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Network contract directed enhanced
service

Frequently asked questions 2021/22

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1. Introduction

The Network Contract Directed Enhanced Service (DES) was introduced during 2019 and will remain in place until at least 31 March 2024. For 2021/22, the [Network Contract DES Directions](#) come into force on 1 April 2021 and the requirements on practices and Primary Care Networks (PCNs), as outlined in the [Network Contract DES specification](#), will apply from that date.

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 2021/22](#)
- b. [Network Contract DES Guidance for 2021/22 in England](#)
- c. Network Contract DES [Participation and Notification of Change Form](#)
- d. Network Contract DES Additional Roles Reimbursement Scheme [Claims Portal](#)
- e. Network Contract DES [Network Agreement and Schedules](#)
- f. [Data Sharing and Data Processing Agreements](#)
- g. [Investment and Impact Fund Guidance 2021/22](#)
- h. [Framework for Enhanced Health in Care Homes](#)
- i. [Early Cancer Diagnosis Guidance](#)
- j. [Structured Medication Reviews and Medicines Optimisation Guidance](#)
- k. [Cardiovascular Disease \(CVD\) Prevention and Diagnosis Supplementary Guidance](#)
- l. Workforce planning template 2021/22 will be [available here](#) when published.

In addition to the above documents, practices and commissioners should be aware of the [cover note](#) published alongside the above documents.

2.2 Once a practice has agreed to participate in the Network Contract DES for 2021/22, can they then later opt out?

After 30 April 2021, a core network practice cannot end its participation in the Network Contract DES except as set out in section 4.9.7 of the [Network Contract DES Specification](#), namely in situations where this is as a result of:

- 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
- d. commissioner determination that the core network practice's participation in the Network Contract DES should cease.

A core network practice may opt out of participating in the Network Contract DES in accordance with sections 4.9.4, 4.9.5 and 4.9.6 respectively of the [Network Contract DES Specification](#).

2.3 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:

- exceptional circumstances within which the PCN's core network practice membership may need to change after 31 May 2021 participation deadline
- or
- a newly formed practice joins a PCN.

The exceptional circumstances are summarised in question 2.2 above and full details are included in sections 6.4, 6.5, 6.6, 6.7, 6.8, 6.9 and 9 respectively of the [Network Contract DES Specification](#). Section 4.5 of the [Network Contract DES specification](#) provides further information for a new practice joining a PCN.

2.4 The Network Contract DES Specification states that core network practices will be auto-enrolled into a subsequent year's Network Contract DES or an in-year variation. What does this mean?

A practice participating in the Network Contract DES for 2021/22 will automatically participate in any subsequent year's Network Contract DES and any variation that may take place in-year prior to the 31 March 2022, unless it opts out in accordance with section 4.9 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 relevant period, they will be auto-enrolled into the updated Network Contract DES.

2.5 Can PCNs merge at any point during the year?

Full details of the process for two or more PCNs to merge is set out in Section 6.9 of the [Network Contract DES Specification](#).

2.6 Are PCNs able to form limited companies and what are the implications for commissioners?

Considering what form a PCN should take, and the potential implications for that form, is a matter for the PCN and local commissioners.

2.7 Is there a definition of what a 'practicing clinician' is in relation to the clinical director role? Can a locum be a clinical director?

The clinical director should be a practicing clinician from one of the PCN's core network practices, working regularly within the PCN (regardless of whether the clinician is directly employed, self-employed or engaged via a sub-contracting arrangement) and be able to undertake the responsibilities of the role, representing the PCN's collective interests.

Locums would not provide the oversight and continuity that a clinical director needs to be able to deliver the role requirements of a clinical director, as set out in the Network Contract DES Specification for 2021/22. See section 5.6 of the [Network Contract DES Guidance](#) for further information.

3. Additional Roles Reimbursement Scheme (ARRS)

3.1 General

3.1.1 What is considered to be whole time equivalent (WTE)?

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 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 ARRS to support delivery of the Network Contract DES requirements.

3.1.3 Is there an age limit on the people whom 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, consideration should be given to how to 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 18s 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.

3.1.4 Can PCNs claim reimbursement for additional hours above the usual WTE hours worked?

A PCN may use its Additional Roles Reimbursement sum to reimburse additional hours worked by PCN staff. This can be done at plain time rates only, and the increase in WTE hours must be clearly recorded in the PCN's claim and on the National Workforce Reporting System.

3.1.5 Has an uplift been applied to the ARRS?

Following confirmation of the 3% pay uplift for Agenda for Change, the maximum reimbursement rates for each role under the ARRS of the Network Contract DES will be uplifted to be in line with the Agenda for Change rates. An initial assumption of an uplift of 2.1% was already applied to the 2021/22 rates from the previous year; the updated rates, which are included prospectively in the Network Contract DES from October, will reflect the full 3%.

This change does not affect the overall value of a PCN's ARRS sum. The ARRS rates are based on a weighted average of the Agenda for Change pay scale. While the Network Contract DES sets out the rules for reimbursement, a PCN will need to determine what the actual salaries are for their additional roles.

3.1.6 Can commissioners waive the 0.5 WTE minimum for clinical pharmacists?

No, the 0.5 WTE for clinical pharmacists is a requirement and PCNs are unable to use the funding to pay for posts recruited to at less than 0.5 WTE.

3.1.7 A core network practice is recruiting a pharmacist who is enrolled on the training pathway. Can the pharmacist continue on the training pathway if the role they are taking is practice-based, rather than PCN-based?

In order to be on the pathway, it is a requirement that the enrolled pharmacist is working at PCN level (rather than at practice level), therefore in this instance they would no longer be eligible for the pathway.

3.1.8 Can PCNs sub-contract a remote clinical pharmacy service under the ARRS clinical pharmacist role? Are there any considerations to using a remote clinical pharmacy service?

A PCN wishing to use an agency or alternative provider to access clinical pharmacist services under the ARRS, needs to ensure that the role outline set out in Annex B of the Network Contract DES Specification is being delivered and that the clinical pharmacists meet the qualification requirements.

Whether the employment or service arrangement includes remote delivery or not, all aspects of the role outline must be delivered by the role or under the service arrangement to be eligible for reimbursement through the ARRS. This would include (but not be limited to):

- working as part of a PCN multidisciplinary team in a patient facing role to clinically assess and treat patients
- developing relationships and working closely with other pharmacy professionals across PCNs and the wider health and social care system
- maintaining a leadership role in supporting further integration of general practice within the wider healthcare teams
- be responsible for the care management of patients with chronic diseases and offering continuity of service.

A consistent approach to the clinical pharmacist(s) working with the PCN through a service agreement would be expected, with clinical pharmacist(s) working with the PCN's existing MDT to ensure they can consistently support and complement the existing workforce. For example, service provision by a different individual every shift would not fulfil the requirements listed above. The Network Contract DES requires clinical pharmacists employed or engaged through the Additional Roles Reimbursement Scheme to be for a minimum of 0.5 WTE.

Additionally, whether or not an arrangement is through direct employment or service arrangement, it must be intended for a minimum of six months. Therefore, a 'pay as you go' arrangement would not be eligible for reimbursement.

The commissioner and PCN must therefore be assured that the requirements of the Network Contract DES are being met in full for a remote service arrangement to be eligible for reimbursement. Commissioners should make an assessment on an individual basis as to whether the service is delivering the full Network Contract

DES requirements, rather than the employment model. Where the requirements of the Network Contract DES are not met, commissioners can withhold the ARRS payments for the relevant role.

3.1.9 Is London Weighting (High Cost Area Supplement) available on the ARRS?

The ARRS includes specific maximum reimbursement rates for PCNs in inner London and outer London (fringe is not included), and updates have been made to the online [claims portal](#) accordingly. Please refer to section 10.5.3 of the [Network Contract DES Specification](#) for details of the inner and outer London maximum reimbursable rates.

3.1.10 Do the mental health practitioners have to be employed by the local secondary care provider of mental health services to be eligible for reimbursement, or can they be a neighbouring provider or another provider like MIND?

The mental health practitioners must be employed by the secondary care provider of community mental health services that covers the PCN geography. This is so that they can provide the necessary links and facilitate access to specialist mental health services where this is clinically appropriate. A local MIND, or similar organisation, would therefore not be an appropriate employing organisation for practitioner roles under ARRS and would render a PCN ineligible to receive reimbursement under ARRS.

3.1.11 Can a PCN employ or engage their own mental health practitioners under ARRS, in addition to those employed and provided by the community mental health provider?

No. To be eligible for reimbursement under ARRS the staff must be employed by the secondary care provider of community mental health services covering the PCN's geography.

3.1.12 Can PCN additional roles be partners in a core network practice, and if so, can the PCN claim reimbursement through ARRS?

The Network Contract DES does not prevent PCN staff from being a partner in a practice. However, the PCN would only be eligible for reimbursement under ARRS for the relevant hours worked in their PCN role (ie undertaking the role

responsibilities outlined in the relevant section of Annex B of the Network Contract DES Specification).

Any hours worked on any other duties not related to their PCN role, including those related to their partnership duties, are not eligible for reimbursement and must be covered/paid out with of the DES arrangement. As such, the claim for reimbursement through ARRS will need to be pro-rata to the relevant WTE hours the individual spends working in their PCN role and delivering the requirements outlined in the DES.

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 clinical commissioning group (CCG) baselines.

3.2.2 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.

3.2.3 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.

3.3 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 ARRS using the national [online claim portal](#).

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 ARRS 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 on parental or sickness leave, can the PCN continue to claim their reimbursement?**

There is no automatic right within ARRS for additional funding to cover sickness and parental leave. However, the PCN would continue to be reimbursed during parental and sick leave, in line with the relevant employment contract provisions (ie 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 parental and sickness absence, but the PCN would only be able to claim for the WTE that was 'absent'.

As set out in the section 7.4.1 of the Network Contract DES Specification and section 7.5 of the [Network Contract DES Guidance](#), if a PCN has available funding within their Additional Roles Reimbursement Sum, they may claim reimbursement

for a temporary contract (including funding below six months if necessary) if this is to enable provision of cover for sickness or parental leave.

Additionally, as set out in section 7.5.8 of the Network Contract DES Specification, whether a bidding practice has a member of staff on paid leave, eg sickness or parental, is a criterion in the process for redistributing any Additional Roles Reimbursement Funding, if applicable. (ie a PCN may submit a bid for redistributed ARRS funding where this is available to cover parental or sickness leave.)

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 How are sickness and parental leave, including any claims for temporary cover, to be made via the mandatory electronic online portal?

A PCN will continue to claim the relevant reimbursement amounts via the online portal for the duration of parental and sickness leave. This claim must be in line with the relevant employment contract provisions, reducing accordingly as the salary is reduced and taking into account any statutory maternity pay (SMP) where applicable. Where a PCN is not paying any sickness or parental leave (with the latter where applicable being over and above SMP), then no claim will be submitted for that role for the duration that sickness and parental payments are not made.

Where a PCN has employed or engaged cover for the duration of sickness or parental leave, then the reimbursement must be claimed in accordance with the terms set out in the Network Contract DES Specification. This claim must also be made from within the PCNs Additional Roles Reimbursement Sum, unless it relates to the use of redistributed funding as set out in section 7.5.8 of the Network Contract DES Specification. A PCN will add the role into the electronic online portal as a new line within the relevant months, using a new unique identifier and ensuring it is also recorded in the National Workforce Reporting Service (NWRS).

3.3.5 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 ie the annual figure would equate to a monthly maximum reimbursement amount for 1 WTE (37.5 hours under the DES).

3.3.6 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.

3.3.7 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 ARRS, regardless of who (eg which core network practice) 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 ARRS, 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 ARRS, 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.

3.3.8 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 eg 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 while 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.

3.3.9 Do all roles reimbursed via ARRS have to fulfil all of the requirements set out in the Network Contract DES Specification for the role?

Any staff reimbursed under ARRS must meet the full requirements set out in the Network Contract DES Specification

3.3.10 How do CCGs transfer claims forms submitted via the portal to finance teams for payment?

At present the portal does not allow approved PCN claim forms to be sent direct to finance teams. In the interim until this process is set up, the Primary Care Workforce team must send the raw approved PCN data to the CCG approver on the first and third week of the month. Please note however, these dates are provisional and could vary depending on workload and priorities within the team.

4. Financial entitlements and payment arrangements

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

Section 10 of the [Network Contract DES Specification](#) and section 10 of the [Network Contract DES Guidance](#) provide details of financial entitlements and payment arrangements in 2021/22.

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

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

The PCN's 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 be a PCN's 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 2021/22 payments will not be able to be made via PCSE Online, 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.
- In 2021/22, 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 PCSE Online.

4.4 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?

Commissioners are required to make payments into the bank account of a nominated GP practice as setup within PCSE Online. This is because any GP practices who are nominated as the payee must be paid via PCSE Online and commissioners cannot make alternative local payment arrangements.

4.5 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). In summary:

- a. Network Contract DES payments will be a mixture of manual and automated payment calculations and processing. The Care Home Premium and ARRS

payments will continue to be processed manually by commissioners and not be calculated automatically via CQRS.

The following four payment calculations – Core PCN Funding, clinical director, Extended Hours Access and NPP – will be automated via CQRS and processed either directly or manually, depending on who the nominated payee is.

Except for the NPP – which will be processed automatically to participating practices – the three PCN payments are to be processed as follows:

- i. for GP provider nominated payees who are setup in PCSE Online – the payment file will be **processed directly from CQRS** PCSE Online.
- 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 using local payment arrangements.

The NPP will be processed directly from CQRS to PCSE Online as with any other practice related payments.

- b. Details of payment calculations for the Investment and Impact (IIF) Fund are available in section 10 and Annex C of the Network Contract DES Specification.

4.6 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, proceeding the month in which the payment is due.

Commissioners must therefore ensure any changes to the ODS information that will impact payments is correct in accordance with section 5.3 of the [Network Contract DES Guidance](#).

4.7 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 Notice.¹ 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 last working day on or before 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 (ie manual payment reconciliation) to ensure the correct payment is made.

4.8 What are Commissioners required to do to ensure that ODS codes are accurate and up to date?

Commissioners (as set out in section 5.3 of the [Network Contract DES Guidance](#)) are required to check the ODS information via one of the options outlined on the following page <https://digital.nhs.uk/services/organisation-data-service/primary-care-networks---publication-of-organisational-data-service-ods-codes> (see section titled 'Where to find the PCN ODS code and information').

Any further queries on accessing the ODS data should be directed to exeter.helpdesk@nhs.net.

4.9 How do PCNs sign up to receive notifications and alerts through CQRS?

To receive notifications or have this facility set up (where it has previously not been setup), please email support@cqrs.co.uk who will be able to provide assistance.

¹ The PCN ODS Change Instruction Notice is available [here](#).

4.10 How can commissioners update registered list sizes for PCN payments in CQRS during the year if enacting their discretion under paragraph 5.13.3 of the Network Contract DES?

Commissioners can make a request to the CQRS helpdesk at support@cqrs.co.uk to request a change to the list size.

4.11 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 be automated via CQRS - see question 4.5. In the event a practice no longer participates in the Network Contract DES, then the payments would need to be stopped.

4.12 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?

Some of the earlier pay codes to support the Network Contract DES had subjective codes split between contract type. Where this is the case, commissioners are required to code according to the type of contract held by the nominated payee, in order for NHAIS validations to function correctly.

From 2020/21 onwards, the pay codes to support Network Contract DES payments are established against the same subjective regardless of contract type, except for the Leadership and Management payment. See Table 3 in section 10 of the [Network Contract DES Guidance](#).

4.13 Do PCNs have to use the national Additional Roles Reimbursement Claim Portal?

Yes, PCNs are required to use the mandatory [online claim portal](#) to submit reimbursement claims under ARRS.

4.14 What level of verification is required for ARRS 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
- 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 What services need to be delivered through the DES? Has this changed in light of COVID-19?

From October 2021, there will be five services offered through the Network Contract DES. These requirements (Structured Medication Review and Medicines Optimisation; Enhanced Health in Care Homes; Early Cancer Diagnosis; Cardiovascular Disease Prevention and Diagnosis; and Tackling Neighbourhood Health Inequalities) are detailed in section 7 of the DES.

The Update to the GP contract agreement in February 2020 guaranteed that the available funding for the PCN ARRS would increase from a maximum of £430m in 2020/21 to a maximum of £746m in 2021/22. This was intended to support the introduction of new PCN services from April. Given reprioritisation necessitated by the pandemic, requirements relating to the additional two services planned for introduction in 2021/22, these will not now be introduced until April 2022

5.1.2 As PCNs can repurpose extended access capacity to support the deployment of the COVID-19 vaccine, can these hours be delivered in core hours rather than in the extended hours period?

There has been no relaxation of the Network Contract DES rules to allow redeployment of capacity into core hours instead of extended hours, so those PCNs must continue to provide their extended hours in the extended hours period in order to qualify for the payment. Capacity in extended hours can be used to support the delivery of the COVID-19 vaccination programme, as appropriate.

For those practices who are delivering vaccinations to cohorts 10 to 12, there continues to be flexibility to use extended access capacity, as well as the PCN workforce, to support delivery of COVID-19 vaccination appointments.

5.2 Enhanced Health in Care Homes

5.2.1 What is a care home under the Network Contract DES, and which 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 If the list of CQC registered care homes contains services that have not been delivered to before, is there an expectation that these homes are now covered under the Network Contract DES?

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. All care homes in this directory are in the scope of the EHCH service, although a PCN and commissioner may agree that certain 'care home' registered beds are outside of the scope of the EHCH service – for example a registers.

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. This scope also applies to the payment of the care homes premium.

5.2.3 What are the requirements regarding registration where care homes are in a different area to the resident's GP Practice and where patients do not wish to register with the practice in a different area?

Under the EHCH service in the DES, each care home should be aligned to a single PCN, with residents supported to re-register with practices in that PCN. Patients may choose not to re-register. 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.

If a patient chooses not to remain registered with a practice, that practice should not refuse this choice. Further guidance on implementation of the EHCH service is available [here](#)

5.2.4 Can a PCN allow a practice from another PCN to provide the Network Contract DES requirements for a care home in their geographical boundary? Or to sub-contract to the local secondary care provider/clinical hub?

Under the EHCH requirements in the Network Contract DES, each care home is aligned to a single PCN, with the residents of that home supported to register with practices in the aligned PCN. Patients will not receive the service if they choose not to re-register.

Commissioners hold responsibility for ensuring that every home in their geographical boundary, as defined by CQC, was aligned to a single PCN by 31 July 2020 and to review this as required where there are PCN changes. Given this requirement, this scenario is not relevant. PCNs can sub-contract requirements if they wish, but would have to meet any costs associated with that sub-contracting.

5.2.5 What is the care home premium?

The care home premium describes a payment that PCNs are entitled to, to support delivery of the EHCH service 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.

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 beds in England and will be payable to PCNs in accordance with section 10.4 of the [Network Contract DES Specification](#) once commissioners have agreed:

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

5.3 Structured medication reviews (SMRs)

5.3.1 Who can undertake SMRs?

SMRs can be undertaken by appropriately trained clinicians. PCNs must ensure that only appropriately trained clinicians working within their sphere of competence should undertake SMRs. These professionals will need to have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop these skills and should be able to take a holistic view of a patient's medication.

Although it is expected that SMRs would be conducted primarily by a clinical pharmacist, they may also be conducted by suitably qualified advanced nurse practitioners who also meet the above criteria, as well as GPs.

Specifically, pharmacists must have completed – or at least be enrolled on – the Primary Care Pharmacy Educational Pathway (PCPEP) or a similar 18-month training programme that includes independent prescribing. However, we recognise there are a number of clinical pharmacists who have the necessary skills and experience to undertake SMRs but have not been completed or enrolled on an approved training pathway (eg PCPEP). The [Centre for Pharmacy Postgraduate Education \(CPPE\)](#) has developed an exemption and equivalence process to

recognise the experience and training, and such clinical pharmacists should only undertake SMRs having completed that recognition process.

It is required that any advanced nurse practitioners who undertake SMRs are experienced in working in a generalist setting and able to take a holistic view of all of the patient's medicines. A SMR is not considered complete until qualified consideration has been given to all of the patient's medication, while involving the patient in decisions about their medicines. Clinicians should be encouraged to collaborate with colleagues across the PCN and elsewhere, including acute care and take a multidisciplinary approach to managing complex situations.

In situations where prescribing is particularly complex (eg mental health or end of life) PCN clinicians undertaking SMRs should establish professional relationships and engage proactively with specialist pharmacists, consultants and other health professionals working across the local healthcare system.

5.3.2 Can SMRs be carried out by clinical pharmacists employed by other organisations?

Yes, SMRs can be carried out by clinical pharmacists employed by other organisations (eg NHS trusts) that support PCNs. See question 5.4.1 for further relevant information.

5.3.3 Can suitably qualified pharmacy technicians complete SMRs on behalf of the PCN?

No, pharmacy technicians cannot undertake a SMR. They can, however, support other appropriately trained clinicians, as part of the PCNs multi-professional team, in the SMR process. PCNs must ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs. See question 5.4.1 for further relevant information.

5.3.4 Should SMRs be conducted with ALL the patients mentioned in the specified groups and in what timescale this should be achieved?

SMRs should be offered to all patients identified and prioritised within the groups listed in the DES service requirements, using appropriate tools. However, the service requirements also state that the actual number of SMRs offered by a PCN

will be determined and limited by its clinical pharmacist capacity, as long as that PCN demonstrates all reasonable on-going efforts to maximise that capacity.

5.3.5 Do PCNs now have to offer SMRs to patients on any opioid, gabapentinoid; benzodiazepine, or z-drug?

SMRs should be offered to all patients identified and prioritised within the groups listed in the DES service requirements, using appropriate tools. This explicitly includes patients on any opioid, gabapentinoid; benzodiazepine; or z-drug.

6. Investment and Impact Fund (IIF)

6.1 How can PCNs monitor their performance against the indicators in the IIF?

The PCN Dashboard hosts a dedicated IIF page where indicative PCN performance against the IIF indicators can be viewed and it will be updated on a monthly basis. The data collection to inform these indicators relies on the relevant coding in GP IT systems.

To access the Dashboard, please either [register](#) on the Insights Platform, or login in using your existing [Insights Platform account](#), and then select the NHS ViewPoint product. A [user guide](#) is available to help navigate the dashboard.

6.2 How frequently is the information on the PCN dashboard updated?

Data on the dashboard is currently refreshed monthly.

6.3 What can a PCN do if they think their IIF achievement in CQRS is incorrect?

For IIF indicators based on a data extract from GP systems, PCNs will have the opportunity to 'declare' their achievement within CQRS. This means that they will have the opportunity to confirm that the data extracted in relation to them, and the calculations performed in respect of that data, are correct.

If a PCN believes that the underlying data for the PCN (or for one or more core network practices within the PCN) is incorrect in relation to an IIF indicator based on a data extract from GP systems, they should decline to declare their

6.5 Do PCNs need to provide to their commissioner a spending plan for IIF earnings?

The PCN must provide a simple written commitment to their commissioner that any money earned through the IIF will be reinvested into additional workforce, additional primary medical services, and/or other areas of investment in a core network practice that support patient care (eg equipment or premises). The written commitment does not have to detail the precise areas of spend, this is for PCNs to determine.

6.6 For social prescribing referrals, can you please confirm which codes will be extracted for payments/data purposes?

The following SNOMED code should be used:

- 871731000000106 | Referral to social prescribing service (procedure)

This indicator only counts referrals made to a social prescribing service, as captured by the SNOMED code provided above. This SNOMED code, denoting referral to a social prescribing service, should be used even when the social prescribing service is provided within the practice or PCN – eg if a social prescribing link worker is employed under ARRS. In this case, the referral is internal to the practice/PCN, but it is still a referral to a distinct service.

This indicator does not count offers of social prescribing because it is necessary to know whether the offer has been accepted. It therefore only counts completed referrals to a social prescribing service.

The purpose of this indicator is to count referrals to a service, not unique patient contacts. As such, this indicator does not count recording (by any means) of unique patient contacts by social prescribing link workers or any other type of healthcare professional (eg care co-ordinators or health and wellbeing coaches).

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This information can be made available in alternative formats, such as large print, and may be available in alternative languages, upon request. Please contact the Primary Care Group at england.gpcontracts@nhs.net.