 2020/21 and will evolve each year, in line with feedback from users and the availability of new information to populate it.
- 5.8.2. The dashboard will include key metrics to allow every PCN to see the benefits it is achieving for its local community and patients and is intended to support local quality improvement. It will enable effective benchmarking between practices within PCNs, and between comparable PCNs, and will be accessible, on request, to all commissioners, providers and arms-length bodies working in health and social care.
- 5.8.3. These indicators will be displayed alongside contextual information for each PCN, including their population size, density and deprivation.
- 5.8.4. An initial version of the dashboard will be launched in April 2020 for user testing, following further development and engagement.

## 6. Sub-contracting of network services

### 6.1 Core Network Practice with sites in different PCNs

- 6.1.1. When a Core Network Practice of a PCN (PCN 1) is looking to sub-contract services/activities to a different PCN (PCN 2) for a proportion of their registered population (for example where it holds a single contract but delivers services from multiple sites, such as a branch surgery), PCN 1 should give careful consideration to how the patients - to whom PCN 2 will provide PCN services/activities - will be identified. This is particularly important where those patients are under a single registered list under a single primary medical services contract.
- 6.1.2. Identification of patients for whom PCN 2 will provide PCN services/activities may, for example, be the patients who usually access care at a GP practice site within PCN 1. The GP practice should also take care not to do anything that could mean that a cohort of registered patients were treated differently e.g. a GP practice should not tell specific patients that they can only access PCN services/activities from sites in PCN 2. This is important as the practice needs to ensure that it does not breach any of the practice's obligations to patients set out in its core primary medical services contract.
- 6.1.3. There are two main options for the sub-contracting of PCN services/activities:

#### 1) Option 1: Sub-contracting via the Network Agreement

- a. In this scenario, the practice will be a Core Network Practice of a PCN (PCN 1) and will be signed up to PCN 1's Network Agreement in the usual way. That Network Agreement will note that it has been agreed that another PCN (PCN 2) will provide PCN services/activities to certain patients of the relevant practice. It would be helpful for PCN 1's Network Agreement to set out the reasoning for this. The relevant practice will also sign the Network

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Agreement of PCN 2 as an “other member” (i.e. not as a Core Network Practice). The details of the sub-contracting arrangement - the financial/service delivery/workforce arrangements - would be set out in an additional schedule of PCN 2’s Network Agreement.

- b. Careful consideration would need to be given to the role that the relevant practice has in PCN 2. The Network Agreement for PCN 2 would need to be clear on:
  - i. setting out what requirements, if any, the relevant practice should be expected to deliver to facilitate the delivery of PCN services/activities to its patients. This might include agreed arrangements for communicating with patients and data sharing, for example;
  - ii. defining which matters of PCN 2 the relevant practice may have an interest/vote in; and
  - iii. whether there is any PCN 2 related information e.g. financial accounts, that it should not be party to.

### **2) Option 2: Entering into a separate specific sub-contract**

- a. In this scenario, the relevant practice could enter into a separate sub-contract with one or more of the Core Network Practices of PCN 2 for the delivery of PCN services/activities. Both PCNs will need to reflect the sub-contracting arrangement in both Network Agreements. In this scenario, it would not be necessary for the relevant practice to sign the Network Agreement of PCN 2.

6.1.4. PCNs will need to carefully consider the pros and cons of each approach, bearing in mind the additional complexity that either of the sub-contracting arrangements may bring and ensure that the agreed position is set out in clear and unambiguous wording. In all cases, the sub-contracting arrangements should include the ability to review/update the sub-contracting arrangements in light of any changes to the Network Contract DES Specification.

6.1.5. In entering in to any sub-contracting arrangement, GP practices should at all times ensure they are complying with the sub-contracting requirements within their individual primary medical services contracts. Where a PCN wishes to sub-contract delivery of network services to a GP federation, this is permitted if the arrangement complies with the sub-contracting requirements in each GP practice’s primary medical services contract.

## **6.2 Sub-contracting of clinical and non-clinical services or matters**

6.2.1. Schedule 3, Part 5 para 44(9) of the GMS Regulations and the equivalent provision in the PMS Regulations states that any sub-contract must prohibit the sub-contractor from further sub-contracting any of the clinical services that it has agreed to provide under the sub-contract. If, therefore, practices have sub-contracted provision of a clinical services to a GP federation, the sub-contract would prohibit the GP federation from sub-contracting the clinical services to another organisation. These provisions in the Regulations are currently being reviewed in relation to onward sub-contracting of clinical services where approval of the commissioner has been given. A further update will be provided as soon as possible.

- 6.2.2. A sub-contractor to a practice or practice(s) will be allowed to onward sub-contract a non-clinical matter that relates to the Network Contract DES where the prior written approval of the commissioner is given. The commissioner's approval will not unreasonably be withheld or delayed.

## 7. Additional Roles Reimbursement Scheme

### 7.1 Workforce planning and ongoing reporting

- 7.1.1. Expanding the workforce is the top priority for primary care, and commissioners must support their PCNs to undertake recruitment under the Additional Roles Reimbursement Scheme to deliver this priority.
- 7.1.2. PCNs are required to plan their future workforce requirements in order to support claims under their Additional Roles Reimbursement Sum each year. As set out in the Network Contract DES Specification, each PCN is required to complete and return to the commissioner by 31 August 2020 the workforce planning template<sup>5</sup>, providing details of its recruitment plans for 2020/21 and by 31 October 2020 indicative intentions through to 2023/24. The commissioner will confirm the plan with each PCN's Clinical Director and, once each plan is agreed, will share with NHS England and NHS Improvement Regional Teams by 30 September 2020 for 2020/21 plans, and by 30 November 2020 for indicative future plans.
- 7.1.2A Following the introduction of two new roles – trainee nursing associate and nursing associate – in the Additional Roles Reimbursement Scheme from October 2020, PCNs and commissioners may need to consider revising the workforce plans to take into account a PCN's decision to employ or engage either or both of these roles for the remainder of 2020/21 and as part of their indicative intentions until 2023/24.
- 7.1.3. The PCN may change these plans at any stage provided that such change is shared with the commissioner as this aids management of the redistribution of Additional Roles Reimbursement Scheme funding across all PCNs, as described in section 6.5 of the [Network Contract DES Specification](#).
- 7.1.4. PCNs and commissioners are encouraged to have ongoing dialogue in relation to workforce strategies, to ensure these are consistent with broader Integrated Care System (ICS) or System Transformation Partnership (STP) workforce strategies.
- 7.1.5. The commissioner must complete and return the six-monthly workforce report to [england.primarycareworkforce@nhs.net](mailto:england.primarycareworkforce@nhs.net). There are plans to develop an online template for future returns, and further details will be made available to commissioners in due course.

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<sup>5</sup> This template is available at <https://www.england.nhs.uk/publication/pcn-workforce-planning-template-2020-21/>

- 7.1.6. PCN Core Network Practices must record within the National Workforce Reporting Service (NWRS) information on any staff employed or engaged through the Additional Roles Reimbursement Scheme.

### System Support for PCNs

- 7.1.7. CCGs and systems are expected to explore different ways of supporting PCNs. These should include, but not be limited to:
- the immediate offer of support from their own staff to help with co-ordinating and running recruitment exercises;
  - the offer of collective/batch recruitment across PCNs. Where groups of PCNs wish to advertise vacancies collectively, CCGs or ICSs should support this;
  - brokering arrangements to support full-time direct employment of staff by community partners, or to support rotational working across acute, community and (in time) mental health trusts, as well as community pharmacy; and
  - ensuring that NHS workforce plans for the local system are as helpful as possible in meeting PCN intentions.

## 7.2 Additional Roles Reimbursement Sum

- 7.2.1. From 1 April 2020, each PCN will be allocated an Additional Roles Reimbursement sum each year, based upon the PCN's weighted population share of the total Additional Roles Reimbursement Scheme funding. To ensure consistency and fairness in allocations, the basis for weighting is the same as for global sum (i.e. Carr-Hill Formula). 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.

- 7.2.2. Each PCN's Additional Roles Reimbursement Sum will use the Contractor Weighted Population<sup>6</sup> as at 1 January of the financial year preceding and be calculated as follows:

$$\text{PCN's weighted population share} = \frac{\text{PCN's weighted population}}{\text{Total England weighted population}}$$

- 7.2.3. The Additional Roles Reimbursement Sum for any given year would be calculated as follows:

$$\text{PCN's Additional Roles Reimbursement Sum} = \text{PCN's weighted population share} \times \text{total national workforce funding}$$

## 7.3 Ready reckoner

- 7.3.1. A [ready reckoner](#) is available to support PCNs to calculate their indicative Additional Roles Reimbursement Sum based on their weighted population.

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<sup>6</sup> Contractor Weighted Population as defined in Annex A of the Statement of Financial Entitlements (SFE) taken as at 1 January of the financial year preceding. The SFE confirms that this is the number of patients arrived at by the Global Sum Allocation Formula.

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Table 1<sup>7</sup> sets out the indicative Additional Roles Reimbursement Sum allocations for different PCN sizes from 2020/21 to 2023/24. Calculations are based on a national population of 60,334,866<sup>8</sup> (figures for both national population and PCN size will, on average, grow proportionally to each other).

- 7.3.2. For 2020/21 the Additional Roles Reimbursement Sum will be calculated using £7.131 per PCN weighted patient as at 1 January 2020. The 2020/21 figures in Table 1 are calculated using £7.131 per PCN weighted patient. The figures for years 2021/22 to 2023/24 are calculated using the formula in section 7.2 and the national population of 60,334,866.

Table 1: Indicative Additional Roles Reimbursement Scheme Sum per PCN weighted population

<b>Table 1</b>	<b>2020/21</b>	<b>2021/22</b>	<b>2022/23</b>	<b>2023/24</b>
<b>Total National Workforce funding</b>	<b>£430,222,000</b>	<b>£746,458,000</b>	<b>£1,026,747,000</b>	<b>£1,412,011,000</b>
<b>PCN Size (weighted)</b>				
15,000	107,000	185,600	255,300	351,000
20,000	142,600	247,400	340,300	468,100
25,000	178,300	309,300	425,400	585,100
30,000	213,900	371,200	510,500	702,100
40,000	285,200	494,900	680,700	936,100
50,000	356,600	618,600	850,900	1,170,100
80,000	570,500	989,800	1,361,400	1,872,200
100,000	713,100	1,237,200	1,701,700	2,340,300
150,000	1,069,700	1,855,800	2,552,600	3,510,400

## 7.4 Entitlements not taken up under the Additional Roles Reimbursement Scheme

- 7.4.1. The Additional Roles Reimbursement Sum funding is only available to fund additional PCN workforce in line with the rules of the scheme.
- 7.4.2. NHS England expects the funding under the Additional Roles Reimbursement Scheme to be used in full, on the terms set out in the Network Contract DES Specification and in this guidance, in each year of the scheme.
- 7.4.3. As set out in the Network Contract DES Specification, each PCN is required to complete a workforce plan which commissioners will use to inform their

<sup>7</sup> For illustrative purposes, both national population and PCN size have been fixed in table 1 to give an indicative view of the funding current PCN population sizes will attract in future as they grow, on average, in line with the growth in the national population. The figures in table 1 do not include any subsequent uplifts that may be agreed to the Agenda for Change pay rates on which the maximum reimbursable sum is based. Figures are therefore subject to change to take this into account in future.

<sup>8</sup> The total England weighted population is equal to the total England registered population.

estimation of likely unclaimed Additional Roles Reimbursement Scheme funding. Following this, commissioners will be required to follow the process for redistributing any unclaimed Additional Roles funding in line with the requirements and process as set out in the Network Contract DES Specification.

- 7.4.4. Any unused funding in a given financial year cannot be carried forward into subsequent years, and a PCN's entitlement to that funding in that year will therefore be lost.

## 7.5 Principle of additionality and baselines

- 7.5.1. To receive the associated funding through the Additional Roles Reimbursement Scheme, a PCN must show that the staff delivering health services for whom reimbursement is being claimed are additional and comply with the principle of "additionality" as set out in sections 6.2 of the [Network Contract DES Specification](#). The additionality rule serves both to protect pre-existing local investment in primary care (e.g. by commissioners), as well as to expand capacity. It is not possible for Core Network Practices or commissioners to stop funding staff identified in the baseline exercise on the grounds that these could instead be funded through PCN reimbursement.
- 7.5.2. Core Network Practices and commissioners will be required to maintain existing funding for baseline staff levels measured as at 31 March 2019 against six of the reimbursable roles – clinical pharmacists, social prescribing link workers, first contact physiotherapists, physician associates, pharmacy technicians and paramedics (from April 2021). The two baselines established during 2019 are as follows (further detail on how the baselines were established is available in the [2019/20 Additional Roles Reimbursement Scheme Guidance](#)):
- a. A PCN baseline declared by the Core Network Practices of the PCN and agreed with the commissioner. It is comprised of the actual whole time equivalent (WTE) staff across these six reimbursable roles and funded by general practice as at 31 March 2019. The PCN baseline will be fixed until 31 March 2024.
  - b. A Clinical Commissioning Group (CCG) baseline declared by the CCG. It is comprised of the WTE patient facing or first contact time of staff across the six reimbursable roles deployed to support general practice or primary medical care services - either in a specific practice or in the wider community - funded<sup>9</sup> by the CCG as at 31 March 2019 (regardless of whether funded due to direct CCG employment or through a contract). Any admin, travel, triage or other time directly related to patient care is included in the WTE. The commissioner is required to maintain funding for these baseline posts and will be subject to audit. CCGs will be obliged to continue to fund baseline posts and will be subject to audit. All CCGs have been fully funded for GP contract

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<sup>9</sup> The six reimbursable roles funded include those directly employed by the CCG.

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costs in their primary medical services allocations. CCG baseline posts will have no bearing on PCN additionality claims.

- 7.5.3. These baselines will be monitored at a national level in line with the *NHS Long Term Plan* commitment that resources for primary medical and community services will increase in real terms by 2023/24 and rise as a share of the overall NHS budget.
- 7.5.4. The purpose of the baseline is to provide a fixed reference point against which additionality claims should be assessed. Thus, changes to baseline numbers will not be permitted. However, in the rare circumstances that it becomes apparent at a later date that the baseline was incorrect, the PCN Clinical Director and CCG Accountable Officer should agree and sign a new declaration confirming that the revised baseline reflects a true position. The changes to the baseline should be reflected, where appropriate, in the next quarterly NWRS and CCG six-monthly returns.
- 7.5.5. The PCN and CCG baselines are fixed for five years. PCN reimbursement claims under the Additional Roles Reimbursement Scheme will be assessed against the PCN baseline only.
- 7.5.6. Practices are required to maintain the declared PCN baseline in order to meet the additionality rules under the Network Contract DES Additional Roles Reimbursement Scheme. Reimbursement claims under the Scheme will be assessed against the PCN baseline only. It should generally be assessed for individual workforce groups, rather than the total number of staff in the PCN baseline in all six reimbursable roles. However, with agreement from the commissioner, a PCN will be able to substitute<sup>10</sup> between clinical pharmacists, first contact physiotherapists and physician associates within the practice-funded PCN baseline posts as outlined in section 6.2.4 of the [Network Contract DES Specification](#).
- 7.5.7. For the purposes of the Additional Roles Reimbursement Scheme claims, WTE is defined as 37.5 hours in line with Agenda for Change (A4C) Terms and Conditions, although this may vary for non-A4C posts. Where A4C does not apply, PCNs should calculate the relevant WTE according to the normal full-time hours for that role in the employing organisation with reimbursement being made on a pro-rata basis accordingly.
- 7.5.8. A PCN baseline will not be established for health and wellbeing coaches, care coordinators, dieticians, podiatrists or occupational therapists. While the PCN baseline will not include these five roles, the additionality principles will still apply. A PCN claiming reimbursement in respect of these five roles does so on the basis that it is for additional staff engaged or employed since 31 March 2019, and that the reimbursement is not being used to subsidise practice-funded roles that existed as at 31 March 2019.

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<sup>10</sup> This substitution will extend to include paramedics from April 2021.

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- 7.5.9. As set out in section 7.6.1 below, any clinical pharmacists who transferred to the PCN by 31 March 2020 are exempt from the PCN baseline.
- 7.5.10. Baseline posts occupied by fixed term appointed staff can be considered to be 'filled' only if they are part of a long-term arrangement, which must be in place for a minimum of six months or more. Equally, PCNs will only be eligible to claim reimbursement for additional posts to be occupied by staff on fixed-term contracts, if these are for a minimum period of six months or more. In these circumstances, PCNs will be able to claim up to the maximum reimbursement amount per WTE as set out in the Network Contract DES Specification for actual salary plus employer on-costs (NI and pension), pro-rata for the period of the contract of employment and relevant WTE.
- 7.5.11. The Additional Roles Reimbursement Scheme cannot distinguish between staff with different job descriptions e.g. a MSK physiotherapist is the same as a non-MSK physiotherapist for the purposes of the baseline and additionality, so long as both roles have an element of patient-facing or first contact care time in specific practices or in the wider neighbourhood or community.

### **Changes to PCN baselines and staffing levels**

- 7.5.12. It is expected that PCN staffing levels will change from time to time. PCNs will be required to notify commissioners at the earliest opportunity of any changes to staffing levels, which may affect the PCN's reimbursement entitlement. The mandatory claim form includes a section to notify commissioners of any changes.
- 7.5.13. The PCN should notify the commissioner that a member of staff who is in the PCN baseline or for which the PCN is claiming reimbursement will cease or has ceased to work for the PCN or (for PCN baseline roles) a Core Network Practice. Where possible, the PCN should notify the commissioner in advance of the member of staff's last day of employment (or the last day of the sub-contract where applicable) but no later than the last day of the calendar month in which the member of staff ceased to be employed/engaged.
- 7.5.14. Where a vacancy arises in a Core Network Practices' PCN baseline WTE, the PCN must apply an equivalent WTE reduction in their workforce funding under the Network Contract DES Additional Roles Reimbursement Scheme. This reduction will be applied from three months (a three-month grace period) after the date at which the vacancy arose and which resulted in the PCN baseline reduction. For example, if one WTE post becomes vacant in a PCN's baseline and is not recruited to within three months, the PCN must deduct one WTE from its reimbursement claim until such time as the PCN baseline vacancy is filled, in order to maintain the principle of reimbursement for additional workforce. Section 9 of the [Network Contract DES Specification](#) provides further information.



## 7.6 Transfer of clinical pharmacists and pharmacy technicians

### Transfer of clinical pharmacists from the Clinical Pharmacist in General Practice Scheme

- 7.6.1. Any clinical pharmacists who were in post as at 31 March 2019 under the *Clinical Pharmacist in General Practice Scheme* were required to transfer to the PCN by 31 March 2020 in order to be eligible for funding through the Additional Roles Reimbursement Scheme and to be exempt from the PCN baseline. Practices are responsible for fully funding any clinical pharmacist posts which have not transferred after the tapering of the *Clinical Pharmacist in General Practice Scheme* funding.

### Transfer of pharmacists from the Medicines Optimisation in Care Homes Scheme

- 7.6.2. For all pharmacists (clinical pharmacists and pharmacy technicians) employed under the *Medicines Optimisation in Care Homes (MOCH) Scheme*, transfer to the PCN must take place by no later than 31 March 2021. Transfer must take place under the relevant requirements for clinical pharmacists or pharmacy technicians as set out in Annex B of the [Network Contract DES Specification](#).
- 7.6.3. PCNs will be required to support any pharmacists who transfer from the MOCH Scheme prior to 31 March 2021 to complete their training. Any MOCH pharmacy technicians transferred will count towards a PCN's eligible limit as outlined in the Network Contract DES Specification.
- 7.6.4. Where MOCH pharmacists do not transfer before 31 March 2021, commissioners are required to align the priorities of the CCG commissioned MOCH team to that of the Enhanced Health in Care Homes service requirements outlined in section 7.3 the [Network Contract DES Specification](#).

## 7.7 Additional Roles Reimbursement Scheme claims process

- 7.7.1. Commissioners should ensure that any staff for which reimbursement is being claimed meet the requirements set out in section 9 of the [Network Contract DES Specification](#).
- 7.7.2. PCNs must use the mandatory [Additional Roles Reimbursement Scheme Claim Form](#), or subsequent online replacement<sup>11</sup>, for all workforce reimbursement claims under the Additional Roles Reimbursement Scheme, in accordance with sections 9.1, 9.2 and 9.10 of the [Network Contract DES Specification](#). Commissioners may ask PCNs for further evidence to support new workforce reimbursement claims, which may include:

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<sup>11</sup> An online claims process is in development and further information will be made available to commissioners and PCNs in due course.

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- a. A signed contract of employment (can remove personal information where appropriate) clearly setting out the salary.
  - b. A contract/agreement with a provider for the provision of services.
  - c. A copy of a Network Agreement – if used as the basis for sub-contracting for services/staff.
- 7.7.3. In the event the practice(s) within the PCN decide to engage the services of staff reimbursable under the Additional Roles Reimbursement Scheme via a sub-contracting arrangement, the PCN will need to agree with the sub-contractor the relevant costs of the service and/or staff while bearing in mind the scheme rules. The rules are that reimbursement can only be claimed for 100 per cent of **actual salary plus employer on-costs (NI and pension)** up to the maximum amount for the relevant role, as outlined in the Network Contract DES Specification and within the PCNs overall Additional Roles Reimbursement Sum.
- 7.7.4. For social prescribing link workers engaged via a sub-contract to an organisation outside the PCN, and not directly employed, the reimbursement claim may include a contribution towards the additional costs charged by a sub-contractor for the delivery of social prescribing services. See section 10.1.8 below for details.
- 7.7.5. Commissioners should ensure that local processes are as straightforward as possible, with clear deadlines for submission of claims, and claims should be processed in a timely manner.
- 7.7.6. Reimbursement claims will be subject to validation and any suspicion that deliberate attempts have been made to subvert the additionality principles or to claim costs above and beyond those allowable, will result in a referral for investigation as potential fraud. PCNs may be asked as part of the validation process to re-confirm the position regarding the number of filled baseline posts at the point a reimbursement claim is made. They may also be asked to provide copies of sub-contracting or Service Level Agreements where they are claiming for staff employed or supplied by a third party.
- 7.7.7. Reimbursement will apply up to the Additional Roles Reimbursement Scheme cap and applies to actual salary plus employer on-costs (NI and pension) only, not to additional hours or recruitment and retention premia agreed in addition.
- 7.7.8. Commissioners may claim back reimbursement monies where it becomes apparent that a PCN was not eligible to claim reimbursement under the Network Contract DES e.g. because it failed to declare a vacant baseline post.

## 8. Additional Roles Reimbursement Scheme Workforce

### 8.1. Additional Roles

- 8.1.1. A PCN may employ or engage any one or more of the ten reimbursable rules in accordance with the details set out in section 6 and section 9 of the [Network](#)

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[Contract DES Specification](#). Annex B of the Network Contract DES Specification sets out the minimum role requirements for each of the ten reimbursable roles from April 2020 (twelve roles from 1 October 2020 with the addition of Nursing Associate and Trainee Nursing Associate) and the associated requirements placed on PCNs.

8.1.2. Table 2 below summaries the key information in respect of these twelve roles. The annual maximum reimbursable amounts per role must be pro-rated by the WTE of the role and the period of employment.

**Table 2: Key information for roles reimbursable under the Network Contract DES Additional Roles Reimbursement Scheme**

<b>Table 2</b>			
<b>Roles</b>	<b>Limit on number eligible for reimbursement</b>	<b>AfC band</b>	<b>Annual maximum reimbursable amount per role<sup>12</sup> (£)</b>
Clinical Pharmacists	No limit	7-8a	55,670
Pharmacy Technicians	One individual pharmacy technician per PCN where the PCN's Patients number 99,999 or less. Two individual pharmacy technicians per PCN where the PCN's Patients number 100,000 or over.	5	35,389
Social Prescribing Link Workers <sup>13</sup>	No limit	Up to 5	35,389
Health and Wellbeing Coaches	No limit	Up to 5	35,389
Care Co-ordinators	No limit	4	29,135
Physician Associates	No limit	7	53,724
First Contact Physiotherapists	One WTE per PCN where the PCN's Patients number 99,999 or less. Two WTE per PCN where the PCN's Patients number 100,000 or over.	7-8a	55,670
Dieticians	No limit	7	53,724
Podiatrists	No limit	7	53,724

<sup>12</sup> The maximum reimbursable amount is the sum of (a) the weighted average salary for the specified AfC band plus (b) associated employer on-costs. These amounts do not include any recruitment and reimbursement premiums that PCNs may choose to offer. If applicable, the on-costs will be revised to take account of any pending change in employer pension contributions. The maximum reimbursement amount in subsequent years will be confirmed in line with applicable AfC rates.

<sup>13</sup> For Social Prescribing Services sub-contracted by a PCN to another provider, PCN may claim a contribution of up to £2400 per year (£200 per month) towards additional costs charged by the sub-contracted provider in line with the rules set out in section 10.1.8 below.

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Occupational Therapists	No limit	7	53,724
Nursing Associate	No limit	4	29,135
Trainee Nursing Associate	No limit	3	25,671

- 8.1.3. From April 2021, paramedics and mental health practitioner roles will be included in the Scheme.

## 8.2. Role descriptions and terms and conditions

- 8.2.1. Employers of staff recruited under the Additional Roles Reimbursement Scheme will determine what terms and conditions, including salary, they offer new staff and may consider using Agenda for Change bands as a guideline. In doing so, they should take a fair approach with regards to remuneration relative to other staff already working within and across the PCN GP member practices.
- 8.2.2. Employers will decide the job descriptions of their own staff, ensuring they incorporate the minimum role requirements outlined Annex B of the [Network Contract DES Specification](#) and bearing in mind the abilities for the roles to support delivery of network services.
- 8.2.3. Decisions to amend terms and conditions of employment for existing staff is a matter for the employer following due process.

## 8.3. Clinical pharmacists

- 8.3.1. A minimum of 0.5 WTE should apply to the clinical pharmacists employed via the Network Contract DES. This is to ensure the clinical pharmacist is able to access timely national training and can deliver continuity of care whilst working across multiple providers within the PCN.
- 8.3.2. Clinical pharmacists being employed through the Network Contract DES funding will either be enrolled in or have qualified from an accredited training pathway that equips the pharmacist to be able to practise and prescribe safely and effectively in a primary care setting (currently, the Clinical Pharmacist training pathway<sup>14,15</sup>) and in order to deliver the key responsibilities of the role. NHS England and Improvement will be arranging a funding mechanism to allow all clinical pharmacists to access and complete an approved training pathway that equips the pharmacist to achieve this.
- 8.3.3. Upon completing the training pathway, the clinical pharmacist receives a 'Statement of Assessment and Progression' which details the learning undertaken and confirms the assessments they have passed. This documentation is available in both hardcopy and electronic format. In addition

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<sup>14</sup> CPPE Clinical Pharmacists in General Practice Training Pathway  
<https://www.cppe.ac.uk/career/clinical-pharmacists-in-general-practice-education#navTop>

<sup>15</sup> CPPE Medicines Optimisation in Care Homes Training Pathway  
<https://www.cppe.ac.uk/career/moch/moch-training-pathway#navTop>

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to this, evidence of training need for any current or future employer can be access through the protected section of the website of the learning provider, which captures the learning of the Clinical Pharmacists participating in their training.

- 8.3.4. This training requirement can be met with pre-existing qualifications / experience on the basis that it meets the learning objectives of the current approved training pathway funded by NHS England and Improvement. The training will be modular and clinical pharmacists are only required to undertake the training they need to complete the portfolio requirements. This accreditation of prior learning should be undertaken by the supervising senior clinical pharmacist and Clinical Director for the PCN.

### Supervision of Clinical Pharmacist

- 8.3.5. All clinical pharmacists will be part of a professional clinical network and will always be clinically supervised by a senior clinical pharmacist and GP clinical supervisor. The following supervision must be in place for senior clinical pharmacists and clinical pharmacists:
- a. Each clinical pharmacist will receive a minimum of one supervision session per month by a senior clinical pharmacist<sup>16</sup>;
  - b. The senior clinical pharmacist will receive a minimum of one supervision session every three months by a GP clinical supervisor; and
  - c. All clinical pharmacists will have access to an assigned GP clinical supervisor for support and development.
- 8.3.6. The ratio of senior to junior clinical pharmacists should be up to one to five, and in all cases appropriate peer support and supervision must be in place.
- 8.3.7. Flexible and innovative approaches to the formation of clinical networks can be adopted and promoted to enhance collaboration/integration across healthcare interfaces.

## 8.4. MOCH pharmacists

- 8.4.1. PCNs will be expected to make operational use of the pharmacist's experience in relation to Care Homes as outlined in section 9.3 below and section 7.3 of the [Network Contract DES Specification](#). This will include:
- a. supporting care homes with local policies and procedures, training, vaccinations and provide support for any challenges the home may have, including:
  - b. ordering and storage of medicines to reduce waste
  - c. supporting care planning and comprehensive geriatric assessments (CGA) structured medication reviews
  - d. link-in to community services, acute trusts and mental health services
  - e. supporting weekly care home rounds, working with the MDT

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<sup>16</sup> This does not need to be a senior clinical pharmacist within the PCN but could be part of a wider local network, including from secondary care or another PCN.

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- f. working with the wider MDT (including external organisations) to support the delivery of Enhanced Health in Care Homes.

### **8.5. Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Coordinators**

- 8.5.1. The Network Contract DES provides reimbursement for three personalised care roles based in primary care: Social Prescribing Link Workers, Health and Wellbeing Coaches and Personalised Care Coordinators. These roles form a resource for GPs and other primary care professionals to provide an all-encompassing approach to personalised care. In the context of the COVID-19 outbreak, these roles can also play a vital role in maintaining the health and wellbeing of those otherwise at risk of loneliness and social isolation. A single point of access is required for these roles to ensure that people receive the right support at the right time and to reduce the burden on general practice. This would generally be via the Social Prescribing Link Worker(s) who work with the other two roles to triage referrals.
- 8.5.2. A PCN's Core Network Practices must identify a first point of contact for each Social Prescribing Link Worker, Health and Wellbeing Coach and Care Coordinator, in order to provide general advice and support, and (if different) a GP to provide supervision. This can be one or more named individuals within the PCN. Individual and group coaching supervision for the Health and Wellbeing coach role must also be available from a suitably qualified or experienced health coaching supervisor.
- 8.5.3. A PCN's Core Network Practices must ensure the Social Prescribing Link Worker(s), Health and Wellbeing Coach(es) and Care Coordinator(s) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP. This GP may be the patient's named accountable GP, or another GP within the relevant Core Network Practice as appropriate.
- 8.5.4. Supporting guidance providing further information to help PCNs employ or engage Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Co-ordinators is available at:
  - a. Social prescribing link workers - <https://www.england.nhs.uk/publication/social-prescribing-link-workers/>
  - b. Health and Wellbeing Coaches - <https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/>
  - c. Personalised Care Institute - <https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/>

### **8.6. Allied Health Professionals**

- 8.6.1. From April 2020, PCNs will be able to claim reimbursement for four Allied Health Professional (AHP) roles, namely first contact physiotherapists,

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dieticians, podiatrists and occupational therapists. This will extend to include paramedics from April 2021.

- 8.6.2. PCNs employing or engaging AHPs must consider the qualifications, experience and capabilities when determining which job description is utilised for the role and considering the minimum role requirements set out in Annex B of the Network Contract DES Specification. Further information on capabilities is available at (while this document refers to the MSK framework, the capabilities have been written for all AHPs):  
[https://www.csp.org.uk/system/files/musculoskeletal\\_framework2.pdf](https://www.csp.org.uk/system/files/musculoskeletal_framework2.pdf).
- 8.6.3. Each AHP employed or engaged by a PCN must have access to appropriate clinical supervision and an appropriate named individual for general advice and support daily.
- 8.6.4. Further information is available at <https://www.england.nhs.uk/ahp/role/>.

### 8.7. Nursing

- 8.7.1. From October 2020, PCNs will be able to claim reimbursement for two nursing roles, namely trainees nursing associates and nursing associates.

## 9. Service requirements

### 9.1. Extended hours access

- 9.1.1. Section 7.1 of the [Network Contract DES Specification](#) sets out the requirements for delivery of extended hours access.

#### Who can deliver Extended Access on behalf of the PCN

- 9.1.2. Where a practice has signed up to the Network Contract DES, they become contractually obliged to offer extended access to its registered patients via the PCN (which can be delivered by the practice or sub-contracted). Therefore, all patients should have access to extended hours services through the PCN, but it will be for the PCN to determine how that offer is made available to all its registered patients.
- 9.1.3. The additional clinical appointments provided by a PCN are to be held at times that take account of patient's expressed preferences and are outside the hours that the PCN Core Network Practices' are required to provide as part of their primary medical services contracts. This means that if a Core Network Practice was required under a General Medical Services (GMS) contract to provide core services at its premises until 6:30pm, the additional clinical appointments could be provided after 6:30pm. If, however, another Core Network Practice in the PCN provided core services at its premises until 8pm, then:
  - a. any additional clinical appointments provided after 6:30pm but before 8pm must not be provided at the later closing practice's premises (as

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these would not be additional hours appointments) but could be provided at the other practice's premises; and

- b. a proportion of the additional clinical appointments must be provided after 8pm.

- 9.1.4. Core Network Practices within a PCN are collectively responsible for the delivery of extended hours access. In the event the commissioner is not satisfied that a PCN is delivering extended hours access in accordance with the Network Contract DES, then the commissioner may take action as set out in section 8 of the [Network Contract DES Specification](#). If a commissioner determines to withhold payment<sup>17</sup>, the amount withheld will be an appropriate proportion of the extended hours access payment and the Core PCN funding payment.
- 9.1.5. PCNs have the flexibility, once providing extended access, to sub-contract those services to other providers in accordance with any sub-contracting provisions of the GP practices' primary medical services contracts.
- 9.1.6. The delivery of extended hours access through the Network Contract DES will be in addition to any CCG commissioned extended access services.

### **Delivery models for PCN extended hours access appointments**

- 9.1.7. It will be up to the PCN to determine the delivery model for the extended hours access appointments as part of the Network Agreement, but PCNs will need to ensure this service is offered to the entire PCN population. The exact model of delivery in each PCN may vary and could include:
  - a. All practices in the PCN continuing to offer extended hours to its own registered list.
  - b. One practice undertaking the majority of the extended hours provision for the PCN's population, with other practices participating less frequently (but those practices' registered patients still having access to extended hours services at other sites).
  - c. One practice offering extended hours to its own registered list and the other practices sub-contracting delivery for their respective patients.
  - d. The PCN subcontracting as a whole to another provider for its collective population.
- 9.1.8. Irrespective of the delivery model, the PCN should ensure that all network patients have access to a comparable extended hours service offer. PCNs should ensure that any sub-contracting arrangements are in accordance with any sub-contracting provisions of the Core Network Practices' primary medical services contracts.

### **Funding for the extended hours access in the Network Contract DES**

- 9.1.9. The full year funding under the Network Contract DES equates to £1.45 per registered patient per annum. On top of this payment of £1.45 per registered

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<sup>17</sup> Payment withheld in this context would be an appropriate proportion of the payments in relation to both extended hours access and Core PCN funding payments.



patient per annum through the Network Contract DES, practices will receive within their global sum payments around £0.50p per patient to cover the expansion in delivery to 100 per cent of patients. Taken together, the two amounts would total a payment of approximately £1.95 (£1.45 plus £0.50p) per registered patient per year.

- 9.1.10. This funding is in addition to funding the practice may already receive from the CCG for delivering their commissioned extended access services.

## 9.2. Structured Medication Reviews (SMRs) and Medicines Optimisation

- 9.2.1. Further guidance related to the implementation and delivery of requirements relating to this service has been published<sup>18</sup>. The Network Contract DES Specification sets out that PCNs must have due regard to that separate guidance in delivery of the service requirements.

### Recording of SMRs on GP IT systems

- 9.2.2. The new coding requirements of this year's GP contract, including the new code for recording a SMR, can be found at section 10.4 of the [Network Contract DES Specification](#). This new code is expected to be released in October 2020 and must be used to record the occurrence of a SMR and follow up appointments.

### Additional metrics and outcomes

- 9.2.3. PCN rates of prescription of high-carbon inhalers and medicines of low priority will be displayed in the Network Dashboard. Metrics on prescribing quality for anti-microbials and drugs that potentially cause dependency, as well as a wider patient outcome measurement, are being considered and will be informed by future developments, such as the implementation of Public Health England's (PHE) report into prescribed medicines<sup>19</sup>. Once finalised, measures of prescribing quality for will be displayed on the new Network Dashboard. In the meantime, the Network Dashboard will link to existing data on prescribing rates of relevant drugs hosted by the BSA and Open Prescribing. Further detail will be contained in the standalone guidance document for the SMR and Medicines Optimisation.

## 9.3. Enhanced Health in Care Homes

### Relationship of DES to Enhanced Health in Care Homes Framework

- 9.3.1. The Network Contract DES and requirements for relevant providers of community physical and mental health services within the NHS Standard Contract establish a consistent, national, model for the Enhanced Health in Care Homes (EHCH) service. Commissioners, PCNs and other providers

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<sup>18</sup> <https://www.england.nhs.uk/publication/structured-medication-reviews-and-medicines-optimisation/>

<sup>19</sup> <https://www.gov.uk/government/publications/prescribed-medicines-review-report>

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should consider these requirements as a minimum standard. The Enhanced Health in Care Homes requirements remain of vital importance during the COVID-19 outbreak, to support the organisation and delivery of a coordinated service to care home residents, many of whom will be at very high risk of a severe negative impact (directly or indirectly) from COVID-19. Good practice is described in the [EHCH Framework](#) which will support implementation of a mature EHCH service.

### Definition of Care Home

- 9.3.2. For the purposes of the EHCH service requirements in the Network Contract DES specification, a 'care home' is defined as a CQC-registered care home service, with or without nursing. Whether each home is included in the scope of the service will be determined by its registration with CQC. The CQC website contains a spreadsheet which can be filtered to show CQC registered care homes. This spreadsheet can be found [here](#) and is titled *CQC care directory – with filters* followed by the date of the latest update. Column C can be filtered to show CQC registered care homes. All care homes in this directory are in the scope of the EHCH service.
- 9.3.3. The EHCH service requirements apply equally to people who self-fund their care and to people whose care is funded by the NHS or their local authority. It is equally applicable to care homes for people with learning disabilities and/or mental health needs and should not be interpreted as only pertaining to care homes for older people. However, secure mental health units are not in scope.

### Alignment of Care Homes to PCNs

- 9.3.4. Commissioners hold overall responsibility for ensuring that each care home is aligned to a single PCN, and this is an ongoing obligation. Commissioners will ensure alignment of existing homes to PCNs by 31 July 2020 and must keep this alignment up to date. In instances after 31 July 2020 where there are changes in circumstance after the initial alignment decision has been made - for example when new homes open, or if there is a change to the PCN such that one or more practices no longer participates in the Network Contract DES - the commissioner must have aligned a PCN to that home within three months of becoming aware of the alignment not being in place.
- 9.3.5. PCNs and commissioners are expected to take into account the following factors when considering which homes align with which PCNs:
- Where the home is located in relation to PCNs and their constituent practices
  - The existing GP registration of people living in the home
  - What contracts are already held between commissioner and practices to provide support to the home, or directly between the home and practices
  - Existing relationships between care homes and practices.
- 9.3.6. PCNs that have care homes allocated to them must provide the EHCH service to those care homes.

## Delivery plan with local partners

- 9.3.7. The plan for delivery of the EHCH service should include:
- a. An agreement between the PCN, relevant providers of community services and mental health, the care home, the commissioner and other local partners on the operating model for the home round and MDT.
  - b. Clear roles and responsibilities for delivery of each EHCH requirement, including the ongoing provision of care described in the personalised care and support plan.
  - c. Agreed risks to the successful delivery of the EHCH service, with clear mitigating actions, owners and timescales for resolution.

## Supporting re-registration of patients

- 9.3.8. In supporting patients to re-register with a practice in the aligned PCN, care homes, PCNs and commissioners must clearly communicate the benefits offered under the EHCH service, and ensure that the patient understands that they will not receive the service if they choose not to re-register. In instances where patients do not have the capacity to understand or make choices on re-registration, this discussion must take place with the person who has power of attorney over their affairs.

## Further guidance

- 9.3.9. Guidance for implementation of the following service requirements - and other aspects of a mature EHCH service - can be found in the [EHCH Framework](#):
- a. establishment and operation of a MDT;
  - b. establishment of information sharing protocols; and
  - c. delivery of a weekly home round.

## 9.4. Early Cancer Diagnosis

- 9.4.1. The NHS Long Term Plan sets two bold ambitions for improving cancer outcomes:
- a. By 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise to 75 per cent.
  - b. Achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis.
- 9.4.2. These ambitions build on and accelerate the significant progress already being made through the delivery of the recommendations of the Independent Cancer Taskforce (2015) and were developed after engagement with patients, clinicians, charities and other experts who came together to define the LTP's priorities.
- 9.4.3. Primary care has a vital role to play in system-wide improvement efforts to increase the proportion of cancers diagnosed early. The new ECD service requirements for PCNs seek to improve referral practice and screening uptake through network level activity. PCNs should make every possible

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effort to begin work on the Early Cancer Diagnosis specification from 1 April unless work to support the COVID-19 response intervenes. Further guidance related to the implementation and delivery of requirements relating to this service, including guidance on the appropriate management of suspected cancer referrals during the Covid-19 outbreak, is [available here](#).

### Recording of safety netting in GP IT systems

- 9.4.4. The new coding requirements of this year's GP contract can be found at section 10.4 of the [Network Contract DES Specification](#). The new code for recording that safety netting has taken place is set for release in April and is expected to be available for use in all local GPIT systems from October 2020.

### 9.5. Social prescribing service

- 9.5.1. A PCN must provide a social prescribing service to their collective patients.
- 9.5.2. This service can be provided by either directly employing Social Prescribing Link Workers or by sub-contracting the provision of the service to another provider. Regardless of which option a PCN chooses to deliver, the PCN should be employing or engaging at least some Social Prescribing Link Worker resource in accordance with section B3 of Annex B of the [Network Contract DES Specification](#).

## 10. Financial entitlements, nominated payee and payment information

### 10.1. Financial entitlements

- 10.1.1. Financial entitlements under the Network Contract DES reflect a blended payment as set out in section 9 of the [Network Contract DES Specification](#).
- 10.1.2. Table 3 provides a summary of the Network Contract DES financial entitlements payable to the PCNs nominated payee. All Network Contract DES payments are inclusive of VAT, where VAT is applicable.

Table 3: Summary of Network Contract DES financial entitlements

Table 3			
Payment details and allocation	Amount	Allocations	Payment timings
Core PCN funding	£1.50 per registered patient <sup>20</sup> per year (equating to £0.125 per patient per month).	CCG core programme allocations	Monthly in arrears <sup>21</sup> by the last day of the month in which the payment applies.
Clinical Director contribution	£0.722 per registered patient <sup>19</sup> per year (equating to £0.060 per patient per month).	PMC allocations	Monthly in arrears <sup>20</sup> by the last day of the month in which the payment applies.
Staff reimbursements	Actual salary plus employer on-costs to the maximum per WTE <sup>22</sup> amounts <sup>23</sup> as outlined in Network Contract DES Specification or Table 2 in this document.	PMC allocations	Monthly in arrears <sup>20</sup> by the last day of the month following the month in which the payment applied.  Payment claimable following start of employment.
Extended hours access	£1.45 per registered patient <sup>19</sup> (equating to £0.121 per patient per month).	PMC allocations	Monthly in arrears <sup>20</sup> by the last day of the month in which the payment applies.
Care home premium	£60 per bed for the period 1 August 2020 to 31 March 2021 (equating to £7.50 per bed per month).	PMC allocations	Monthly in arrears <sup>20</sup> by the last day of the month in which the payment applies.
PCN Support payment	£0.27 per weighted patient <sup>24</sup> for the period 1 April 2020 to 30 September 2020 (equating to £0.045 per weighted patient per month).	PMC allocations	Monthly in arrears <sup>20</sup> by the last day of the month in which the payment applies.
Additional funding from October 2020	Amount to be confirmed and covering the period 1 October 2020 to 31 March 2021.	PMC allocations	See paragraph 10.1.2.A below

<sup>20</sup> Based on the patient numbers as at 1 January immediately preceding the financial year. For example, the 1 January 2020 patient figures are used for the 2020/21 financial year.

<sup>21</sup> As per local payment arrangements (to account for where commissioners or Regional Teams do not have a payment run on the last day of the month).

<sup>22</sup> WTE is usually 37.5 hours in line with Agenda for Change Terms and Conditions, although this may vary for non-A4C posts. Where A4C does not apply, PCNs should calculate the relevant WTE according to the normal full-time hours for that role in the employing organisation with reimbursement being made on a pro-rata basis accordingly.

<sup>23</sup> The annual maximum amounts for 2020/21 as outlined in the Network Contract DES are to be pro-rated on the proportion of the year that an individual is in post.

<sup>24</sup> Based on the weighted patient numbers as at 1 January 2020.

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- 10.1.2.A. The reference in the Table 3 above to “Additional funding from October 2020” is a reference to the Investment and Impact Fund (IIF) which was introduced with effect from 1 October 2020. Further detail on how the IIF operates and associated payments can be found in Section 9.9A and Annexes C and D of the Network Contract DES Specification and the separate IIF guidance<sup>25</sup>.
- 10.1.3. Payments due to the PCN nominated payee will be made by the commissioner, no later than the last day of the month or the last day of the following month in which the payment claim was made for staff reimbursement and in line with local payment arrangements. For the Core PCN Funding, Clinical Director contribution, extended hours access and PCN Support Payments these payments will start from no later than the end of the month in which the participation of the Core Network Practices of a PCN have been confirmed and in line with local payment arrangements, providing that the ODS Change Instruction Notice has been submitted prior to the payment being made. The ODS Change Instruction Notice needs to be submitted by the last working day on or before the 14<sup>th</sup> day of any month and where it is submitted after this time, the change and payment will not take effect until the end of the following month.
- 10.1.4. Where the PCN is a Previously Approved PCN and the first payment is paid after April 2020, the first payment will be backdated to include payments due from 1 April 2020. Where the PCN is a new proposed PCN after 1 April 2020, the PCN will only be entitled to receive payments for the months for which it delivers the requirements of the Network Contract DES. Refer to section 10.3 for further information on how payment calculations for 2020/21 will be managed.
- 10.1.5. Apart from the PCN Core Funding payment (i.e. the £1.50 per head payment), all other Network Contract DES payments and the Network Participation Payment will be payable from CCG Primary Care Medical allocations<sup>26</sup>. The Core PCN Funding payment is payable from CCG core allocations<sup>27</sup> and is set out in the NHS Operational Planning and Contracting Guidance 2020/21<sup>28</sup>.

### **Network Participation Payment**

- 10.1.6. In addition to the payments made to the PCNs nominated payee under the terms of the Network Contract DES, practices participating in the Network Contract DES will be entitled to the Network Participation Payment (NPP) - as set out in the General Medical Services Statement of Financial Entitlements and Network Contract DES Specification. This payment is

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<sup>25</sup> <https://www.england.nhs.uk/publication/investment-and-impact-fund-2020-21/>

<sup>26</sup> <https://www.england.nhs.uk/publication/investment-and-evolution-update-to-the-gp-contract-agreement-20-21-23-24/>

<sup>27</sup> Details available at the following link: <https://www.england.nhs.uk/publication/ccg-allocations-2019-20-to-2023-24-core-services/>

<sup>28</sup> <https://www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21/>

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£1.761 per weighted patient per year, equating to £0.147 per patient per month. The numbers of weighted patients are based on the weighted contractor population taken as at quarter 4 immediately preceding the financial year (i.e. at 1 January in the preceding financial year). For example, the 2020/21 weighted contractor population figure will be that for quarter 4 in the 2019/20 financial year i.e. at 1 January 2020.

- 10.1.7. The NPP will be paid monthly in arrears on or before the last day of the month following the month in which the payment is due (i.e. payment for April will be made on or before the end of May). Where a practice is a Core Network Practice of a Previously Approved PCN and the first payment is paid after April 2020, the first payment will be backdated to include payments due from 1 April 2020. Where a practice is a Core Network Practice of a new proposed PCN after 1 April 2020, the practice will only be entitled to receive the NPP for the months for which it is actively participating in the Network Contract DES. Refer to section 10.3 below for further information on how payment calculations for 2020/21 will be managed.

### **Sub-contracted social prescribing service**

- 10.1.8. For Social Prescribing Services sub-contracted by a PCN to another provider, PCN may claim a contribution towards additional costs charged by the sub-contracted provider. A PCN may claim a contribution of up to £200 per month (£2,400 per year) for each WTE that the sub-contracted provider has apportioned to the PCN related activity. The overall contribution claimed cannot exceed £200 per month and the total amount claimed must not exceed the maximum reimbursable amount for a social prescribing link worker. PCNs may wish to ensure that any sub-contracting agreement explicitly states the relevant costs (or WTE equivalent) as a copy may be requested by commissioners as evidence to support a reimbursement claim.

### **PCN Support Payment and additional payment**

- 10.1.9. A PCN is entitled to a PCN Support Payment. This payment will be payable for the period 1 April 2020 to 30 September 2020 in accordance with the Network Contract DES Specification.
- 10.1.10. Through the IIF, £24.25 million is available to PCNs from 1 October 2020 to 31 March 2021 in accordance with the Network Contract DES Specification. Further guidance on the IIF has been published separately<sup>29</sup>.

## **10.2. Network Contract DES nominated payee**

- 10.2.1. The following paragraphs in the [Network Contract DES Specification](#) set out the factual points regarding who can hold the Network Contract DES and be the nominated payee:

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<sup>29</sup> <https://www.england.nhs.uk/publication/investment-and-impact-fund-2020-21/>

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- a. Paragraph 2.2.8 – “the “**Nominated Payee**” refers to a practice or organisation (which must hold a primary medical services contract) that receives payment of the applicable financial entitlement set out in this Network Contract DES Specification.”
- b. Paragraph 9.1.1 – “A practice participating in the Network Contract DES acknowledges that payments made under the Network Contract DES are dependent on the Core Network Practices of a PCN working together to deliver the requirements of this Network Contract DES.”
- c. Paragraph 9.1.5 – “The commissioner must ensure that payments due to a PCN set out in this Network Contract DES are made into the bank account of the Nominated Payee. The PCN must inform the commissioner of the relevant payment details of its Nominated Payee. The PCN will include in the Network Agreement the details of arrangements with the Nominated Payee and may indicate the basis on which the Nominated Payee receives the payments on behalf of the other practices, e.g. as an agent or trustee.”

10.2.2. The nominated payee must be party to the PCN’s Network Agreement. This is because the Network Agreement forms the legal agreement between the constitute members of the PCN. It will set out how the PCN has agreed to use the DES funding to support delivery and how the PCN has agreed the funding will be apportioned between the members within the PCN.

### **Nominated Payee – who is eligible?**

- 10.2.3. 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 and be party to the Network Agreement.
- 10.2.4. An APMS provider (including a provider who holds a hybrid NHS Standard Contract that is delivering primary medical 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 that a GP Federation holding an APMS contract for extended access or improved access (or another reason), could be nominated as the payee if all the Core Network Practices of the PCN agree. It also means that the same GP Federation could be nominated to be the payee for more than one PCN.
- 10.2.5. There are a few considerations that PCNs and commissioners should be mindful of in nominating a non-GP Practice APMS provider (i.e. a provider who does not hold the APMS contract for delivery of essential primary medical care services). See section 10.3.12 below.

### **10.3. Network Contract DES Payments**

- 10.3.1. Network Contract DES payment calculations were **not automated** via CQRS between April to August 2020. Commissioners were therefore required to make manual payments for all Network Contract DES payments, including the practice-level NPP, until such time as the relevant CQRS



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calculations went live. This section provides updated information on which payments will continue to be manually processed and which will be automated through CQRS from September 2020.

### Manual payment arrangements from September 2020

- 10.3.2. The Care Home Premium and Additional Roles Reimbursement Scheme payments will continue to be processed manually by commissioners and not be calculated automatically via CQRS. From October 2020, the rate of the Additional PCN funding (i.e. the IIF Total Achievement Payment) for each PCN is expected to be calculated automatically by CQRS and further information will be made available prior to the payments being due. These PCN payments are to be made to the nominated payee in accordance with section 9 of the [Network Contract DES Specification](#) and using the relevant national subjective and other finance system codes outlined in section 10.3.11 below, as follows:
- a. where the nominated payee is a GP practice setup within NHAIS<sup>30</sup> (also known as Exeter), the commissioner will be required to process payments via a manual variation to NHAIS; OR
  - b. where the nominated payee is a non-GP practice APMS provider the commissioner will be required to make local payment arrangements.
- 10.3.3. For new proposed PCNs approved after 1 April 2020, the PCN will only be entitled to receive the monthly payments for the months it delivers the service requirements of the Network Contract DES. Similarly, the NPP will only be payable to a Core Network Practice of a new proposed PCN for the months they deliver the requirements of the Network Contract DES.
- 10.3.4. The PCN's nominated payee will be required to sign up and submit the monthly claims via Tradeshift <https://www.sbs.nhs.uk/supplier-einvoicing>. Tradeshift is an [online e-invoicing platform](#) which NHS England is introducing to all suppliers. Tradeshift allows registered suppliers to upload their own invoices direct to the portal and track progress of the payment. It reduces payment times, cuts out postage and makes the whole process more efficient.

### Automated payment arrangements from September 2020 (due to CQRS calculations going live)

- 10.3.5. From September 2020, four payment calculations – the Core PCN Funding, Clinical Director, Extended Hours Access and NPP – **will be automated** via the CQRS. Apart from the NPP, these PCN payments are to be processed as follows:
- a. For GP practice nominated payees – the payment file will be processed directly from CQRS to NHAIS (and subsequently PCSE Online when available).

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<sup>30</sup> Or Primary Care Support England (PCSE) Online when this replaces NHAIS.

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- b. For non-GP practice APMS provider nominated payees - commissioners will be required to make manual payments, using the payment calculation information supplied by CQRS – details to be confirmed on how this will be provided. The payments are to be made to the nominated payee, using the relevant national subjective and other finance system codes (see 10.1.10.3.11 below) using local payment arrangements.
- 10.3.6. The NPP will be processed directly from CQRS to NHAIS (and subsequently PCSE Online when available) as with any other practice related payments. Practices will need to ensure that they validate the payment in CQRS before it proceeds for validation by the commissioner.
- 10.3.7. CQRS will calculate these four payments using the PCN ODS reference data towards the end of each month. Commissioners should ensure that any changes to the PCN ODS reference data are submitted using the PCN ODS Change Instruction Notice<sup>31</sup> by the last working day on or before the 14<sup>th</sup> day of each month, so as to ensure the changes take effect prior to the CQRS payment calculation date. In the event a PCN ODS Change Instruction Notice is completed after the 14<sup>th</sup> day of a month, then changes will not take effect until the subsequent month and the commissioner may be required to follow a manual exception process (i.e. manual payment reconciliation) to ensure the correct payment are made.
- 10.3.8. Commissioners will need to ensure the NPP and PCN payments within CQRS are all validate through the two approval steps.

### **Additional payment information**

- 10.3.9. A PCN is required to use the national mandatory [Additional Roles Reimbursement Scheme Claim Form](#) for all workforce claims. This claim form is to be completed and submitted on a monthly basis in accordance with the instructions from the commissioner. Commissioners are to inform PCNs as soon as possible where claim forms should be returned to. NHS England and NHS Improvement are in the process of developing an online platform to replace this claim form and further information will be made available in due course.

### **Payment arrangements from April 2021**

- 10.3.10. Work is being undertaken to support the introduction of 'any nominated payee' from 2021/22. This is to allow for a non-GP provider to be a PCN's nominated payee and/or for a separate bank account to be link to the PCN ODS code. Further information will be made available in due course.

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<sup>31</sup> The PCN ODS Change Instruction Notice is available [here](#).

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**National subjective and finance system codes for Network Contract DES**

10.3.11. Tables 4 and 5 set out the relevant subject and finance system codes that commissioners will be required to use. Table 4 includes those codes available from April 2020 to support all payments under the 2020/21 Network Contract DES Specification and Table 5 includes those codes available from April 2021.

Table 4: National subjective and finance system codes for Network Contract DES payments

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
Network Participation Payment	PARTIA	A	C&M-APMS PCN DES Participation	521610XO
	PARTIG	G	C&M-GMS PCN DES Participation	521610XW
	PARTIP	P	C&M-PMS PCN DES Participation	521610YD
Core PCN funding	PCNSUA	A	C&M-APMS PCN DES PCN support	521610ZE
	PCNSUG	G	C&M-GMS PCN DES PCN Support	521610ZI
	PCNSUP	P	C&M-PMS PCN DES PCN Support	521610ZL
Clinical Director contribution (population-based payments)	CLINDA	A	C&M-APMS PCN DES Clinical Director	521610YE
	CLINDG	G	C&M-GMS PCN DES Clinical Director	521610YI
	CLINDP	P	C&M-PMS PCN DES Clinical Director	521610YN
Staff reimbursements	CPHARA	A	C&M-APMS PCN DES Clin Pharmacist	521610UD
	CPHARG	G	C&M-GMS PCN DES Clin Pharmacist	521610UE
	CPHARP	P	C&M-PMS PCN DES Clin Pharmacist	521610UO
	SPRESA	A	C&M-APMS PCN DES Soc Prescribing	521610VD
	SPRESG	G	C&M-GMS PCN DES Soc Prescribing	521610VE
	SPRESP	P	C&M-PMS PCN DES Soc Prescribing	521610VI
	PHYSIA	A	C&M-APMS PCN DES Physiotherapist	521610VO
	PHYSIG	G	C&M-GMS PCN DES Physiotherapist	521610WD
	PHYSIP	P	C&M-PMS PCN DES Physiotherapist	521610WE
	PASSOA	A	C&M-APMS PCN DES Physician Assoc	521610WI
	PASSOG	G	C&M-GMS PCN DES Physician Assoc	521610WO

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Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
	PASSOP	P	C&M-PMS PCN DES Physician Assoc	521610XA
	DIETIA	A	C&M-APMS PCN DES Dieticians	5216108A
	DIETIG	G	C&M-GMS PCN DES Dieticians	
	DIETIP	P	C&M-PMS PCN DES Dieticians	
	PHARTA	A	C&M-APMS PCN DES Pharmacy technicians	5216108B
	PHARTG	G	C&M-GMS PCN DES Pharmacy technicians	
	PHARTP	P	C&M-PMS PCN DES Pharmacy technicians	
	PODIAA	A	C&M-APMS PCN DES Podiatrist	5216108C
	PODIAG	G	C&M-GMS PCN DES Podiatrist	
	PODIAP	P	C&M-PMS PCN DES Podiatrist	
	OCCTHA	A	C&M-APMS PCN DES Occupational Therapists	5216108D
	OCCTHG	G	C&M-GMS PCN DES Occupational Therapists	
	OCCTHP	P	C&M-PMS PCN DES Occupational Therapists	
	HWELLA	A	C&M-APMS PCN DES Health and Wellbeing Coach	5216108E
	HWELLG	G	C&M-GMS PCN DES Health and Wellbeing Coach	
	HWELLP	P	C&M-PMS PCN DES Health and Wellbeing Coach	
	CARECA	A	C&M-APMS PCN DES Care Coordinator	5216108F
	CARECG	G	C&M-GMS PCN DES Care Coordinator	
	CARECP	P	C&M-PMS PCN DES Care Coordinator	
Care home premium	CHOMPA	A	C&M-APMS PCN DES Care Home Premium	5216108G
	CHOMPG	G	C&M-GMS PCN DES Care Home Premium	
	CHOMPP	P	C&M-PMS PCN DES Care Home Premium	
Extended hours access	EXTHDA	A	C&M-APMS Extended Hours Access DES (APMS)	521610UN
	EXTHDG	G	C&M-GMS Extended Hours Access DES (GMS)	521610V8
	EXTHDP	P	C&M-PMS Extended Hours Access DES (PMS)	521610VW
PCN Support Payment	SUPPPA	A	C&M-APMS PCN Support Payment (APMS)	5216108K
	SUPPPG	G	C&M-GMS PCN Support Payment (GMS)	

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Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
	SUPPPP	P	<i>C&amp;M-PMS PCN Support Payment (PMS)</i>	
IIF Aspiration Payment	IIFASA	A	<i>C&amp;M-APMS IIF Aspiration</i>	5216108H
	IIFASG	G	<i>C&amp;M-GMS IIF Aspiration</i>	
	IIFASP	P	<i>C&amp;M-PMS IIF Aspiration</i>	
IIF Achievement Payment	IIFACA	A	<i>C&amp;M-APMS IIF Achievement</i>	5216108I
	IIFACG	G	<i>C&amp;M-GMS IIF Achievement</i>	
	IIFACP	P	<i>C&amp;M-PMS IIF Achievement</i>	

Table 5: National subjective and finance system codes for paramedics for use from 1 April 2021

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
Staff reimbursements	HOMRRA	A	<i>C&amp;M-APMS PCN DES Home/RR paramedic</i>	521610XD
	HOMRRG	G	<i>C&amp;M-GMS PCN DES Home/RR paramedic</i>	521610XE
	HOMRRP	P	<i>C&amp;M-PMS PCN DES Home/RR paramedic</i>	521610XI

### Payment considerations

- 10.3.12. The following sets out a number of considerations for commissioners and networks with regards to who is nominated the payee and how payments will be processed:
- a. The nominated payee must be party to the Network Agreement (this could mean party to more than one Network Agreement if it is a GP Federation).
  - b. As outlined above non-GP Practice APMS providers are not currently setup within NHAIS (also known as Exeter) and as such, this system cannot be used to process the payments. In 2020/21, Commissioners will therefore need to put in place local payment arrangements to make payments to a non-GP Practice APMS provider.
  - c. APMS contracts are time limited. In the event a non-GP practice APMS provider acting as a nominated payee no longer holds an APMS contract, then the nominated payee will need to be changed to be a provider who holds a primary medical services contract. In this circumstance, the PCN would also need to update their Network Agreement accordingly.
  - d. There are VAT considerations for the PCN if the APMS provider (e.g. GP Federation) charges any commission for their services in being the nominated payee. These charges would not be reimbursed by commissioners and would remain a liability for the PCN to manage. Further information on VAT is available in the [Network Contract DES and VAT Information Note](#).

## 11. Frequently Asked Questions

- 11.1. A set of [Frequently Asked Questions](#) for the Network Contract DES has been published by NHS England and NHS Improvement and will be updated periodically throughout the year.