

Network Contract Directed Enhanced Service

Frequently Asked Questions 2020/21

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Equalities and health inequalities statement

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- 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 Network Contract 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 document provides a number of frequently asked questions (FAQs), providing additional information to PCNs and commissioners. It will be updated periodically throughout the year and does not take precedence over the Network Contract DES Specification.

2. General FAQs

2.1 Where can I find the relevant Network Contract DES Documents?

The Network Contract DES documents can be found at the following links:

- a. [Network Contract DES Specification: PCN Requirements and Entitlements 2020/21](#)
- b. [Network Contract DES Guidance for 2020/21 in England](#)
- c. Network Contract DES [Practice Participation Form](#)
- d. Network Contract DES Additional Roles Reimbursement Scheme [Claim Form](#)
- e. Network Contract DES [Network Agreement and Schedules](#)
- f. [Data Sharing and Data Processing Agreements](#)
- g. [Framework for Enhanced Health in Care Homes](#)
- h. [Early Cancer Diagnosis Guidance](#)
- i. [Workforce planning template 2020/21](#)

In addition to the above documents, practices and commissioners should be aware of the [cover note](#) published alongside the above documents. This note outlines the revisions to the 2020/21 Network Contract DES in light of COVID-19.

2.2 Is funding available to provide PCN staff with IT equipment?

It is expected that PCN staff will be supported using existing commissioning arrangements, specifications, standards and enabling systems. Until funding for the IT services required by PCNs is clarified, CCGs will have the discretion, subject to funding availability and arrangements with their delivery partners, to consider requests for provision of equipment and support on an interim basis.

2.3 Once a practice has agreed to participate in the Network Contract DES for 2020/21, can they then later opt out?

After 31 May 2020, a Core Network Practice cannot end its participation in the Network Contract DES except as set out in section 4.14 of the [Network Contract DES Specification](#) in one of the following exceptional circumstances:

- a. expiry or termination of the Core Network Practices primary medical services contract;
- b. an irreparable breakdown in relationships or an expulsion;
- c. commissioner consent due to merger or split of a Core Network Practice; or
- d. commissioner determination that the Core Network Practice's participation in the Network Contract DES should cease.

Further information with regards to these circumstances is included in the sections 5.13, 5.14, 5.15 and 8 respectively of the [Network Contract DES Specification](#).

2.4 Can the Core Network Practice membership of a PCN change during the year?

In most circumstances, the Core Network Practices of a PCN are expected to remain constant throughout the year following their participation in the Network Contract DES having been approved by the commissioner. However, PCN membership may change during the year due to either:

- a. exceptional circumstances within which the PCNs Core Network Practice membership may need to change after 31 May 2020 participation deadline, or
- b. a new practice joins a PCN.

The exceptional circumstances are summarised in question 2.3 above and full details is included in sections 5.8, 5.12, 5.13, 5.14 and 5.15 of the [Network Contract DES Specification](#). Section 5.16 of the Network Contract DES specification provides further information for a new practice joining a PCN.

2.5 The Network Contract DES Specification states that Core Network Practices will be auto-enrolled into a subsequent years Network Contract DES or an in-year variation. What does this mean?

A practice participating in the Network Contract DES for 2020/21 will, as part of the requirements, agree to automatically participate in any subsequent years Network Contract DES and any variation that may take place in-year prior to the 31 March, unless it chooses not to in accordance with section 4.13 of the [Network Contract DES Specification](#). This means that unless a practice chooses to opt out of the subsequent Network Contract DES or in-year variation during the one calendar month from the publication of the specification by NHS England and NHS Improvement, they would be auto-enrolled into the updated Network Contract DES.

3. Additional Roles Reimbursement Scheme

3.1. General

3.1.1 What is considered to be whole time equivalent?

Whole time equivalent (WTE) is usually 37.5 hours in line with Agenda for Change (A4C) Terms and Conditions, although this may vary for non-A4C posts. Where A4C

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does not apply, PCNs should calculate the relevant WTE according to the normal full-time hours for that role in the employing organisation.

PCNs should note that the maximum reimbursable amounts per role under the Network Contract DES are based on WTE being 37.5 hours per week. As such, the reimbursement claimed would need to be pro-rata according to the hours worked and for the proportion of the year that the individual was in post.

3.1.2 Do PCNs have to recruit a specific number of each of the roles each year from their Additional Roles Reimbursement Sum?

PCNs do not have to recruit a fixed or expected number of staff in specific roles. It is up to PCNs to decide the mix of workforce they require from the reimbursable roles under the Additional Roles Reimbursement Scheme in order to support delivery of the Network Contract DES requirements.

There is currently a limitation on the number of pharmacy technicians and first contact physiotherapists a PCN can recruit or engage, as follows:

Roles	Limit on number eligible for reimbursement
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.
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.

3.1.3 If clinical pharmacists are provided to the PCN through a contracting arrangement with another organisation, will they be able to access the training and development provided as part of the Network Contract DES?

The full training being funded by NHS England and NHS Improvement for clinical pharmacists working in PCNs, will at the current time, take approximately two years to complete. Due to this, there are some limits on the access to this training:

- a. clinical pharmacists providing short term cover will not be eligible to participate in this training offer; and
- b. clinical pharmacists working in PCNs as part of a temporary arrangement between the employing organisation and the PCN will not be eligible to participate in this training offer and not be eligible for reimbursement under the Network Contract DES Additional Roles Reimbursement Scheme.

3.1.4 Is there an age limit on the people Social Prescribing Link Workers or Health Coaches can work with or support?

No, there is no age limit. Social prescribing can be a very positive method of support for children and young people, particularly in areas such as mental health and emotional wellbeing. To deliver Social Prescribing to this age group you need consider how you will work in partnership with a range of services, both statutory, voluntary and community sector to ensure the support is personalised for the age group and delivered by professionals with experience of working directly with children and young people. Many areas are already delivering social prescribing to under 18's and are seeing positive outcomes and impact. It is also expected that where a Social Prescribing Link Worker, or a Health Coach, is working with or supporting a child or young person then the appropriate (and where relevant) engagement with their parent, carer or guardian would also apply.

3.2. Baseline and additionality

3.2.1 How are staff roles that were vacant at the time the baseline was taken to be accounted for? Were they included in the baseline?

The baseline should only have recorded those posts that had staff in post, with a signed contract of employment, as at 31 March 2019. As such, any posts that were vacant as at 31 March 2019 should not have been included in either the PCN or CCG baselines.

3.2.2 In some areas, pilots were underway involving some of the relevant reimbursable roles and were due to end after 31 March 2019. Should these staff have been included in the relevant baseline?

Yes, all practice and CCG-funded roles with staff in post as at 31 March 2019 should have been included in the relevant baseline – irrespective of whether they were established on a fixed-term basis. Pilot posts funded by local authorities or voluntary sector organisations should have been excluded from the baseline.

3.2.3 Should a reimbursable role included in the CCG baseline as at 31 March 2019, that was funded by a commissioner on a fixed-term contract or part of a pilot, continue to be funded following the end of the fixed term contract or pilot?

Yes, this expectation was clearly set out in [Investment and Evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan](#). The aim of the Additional Roles Reimbursement Scheme is to fund additional workforce capacity in general practice. As with any snapshot baseline assessment, there will be winners and losers but there is a clear expectation that if commissioners were funding posts as at 31 March 2019, then that funding should be maintained on an ongoing basis. Commissioners will be subject to audit to ensure this funding is maintained.

3.2.4 How should Social Prescribing Link Workers (SPLWs) have been reflected in the baseline if they were funded by a number of CCGs in a Sustainability and Transformation Partnership (STP), but commissioned by the County Council who sub-contract the voluntary sector organisation for their provision?

They should have been included in the CCG baseline as they were CCG funded posts.

3.2.5 The Network Contract DES Guidance states that commissioners are expected to continue to fund CCG baseline posts. Does this apply to the CCG funded posts on the national *Clinical Pharmacist in General Practice Scheme* and *Medicines Optimisation in Care Homes Scheme*, where these staff have transferred to PCNs?

No. This is the only exception and commissioners will not be required to continue to fund Clinical Pharmacist or Pharmacy Technician posts on the national schemes that have transferred to PCNs.

3.2.6 Should the baseline have sought to capture all commissioner contracted pharmacists, including those working in Medicine Optimisation?

If these staff were supporting general practice and had a patient-facing element to their role, then the relevant whole time equivalent (WTE), including associated administration or travel time, should have been included in the CCG baseline. Those staff undertaking non-patient facing CCG activities should be excluded.

3.2.7 Should locums and sessional staff (in any of the reimbursable roles) who are used by practices for short periods of time have been included in the relevant baseline?

Short-term cover arrangements should not be included in the baseline but regular or long-term cover arrangements e.g. those lasting six months or more should be recorded in the relevant baseline, if those arrangements were in place as at 31 March 2019.

Regular sessions provided as part of a service contract should be included with the appropriate WTE calculated.

For maternity leave, the person for whom the locum or sessional staff were providing cover for would have been included in the baseline and so there was no need to also record cover.

3.2.8 How should staff who were employed by GP Federations have been recorded in the baseline?

This depends on who was funding the posts. If practices were providing the funding, then the posts should have been included in the PCN baseline. If the posts were being funded by another NHS organisation, then they should be included in the CCG

baseline. As outlined in the [2019/20 Additional Roles Reimbursement Guidance](#), those clinical pharmacists funded by national schemes should have been counted in the baseline relevant to who had responsibility to cover the costs once the national funding tapered.

3.2.9 How should commissioners have recorded and provided the declarations of the Clinical Director and CCG accountable officers in relation to agreeing the PCN baseline?

The baseline survey template completed by commissioners and returned via NHS England and NHS Improvement Regional Teams contained space for this declaration. However, it is important that the PCN and commissioner have a document that they have both signed that can be used as evidence for audit purposes.

3.2.10 How will changes to PCN Core Network Practice membership be taken into account in relation to the PCN baseline?

The Core Network Practices in a PCN should agree with the commissioner how the PCN workforce baseline should be amended to reflect a practice joining or leaving the PCN. If a practice is moving to a different PCN, a proportion of the baseline may be transferred to the new PCN's baseline. Any changes should be reflected in National Workforce Reporting Service and CCG six-monthly returns.

3.2.11 A clinical pharmacist was in post on the 31 March 2019 and included in the PCN baseline but leaves after this date. Can a new clinical pharmacist be recruited and be exempt from the additionality rule?

If the post was filled on 31 March 2019 and the PCN transferred in this post prior to the deadline of 31 March 2020, then the post would be exempt from the additionality rule, regardless of whether or not it was filled or vacant in the period between 1 April to 31 March 2020. The PCN could claim reimbursement under the Additional Roles Reimbursement Scheme for this post once refilled.

However, if the post was not transferred and remained a practice-level post, then after 3 months of the post becoming vacant the PCN lose reimbursement for an appropriate post under the Additional Roles Reimbursement Scheme until such time as the baseline practice post was refilled.

3.2.12 A clinical pharmacist on the CCG baseline remained on the Clinical Pharmacists in General Practice scheme but has now left their post. Does the CCG have to maintain the funding for this post?

Yes. The clinical pharmacist does not count as an exception under the additionality rules and the CCG is required to maintain this level of funding in primary care workforce.

3.2.13 Some clinical pharmacists had been recruited by Acute Trusts, Agencies, GP Federations and commissioners – should they have been

counted in the baseline and were they allowed to transfer across to a PCN and be exempt from the additionality principles?

There are a number of scenarios depending on how the clinical pharmacists were funded:

- a. If funded as part of one of the national reimbursement schemes - *Clinical Pharmacists in General Practice Scheme* or *Medicines Optimisation in Care Homes Scheme* - then they should have been included in the PCN baseline unless they transferred to the PCN by the deadline of 31 March 2020.
- b. If funded directly by a practice, then they should have been included in the PCN baseline. These clinical pharmacists were not able to transfer to a PCN and they are not exempt from the additionality principles.
- c. If funded by a CCG, Acute Trust or another organisation and providing patient facing services in primary care, then only the WTE associated with the patient facing service should have been included in the CCG baseline. These clinical pharmacists could not be transferred to a PCN and be exempt from the additionality principles.

3.3. Reimbursement claims

3.3.1 Once the PCN has provided evidence of a contract of employment, and the PCN is being reimbursed, can the reimbursement be setup as a recurrent monthly payment rather than the PCN claiming each month?

PCNs will need to claim on a monthly basis for all staff recruited or engaged via the Additional Roles Reimbursement Scheme using the [national claim form](#). Therefore, establishing a recurrent payment for these roles will not be possible under the current reimbursement process.

3.3.2 Is the reimbursement, once claimed, guaranteed?

Once claimed, PCNs will be entitled to continue to receive reimbursement on an ongoing basis as part of their Additional Roles Reimbursement Sum so long as they continue to meet the requirements set out as part of the Network Contract DES, which will exist until at least 31 March 2024. As set out in [Investment and Evolution: Update to the GP contract agreement 2020/21 – 2023/24](#), staff employed or engaged through the Addition Roles Reimbursement Scheme will be considered as part of the core general practice cost base beyond 2023/24.

3.3.3 What happens if a member of reimbursed staff goes parental or sickness leave, can the PCN continue to claim their reimbursement?

The PCN would continue to be reimbursed during maternity and sick leave, in line with the relevant employment contract provisions (i.e. as salary is reduced as appropriate then the level of reimbursement also would be reduced), as they have employment costs associated with this absence and it is then up to the PCN as to whether they employ temporary cover or not. This may be an additional expense on

top of the employer's responsibility to pay for maternity and sickness absence, but the PCN would only be able to claim for the WTE that was `absent`.

As set out in the Network Contract DES Specification, whether or not a bidding practice has a member of staff on paid leave, e.g. sickness or parental, is a criterion in the process for redistributing any Additional Roles Reimbursement Funding, if applicable.

For clinical pharmacists, it is not possible to offer temporary staff access to the NHS England and NHS Improvement commissioned training pathway or Independent Prescribing training. As such, PCNs will need to ensure the clinical pharmacist providing the cover has completed the required training.

3.3.4 The funding figures given state maximum values for the staff grading. If a PCN employs someone at the tail-end of the financial year, can they claim the full year reimbursement value (if that cost has actually been incurred) or is the annual figure a total of a maximum monthly reimbursement figure?

The maximum reimbursement amount is to apply on a pro-rata basis on the proportion of the year that an individual is in post i.e. the annual figure would equate to a monthly maximum reimbursement amount.

3.3.5 The guidance states that the CCG baseline will have no bearing on PCN additionality claims. Is this correct?

Yes, that is correct. CCGs are expected to maintain their baseline funding levels and PCN reimbursement claims are only assessed against the PCN baseline.

3.3.6 What happens to reimbursement if a role within the PCN baseline becomes vacant?

When a vacancy occurs within one of the reimbursable roles in the PCN baseline, this has eligibility implications for claims being made under the Additional Roles Reimbursement Scheme, regardless of who employs the vacant post within the PCN baseline.

In such circumstances, after the three months' grace period of the post becoming vacant, the PCN would not be eligible to claim for one of the same roles (to that of the vacancy) through the Additional Roles Reimbursement Scheme, until such time as the vacant post is refilled. This is due to the PCN no longer meeting the additionality rules outlined in the Network Contract DES specification.

By way of an example - if a clinical pharmacist role becomes vacant in the PCN baseline and is not filled within three months, the PCN would not be eligible to claim for one clinical pharmacist under the Additional Roles Reimbursement Scheme, until such time as the vacancy is filled. In the interim, the PCN would need to agree how the PCN clinical pharmacist for which funding cannot be claimed will be resourced.

3.3.7 Can the PCN claim reimbursement for a proportion of a 1 WTE for the reimbursable roles to allow the individuals to work across multiple settings e.g. the PCN and a CCG?

Yes, this is permitted within the rules of the scheme although PCNs will only be able to claim reimbursement for the proportion of time the individual or service is being provided to the PCN.

With regards to clinical pharmacists, a minimum of 0.5 WTE applies to clinical pharmacists employed or engaged via the Network Contract DES so as 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. Providing that each individual clinical pharmacist works a minimum of 0.5 WTE then the PCN(s) can claim the relevant WTE reimbursement in accordance with the Network Contract DES. As such, if a single clinical pharmacist is working across multi-PCNs then they must in total work a minimum of 0.5 WTE.

3.3.8 There is a limited availability of some or all of the reimbursable roles and the PCN has been unable to recruit or engage staff to aid delivery of all of the Network Contract DES requirements. Is it possible to claim reimbursement for staff that can only partially deliver the requirements?

No. Any staff reimbursed under the Additional Roles Reimbursement Scheme must meet the full requirements set out in the Network Contract DES Specification.

3.3.9 To be able to draw down Additional Roles Reimbursement Sum funding, in addition to recruiting additional staff into the PCN itself, can PCN's contract with another organisation to provide those staff?

Yes. PCNs can contract with another provider to provide PCN staff and the PCN can then claim reimbursement. However, the PCN will only be able to claim up to the maximum reimbursement for the relevant post per WTE and may be asked to provide a copy of the agreement or contract to commissioners as part of its claim. Therefore, it may be sensible for any agreement or sub-contract to clearly set out the staff costs and also include copies of job descriptions (JDs) confirming that the staff's JDs meet the requirements of Annex B of the Network Contract DES Specification.

Where a contract for staff is in place there may be VAT considerations for the PCN. The commissioner will not reimbursement any VAT incurred.

3.3.10 A Clinical Pharmacist included in the PCN baseline transferred to the PCN before the 31 March 2020. They have now handed in their notice. Does the PCN have to fill this vacancy to avoid having an equivalent reduction in their claims under the Additional Roles Reimbursement Scheme?

Clinical Pharmacists transferred by 31 March 2020 from the *Clinical Pharmacists in General Practice Scheme* are exempt from the additionality rule and not included in the PCN baseline. This means that if a clinical pharmacist employed via the scheme

leaves employment after they are transferred to work as part of the PCN multi-disciplinary team (MDT), then the vacant post does not need to be recruited to before being able to claim or continuing to claim for an equivalent post under the Additional Roles Reimbursement Scheme. This is because any of the Additional Roles engaged via the PCNs Additional Roles Reimbursement Sum can be replaced as staff leave and PCNs have the ability to shape their workforce.

3.3.11 In the scenario described in question 3.3.10, could the PCN choose to replace the clinical pharmacist with another workforce role, for example a physician associate or dietician?

Under the Additional Roles Reimbursement Scheme, the PCN will be able to employ or engage any of the reimbursable roles to fill this post. As such, if a clinical pharmacist transferred to work as part of the PCNs MDT, the PCN is free to replace this role with whichever of the Additional Roles they wish. However, PCNs cannot claim for posts that are vacant and as such can only claim reimbursement once there are costs being incurred and providing they do not exceed the PCNs overall Additional Roles Reimbursement Sum.

3.3.12 Do clinical pharmacists or pharmacy technicians employed or engaged through the Additional Roles Reimbursement Scheme need to undertake the training and development provided by CPPE or is it optional?

All clinical pharmacists and pharmacy technicians employed through the Network Contract DES must be enrolled in, undertaking or qualified from the relevant training pathway that equips them to be able to practise, and where appropriate prescribe safely and effectively, in a primary care setting and to deliver the key responsibilities outlined in the Network Contract DES. This training is currently the CPPE Clinical Pharmacist training pathways^{1,2}.

However, clinical pharmacists and pharmacy technicians will have a range of prior experience, training and qualifications, which may lead to exemption from some modules in the pathway. Please refer to the guidance developed by CPPE, in conjunction with NHS England and NHS Improvement and Health Education England, in relation to equivalent learning exemptions. The document is on the [CPPE website](#).

In addition, clinical pharmacists are required to undertake Independent Prescribing training, if they do not already hold this qualification. This is in addition to the training pathway.

Clinical Pharmacists and Pharmacy Technicians employed by PCNs that do not undertake and complete the required training will not meet the terms of the Additional Roles Reimbursement Scheme and the PCN will therefore not be able to claim reimbursement for this role Scheme.

¹ <https://www.cppe.ac.uk/career/clinical-pharmacists-in-general-practice-education#navTop>

² <https://www.cppe.ac.uk/wizard/files/general-practice/clinical-pharmacists-in-general-practice-education-brochure.pdf>

4. Financial entitlements and payment arrangements

4.1. Where can I find information on the Network Contract DES financial entitlements and payment arrangements?

Section 9 of the Network Contract DES Specification and section 10 of the Network Contract DES Guidance provide details of financial entitlements and payment arrangements in 2020/21.

4.2. What providers can be the nominated payee for a PCN?

A PCNs nominated payee must hold a primary medical services contract and be party to the PCNs Network Agreement. This includes providers who hold an APMS contract as part of a hybrid NHS Standard Contract Schedule 2L arrangement.

The PCNs Core Network Practices must all agree who the nominated payee is, and commissioners must ensure the nominated payee information is included in the PCN ODS data.

4.3. Can a GP Federation who holds an APMS contract for out-of-hours or improved access by a PCNs nominated payee?

Yes, providing the GP Federation holds an APMS contract and all PCN Core Network Practices agree. The same applies if the GP Federation's APMS contract is part of a hybrid NHS Standard Contract Schedule 2L arrangement.

In nominating a GP Federation, PCNs should be mindful that:

- The GP Federation will need to be party to the Network Agreement and the Network Agreement will need to clearly set out the agreement on the financial arrangements.
- In 2020/21 payments will not be able to be made via NHAIS³ or its subsequent replacement, if the nominated payee is not setup in this system (this is most likely the case for any GP Federation). GP Federations who are the nominated payee will need to invoice for payment using the Tradeshift process (see section 10.3 of the Network Contract DES Guidance).
- In the event a GP Federation no longer holds an APMS contract then the nominated payee would need to be changed to be a provider who holds a primary medical services contract.
- In the event a GP Federation charges a commission to the PCN, there may be VAT considerations and these charges will not be reimbursed by the commissioner.

Commissioners should be mindful that:

- Payments must be made to the single nominated payee and the nominated payee must always hold a primary medical services contract.

³ Also known as Exeter.

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- In 2020/21, commissioners will be required to make payments to the non-GP providers using local payment arrangements.
- Commissioners will be required to use the relevant national subjective and other finance system codes and provide any information as required to support national reporting of primary medical services expenditure.
- Commissioners will need to ensure relevant financial reporting information is provided to NHS England and NHS Improvement to monitor spend against the Network Contract DES – specifically where payments are not being made via NHAIS or its subsequent replacement.

4.4. Will Network Contract DES payments be automated?

Section 10.3 of the Network Contract DES Guidance provides details of when and which payments will be automated via the Calculating Quality Reporting Service (CQRS) during 2020/21. In summary:

- a. For the months April, May and June - commissioners will be required to manually calculate and process all Network Contract DES payments, including the Network Participation Payment (NPP) and any applicable backfill. These payments should be made in accordance with section 9 of the Network Contract DES Specification.

Where the nominated payee is:

- i. setup in NHAIS⁴, the commissioner will be required to use a payment instruction notification via a monthly payment schedule (the route for notifying PCSE) in order to process the payments; or
 - ii. if not setup in NHAIS¹ (likely to be a non-GP APMS provider), the commissioner will be required to make local payment arrangements.
- b. From July onwards – the payment calculations for four payments – Core PCN Funding, Clinical Director, Extended Hours Access and NPP – will be automated via CQRS. With the exception of the NPP the three PCN payments are to be processed as follows:
 - i. for GP provider nominated payees who are setup in NHAIS – the payment file will be processed directly from CQRS to NHAIS (and subsequently PCSE Online when available).
 - ii. for non-GP APMS provider nominated payees - commissioners will be required to make manual payments, using the payment calculation information supplied by CQRS. The payments are to be made to the nominated payee, using the relevant national subjective and other finance system codes (see **Error! Reference source not found.**) using local payment arrangements.

The NPP will be processed directly from CQRS to NHAIS (and subsequently PCSE Online when available) as with any other practice related payments.

⁴ Or Primary Care Support England (PCSE) Online when this replaces NHAIS.

4.5. How will the three PCN payments automated via CQRS link the Core Network Practices in a PCN and when will these calculations be made each month?

CQRS will use the PCN Organisational Data Service (ODS) information on practice to PCN relationships to aid calculating payments of the Core PCN Funding, Extended Hours Access and Clinical Director. These calculations will be undertaken towards the end of each month.

4.6. How will the automated payment calculations be adjusted if there are changes to a PCN's Core Network Practice membership in-year?

Commissioners should ensure that any changes to the PCN ODS reference data are submitted using the PCN ODS Change Instruction Notice⁵. This form must be submitted by the last working day on or before the 14th 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 14th day of a month, then changes will not take effect until the subsequent month. The commissioner may then be required to follow a manual exception process (i.e. manual payment reconciliation) to ensure the correct payment is made.

4.7. Some PCNs would prefer for the Network Contract DES payments to be made into a newly established separate PCN bank account rather than the GP practice nominated payee's bank account. Is this allowed?

In 2020/21, like in 2019/20, commissioners will be required to make payments into the bank account of a nominated GP practice as setup within NHAIS, or its subsequent replacement. This is because any GP practices who are nominated as the payee must be paid via NHAIS, or its subsequent replacement, and commissioners cannot make alternative local payment arrangements.

4.8. Will the Network Participation Payment – due to individual practices – be an automatic payment in the same way as the Global Sum payments?

The Network Participation Payment will not be an automated payment. The commissioner will be required to make the payment via a variation to NHAIS (Exeter).

As this payment will be a set amount per patient per year, commissioners will be able to calculate what each practice is due over the 12-month period. Commissioners can then set the monthly payments up as a variation to NHAIS as 12 equal payments.

In the event a practice no longer participates in the Network Contract DES, then the payments would need to be stopped.

⁵ The PCN ODS Change Instruction Notice is available [here](#).

4.9. Some of the Network Contract DES pay codes are split between GMS, PMS and APMS. As these payments will be paid to the PCN's nominated payee and not individual practices, which of the codes should commissioners make payments against?

Commissioners will be required to code according to the type of contract held by the nominated payee, in order for NHAIS validations to function correctly. The new pay codes requested to support new Network Contract DES payments from 2020/21 have been established against the same subjective regardless of contract type.

4.10. Do PCNs have to use the national Additional Roles Reimbursement Claim form?

Yes, PCNs are required to use the mandatory claim form to submit reimbursement claims under the Additional Roles Reimbursement Scheme.

Development is underway to create an online claims process in future and further information will be made available in due course.

4.11. What level of verification of is required for Additional Roles Reimbursement Scheme claims?

PCNs will be required to make monthly claims for payment once the staff member is in post or the service sub-contract has started. Claims must only be for 'additional' staff as outlined in the Network Contract DES Specification and commissioners will need to ensure the claims meet the additionality principles. PCNs must inform commissioners of any changes to the employment or sub-contract that would result in payments changing or ceasing.

Commissioners are able to request information or evidence to validate claims and these may include, but are not limited to, a:

- signed contract of employment (can remove personal information where appropriate, except for the name of the Clinical Pharmacist which is required to evidence training requirements are met) clearly setting out the salary;
- contract or agreement with a provider for the provision of services; and/or
- copy of a Network Agreement – if used as the basis for sub-contracting for services or staff.

5. Network Contract DES service requirements

5.1. General

5.1.1. When will the new service requirements be introduced? Has this changed in light of COVID-19?

In response to COVID-19 pressures, the Structured Medication Review and Medicines Optimisation requirements will be introduced from 1 October 2020 rather

than 1 April 2020. Networks should make every possible effort to begin work on the Early Cancer Diagnosis specification as planned unless work to support the COVID-19 response intervenes, and the contractual start date for this work is 1 October in recognition of this possibility.

The Enhanced Health in Care Homes (EHCH) requirements will continue in line with the dates set out in the 2020/21 GP contract deal. We will ensure alignment with COVID-19 pathways.

5.1.2. Are the service requirements and their start dates set in stone, or will they be changed as we know more about the COVID-19 response?

These measures will be kept under review over the coming weeks and months, and are being supplemented by other action – relating to the GP contract and beyond – to support and sustain general practice during the COVID-19 situation.

The EHCH requirements support the delivery of an effective response to COVID-19 for care home residents. Some elements of the service may need to be delivered differently in light of developing advice on how to manage COVID-19 in care homes. We are confident that there is sufficient flexibility in the contractual requirements to allow for varied methods of delivery.

5.2. Enhanced Health in Care Homes

5.2.1. What is a care home or what homes are in and out of the scope of the service?

For the EHCH requirements, a 'care home' is defined as a Care Quality Commission (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, which can be found in the CQC's 'care home directory with filters', which is updated monthly [here](#). All CQC-registered care homes with or without nursing are in the scope of the service.

5.2.2. How does the care home premium work? We have a lot of care homes in our area, how has this been reflected in the funding?

The care home premium describes a payment that PCNs are entitled to, in order to facilitate delivery of services to patients in care homes. PCNs will be paid £120 per bed per year on a recurrent basis for beds within care homes that they are aligned to. Given that the delivery requirements of the 2020/21 EHCH requirements do not come into effect until 30 September 2020, this funding is on a half-year (£60 per bed) basis in the first year. PCNs are eligible for the payment regardless of whether beds are occupied.

Funding for the care home premium is included in CCG primary medical care allocations. The funding level has been based on CQC data on registered care home

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beds in England and will be payable to PCNs in accordance with section 9.7 of the Network Contract DES Specification once commissioners have agreed:

- a. the alignment of care homes to PCNs; and
- b. that PCNs have appropriately and comprehensively coded residents in care homes using the SNOMED codes available for this.

Commissioners can then distribute the 'care home premium' funding to the PCN aligned to each home. The commissioner must arrange for payment to be made to the PCN on a monthly basis from 1 August 2020 at a rate of £7.50 per bed per month for the period 1 August 2020 to 31 March 2021 based on the number of relevant beds in the PCN's aligned care homes.

Subject to sections 9.7.5 and 9.7.7 of the Network Contract DES Specification, the amount calculated as the care home premium payment is payable in eight equal monthly instalments and the commissioner must arrange for payment to be made no later than the last day of the month in which the payment applies and taking into account local payment arrangements.

Where a new proposed PCN is approved after 1 August 2020, the PCN will only be entitled to receive the monthly instalments for the months it delivers the service requirements of the Network Contract DES.

5.2.3. How do we align care homes to PCNs? What happens when there are border issues?

Alignment of a care home to a single PCN will ensure consistency of care for people living in that home, and help care homes, PCNs and providers of community services to build the strong working relationships and integrated care arrangements that are crucial to the success of the EHCH model.

Commissioners hold overall responsibility for ensuring that each care home is aligned to a single PCN, and this is an ongoing obligation. Commissioners should seek to reach agreement with care homes and PCNs on which PCN will be aligned to which home. In instances where agreeing alignment proves difficult, commissioners should try to broker an agreement with the home, PCN and other interested groups -such as Local Medical Committees (LMCs) - before allocating alignment.

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; and
- existing relationships between care homes and practices.

PCNs that have care homes aligned to them must provide the EHCH service to those care homes.

We recognise that delivery of care to care homes can be challenging when the home sits on the boundary of two Integrated Care Systems (ICS), commissioners or PCNs. The service requirements outlined in [Investment and Evolution: Update to the GP contract agreement 2020/21 – 2023/24](#) states that by 31 July 2020, PCNs should agree the care homes for which they have responsibility for with its commissioner, and that they should agree a plan for how the service would work with local partners – which could include neighbouring PCNs or commissioners where relevant. As part of the alignment process, people in the care home should be supported to re-register with a practice within the aligned PCN. Further guidance on supporting this re-registration will be found in the updated [Enhanced Health in Care Homes framework](#).

5.2.4. Is existing Local Incentive Scheme (LIS) or Local Enhanced Services (LES) funding guaranteed?

Unless commissioned services are considered to support the national COVID-19 response, LIS/LESs should cease, based on local discretion. Funding, particularly to support staffing, should be maintained and re-directed to the primary medical care COVID-19 response.

Given the importance of care homes services to the COVID-19 response, and the continued implementation of the EHCH service through the Network Contract DES, commissioners should not decommission local care homes services until the requirements in the DES come into effect from the 1 October 2020, and should ensure a carefully managed transition from local to national requirements.

Where the requirements in an existing LIS/LES exceed those in the DES, commissioners must, engaging with PCNs and LMCs and taking account of the PCN employment liabilities directly linked to delivery of the LIS/LES, consider maintaining this higher level of service provision to their patients, alongside an appropriate portion of existing funding additional to the entitlements of the national contract. And all funding previously invested by CCGs in LIS/LES arrangements which are now delivered through the DES must be reinvested within primary medical care. LMCs should be engaged on reinvestment proposals and provided with an annual report – drawn from commissioner annual accounts – of how the commissioner has used its primary medical care funding allocation; and PCNs do not carry contractual responsibility for any failure by community service providers to deliver their part of the service, and vice versa.

5.2.5. How do MDTs or the home round work, and how can we set them up? Do they need to be in person?

A key part of the EHCH service is the establishment of the MDT and delivery the weekly 'home round' for patients registered with the PCN in the PCN's aligned care home. Both requirements are delivered jointly with providers of community physical and mental health (whose contracts describe their responsibilities in this respect). Membership of the MDT outside of the core team will vary depending on the local expertise and resources available and the needs of the care home population.

The MDT should use risk stratification tools and clinical judgement to ensure it focuses attention on those individuals with the greatest potential to benefit, in particular when identifying people who should be seen during the home round. The home round usually follows the MDT meeting, with all MDT members agreeing the most appropriate clinician to assess the person on each occasion.

The form and method of delivery of the home round and the MDT should be determined by clinical judgement. PCNs may make use of digital technology to support delivery and, during the response to COVID-19, we expect delivery of the Enhanced Health in Care Homes service to be carried out remotely where it is clinically appropriate to do so.

5.3. Structured Medication Reviews (SMRs)

5.3.1. When will further information on the SMR service requirements be available?

Further guidance on the Structured Medication Review and Medicines Optimisation service will be published ahead of the 1 October.

5.4. Early Cancer Diagnosis

5.4.1. Do we still need to deliver the service, given the letter of 19 March 2020?

PCNs should make every possible effort, to begin work on the early Cancer Diagnosis requirements as planned, unless work to support the COVID-19 response intervenes.

People who are concerned about any symptoms related to suspected cancer should still contact their GP and GPs should make sure they continue to refer those for suspected cancer for diagnostic tests as normal.

5.4.2. What is the relationship between the Early Cancer Diagnosis service requirements and the planned Quality and Outcomes Framework (QOF) Quality Improvement (QI) module? Do we still need to deliver the service in 2020/21, given that QOF is changing in 2020/21?

QOF income for 2020/21 will be protected as necessary, even if QOF requirements for the year change.

PCNs should make every possible effort, to begin work on the Early Cancer Diagnosis requirements as planned, unless work to support the COVID-19 response intervenes.

5.4.3. Will this increase the volume of onward referrals and put pressure on the system?

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It is important that even during the response to COVID-19, patients with serious urgent conditions such as cancer are treated appropriately. NHS England and NHS Improvement have issued guidance to the system on appropriate management of two-week wait referrals for suspected cancer during this period, in which Primary Care and PCNs will play a crucial role:

<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/cancer-alliance-information-on-managing-cancer-referrals-19-march-2020.pdf>

6. Network Contract DES Indicators

6.1. What indicators are associated with the service requirements and how will data be collected?

Indicators relating to three of the service requirements will be included in the Network Dashboard to support local quality improvement. These indicators will be published as part of the launch of the Network Dashboard.

Some of these indicators will draw on existing, published, data sources and others will rely on coding in GP IT systems. Data collection to inform these indicators has been described in the Network Contract DES for 2020/21. Further details on SNOMED coding will be released with the business rules.