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# **Network Contract Directed Enhanced Service**

Guidance for 2022/23 in England

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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 2022/23, the [Network Contract DES Directions](#) come into force on 1 April 2022 and, following participation in the DES, the requirements on practices and Primary Care Networks (PCNs), as outlined in the [Network Contract DES specification](#), will apply from that date.
- 1.2. This guidance provides supporting information for commissioners and practices. It does not take precedence over the Network Contract DES Specification.
- 1.3. The ongoing COVID-19 situation and COVID-19 vaccination programme is placing substantial pressures on general practice, and we are very grateful to all colleagues for the work they are doing to respond swiftly and professionally. NHS England has announced a number of changes to the Network Contract DES for 2022/23, as set out in [General practice contract arrangements in 2022/23](#). The Network Contract DES and this guidance reflect those changes.
- 1.4. This document has been updated since 2019/20 version 1 was agreed by NHS England and the British Medical Association's (BMA) General Practitioners Committee England (GPCE).
- 1.5. From 1 July 2022, during the period of the 2022/23 Network Contract DES, Clinical Commissioning Groups (CCGs) were dissolved and their functions were transferred to Integrated Commissioning Boards (ICBs) as the legal entity at the heart of Integrated Commissioning Systems (ICSs). The delegation of management of primary medical services contracts, including the Network Contract DES, has been taken on by ICBs from CCGs. References in this guidance to "commissioner" are therefore references to CCGs while they exercise those delegated powers and to ICBs after ICBs have taken on and exercised those powers after 1 July 2022.

## 2. Participation in the Network Contract DES

### 2.1. Participation process

- 2.1.1 From April 2022 onwards, all Core Network Practices of Previously Approved PCNs will automatically participate in the 2022/23 and subsequent year's Network Contract DES, and any in-year variations unless a Core Network Practice chooses to opt out of participation. An opt-out and opt-in window will apply from the date of publication by NHS England of the Network Contract DES Specification or any Network Contract DES Variation. For the 2022/23 Network Contract DES, this opt-out and opt-in window will apply until 30 April 2022 and allows for:
  - a. Core Network Practices to opt-out of the 2022/23 Network Contract DES following automatic participation; or
  - b. Non-participating practices wishing to participate to opt-in to the 2022/23 Network Contract DES.

- 2.1.2 In the event of an in-year variation to the Network Contract DES, all Core Network Practices will automatically participate in the variation unless they choose to opt out, in which case they must do so within a 30 calendar day window from the date of publication by NHS England of the variation. Any variations to the Network Contract DES will be made nationally by NHS England; local variations to the Network Contract DES Specification, including to the requirements or financial entitlements, must not be made.
- 2.1.3 A New Practice may join a Previously Approved PCN at any time during the year.

#### Previously Approved PCNs with no changes to their Core Network Practice membership

- 2.1.4 Previously Approved PCNs without any changes to their Core Network Practice membership will automatically participate in the 2022/23 Network Contract DES. There is no need for the practices in these PCNs to submit a participation form to their commissioner. A written variation of the primary medical services contract of each Core Network Practice is required to ensure the relevant Network Contract DES Specification forms part of that contract and the commissioner will issue notification through the Calculating Quality Reporting Service (CQRS) for practices to accept. PCNs must ensure their Network Agreement has been updated as necessary.

#### Previously Approved with changes to their Core Network Practice membership

- 2.1.5 Where a Previously Approved PCN has one of the following scenarios which leads to a change in the Core Network Practice membership:
- a. a Core Network Practice from another PCN joining; and/or
  - b. a non-participating practice joining; and/or
  - c. a New Practice joining; and/or
  - d. a Core Network Practice opting out of participating,

the Core Network Practices must follow the steps as set out in section 4.4 of the Network Contract DES Specification to seek approval of the change to the PCN's Core Network membership. PCNs must complete the [Network Contract DES Participation and Notification Form](#) included at Annex A of the Network Contract DES Specification to provide the required information and submit it to the commissioner by the 30 April 2022 or in the case of a Network Contract DES Variation, by the 30<sup>th</sup> calendar day following publication by NHS England of the variation. A single Participation Form can be submitted for a PCN.

- 2.1.6 Commissioners will consider all the information provided and confirm to the PCN as soon as possible (at the latest, within one month of receipt of the notification) whether or not the practices' participation in the Network Contract DES is confirmed.
- 2.1.7 PCNs are encouraged to submit the information to the commissioner as soon as possible to support payments, and prior to the next local payment

deadline to avoid any disruption in payment. Commissioners should liaise with the PCN to confirm timescales. Where a local payment date has been missed, the commissioner will make the relevant payment in the next month. Where a Previously Approved PCN with changes requires payment adjustment, the commissioner will make these manually in the next month.

- 2.1.8 Commissioners are not required to wait for 100 per cent geographical coverage in order to approve Core Network Practice participation and PCN continuation or formation.

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

- 2.2.1. Where a practice wishes to participate in the Network Contract DES but is unable to find a PCN to join, commissioners will have the ability as a last resort to allocate a practice to a PCN as a Core Network Practice. It is not anticipated that this will happen on a regular basis as it is expected that disagreements over joining a PCN should be managed through mediation, supported by the commissioner and the Local Medical Committee (LMC).
- 2.2.2. Where agreement cannot be reached through mediation, in order to ensure maximum population coverage through the Network Contract DES, a commissioner may allocate the practice to a PCN, with the full engagement of the LMC, in line with the process as set out in section 4.6 the [Network Contract DES Specification](#).

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

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

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

### 4.1. Key considerations

- 4.1.1. Commissioners are required to ensure that any patients of a practice that is not participating in the Network Contract DES have access to network services.
- 4.1.2. In those instances where a practice has chosen not to sign up to the Network Contract DES and a commissioner is required to secure network services for the patients of that practice, a commissioner may contract with any other suitable provider for the delivery of network services, such as another PCN or a community services provider. Commissioners must, subject to procurement rules, initially seek to offer the provision of the network service to another Previously Approved PCN via a local agreement. If no Previously Approved PCN is suitable, the commissioner, subject to procurement rules, may offer the network service to any suitable provider and, for the avoidance of doubt, any other suitable provider would not include the practice that has opted out of the Network Contract DES. In commissioning any suitable provider, this must not be on terms better than those set out in the Network Contract DES (including any additional funding) nor divide the service into smaller components. Non-PCN providers commissioned to deliver network services will not be eligible for the Network Participation Payment.
- 4.1.3. The guidance below applies to those instances where a commissioner is contracting with a PCN through a local agreement to deliver network services to such patients.
- 4.1.4. Commissioners will need to work with PCNs to agree how any patients from a non-DES practice - a practice not signed up to the Network Contract DES - can be covered by a PCN. The local agreement would usually be with:
  - a. a single Core Network Practice (as a signatory on behalf of a PCN in a lead provider type of arrangement), or
  - b. with all the Core Network Practices in the PCN (as a multi-signatory agreement)<sup>1</sup>.
- 4.1.5. These local agreements will be managed locally and the patient population of a non-DES practice, for whom a PCN is providing network services, will not be accounted for within the PCN ODS reference data.
- 4.1.6. There may be circumstances where more than one GP practice in an area is not participating in the Network Contract DES. Where a single PCN will be

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



providing cover for multiple non-DES practices, this can be via either a single or multiple local agreement(s).

4.1.7. Having agreed which PCN or provider will provide the cover, commissioners will need to ensure the following services/activities<sup>2</sup> are provided to patients of the non-DES practice in accordance with the timescales for these services/activities:

- a. a social prescribing service;
- b. from 1 April 2022 until 30 September 2022, the extended hours access requirements as listed at section 8.1 of the Network Contract DES specification;
- c. from 1 April 2022 until 30 September 2022 the preparatory requirements for Enhanced Access;
- d. from 1 October 2022, the Enhanced Access requirements as listed at section 8.1 of the Network Contract DES Specification
- e. the Medication Review and Medicines Optimisation requirements as listed at section 8.2 of the Network Contract DES Specification;
- f. the Enhanced Health in Care Homes requirements as listed at section 8.3 of the Network Contract DES Specification;
- g. the Early Cancer Diagnosis requirements as listed at section 8.4 of the Network Contract DES Specification;
- h. the Cardiovascular Disease (CVD) Prevention and Diagnosis requirements as listed at section 8.6 of the Network Contract DES Specification;
- i. the Tackling Neighbourhood Health Inequalities requirements as listed at section 8.7 of the Network Contract DES Specification;
- j. the Anticipatory Care requirements as listed at section 8.8 of the Network Contract DES Specification; and
- k. the Personalised Care requirements as listed at section 8.9 of the Network Contract DES Specification.

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

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

- a. A provision requiring the PCN to provide to the commissioner any details of non-co-operation by a non-DES practice with the PCN who is providing network services via the local agreement to the non-DES practice's patients. This information will be used by the commissioner to consider whether to take any action under the non-DES practice's primary medical services contract;

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<sup>2</sup> The list outlines the 2022/23 requirements. Commissioners and PCNs will need to review local agreements in future years to ensure they remain aligned to any changes to the Network Contract DES Specification.



- b. Breach – how breaches by the PCN providing cover are dealt with by the commissioner; and
- c. Boilerplate provisions – the usual contractual provisions about commencement, duration, extension, break-clause, termination, variation, dispute resolution, entire agreement, surviving provisions, governing law, etc.

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

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

## 4.2. Payments under a local agreement

4.2.1. For the purposes of the Network Contract DES, payments to a PCN for the provision of PCN services/activities are mostly calculated by reference to the sum of its Core Network Practices' registered lists as at 1 January each year. This sum will not therefore include patients from practices who are not participating in the Network Contract DES. Instead, the patients of practices not participating in the Network Contract DES would need to be accounted for under the local agreement put in place with the PCN that will be providing cover. These local agreements will not be supported by either the General Practice Extraction Service (GPES) or the Calculating Quality Reporting Service (CQRS) and commissioners will be required to manage these out-with of these systems.

4.2.2. In respect of payments under the local arrangement, the simplest approach would be for the commissioner to consider replicating or clearly referring to the relevant payment provisions in section 10 of the Network Contract DES Specification but calculated with reference, where appropriate, to the registered patient size of the non-DES practice. These could include payments that reflect:

- a. Core PCN funding;
- b. extended hours access;
- c. enhanced access
- d. care homes premium;
- e. clinical director funding;
- f. leadership and management payment; and
- g. **PCN Capacity and Access Support Payment**

4.2.3. The commissioner and PCN may need to consider on a case by case basis the extent to which the total number of patients that the PCN provides services to (i.e. including the non-DES practice patients) would require additional workforce capacity, in order to support delivery of network services and therefore what, if any, workforce related payments should be reflected in the local arrangements.

- 4.2.4. There may also need to be consideration of whether the Clinical Director of the PCN acts on behalf of the non-DES practice. If so, then consideration would need to be given to whether a payment in respect of this (calculated with respect to the patient list size of the non-DES practice) is appropriate.
- 4.2.5. Commissioners will have local discretion as to whether or not any additional funding can be made available, in part or in full to the PCN providing the cover for the non-DES practice.
- 4.2.6. The non-DES practice will not be entitled to the Network Participation Payment if not participating in the Network Contract DES.

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

- 4.3.1. To support co-operation between all practices in delivering PCN related services to their patients, regardless of whether or not a practice is participating in the Network Contract DES, the GMS and PMS Regulations require all practices to:
  - a. co-operate with Core Network Practices of PCNs who are delivering the Network Contract DES services/activities to the collective registered population and as required engage in wider PCN meetings with other PCN providers;
  - b. inform their patients, as required, of changes to PCN services/activities;
  - c. support wider co-operation with other non-GP provider members of the PCN;
  - d. as clinically required, support the delivery of PCN services/activities, be party to appropriate data sharing and data processing arrangements, that are compliant with data protection legislation; and
  - e. share non-clinical data with members of the PCN to support delivery of PCN business and analysis, following a process that is compliant with data protection legislation.
- 4.3.2. Alongside the above, a practice's compliance with the GMC Good Medical Practice to act in the best interests of patients and not put them at risk of harm, should provide assurance that non-DES practices will co-operate with the delivery of PCN services/activities. In the event a non-DES practice does not co-operate, the commissioner will need to be made aware of, and address, the matter appropriately in line with normal contract management arrangements.

## **5. PCN Organisational Requirements**

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

- 5.1.1. Under the Network Agreement, PCN membership is divided into two categories – Core Network Practices and other PCN members. Core Network

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

- 5.1.2. The Core Network Practice membership of a PCN must cover a Network Area that aligns with a footprint that would best support delivery of services to patients in the context of the relevant ICS. The Network Area must also:
- a. cover a boundary that makes sense to:
    - i. the Core Network Practices of the PCN;
    - ii. other community-based providers which configure their teams accordingly; and
    - iii. the local community;
  - b. cover a geographically contiguous area;
  - c. not cross Clinical Commissioning Group (CCG) or ICS boundaries except where:
    - i. a Core Network Practice's boundary or branch surgery crosses the relevant boundaries; or
    - ii. the Core Network Practices are situated in different CCGs.
- 5.1.3. From contractual perspective, a primary medical services provider who holds either:
- a. a single eligible primary medical services contract will only be able to hold one Network Contract DES and be a Core Network Practice of a single PCN, this applies regardless of whether or not the single primary medical care provider has multiple sites spanning large areas and/or commissioner boundaries; or
  - b. multiple eligible primary medical care contracts will be able to have each of those contracts varied to include the Network Contract DES and each practice will be a Core Network Practice of the relevant PCN(s).
- 5.1.4. A practice not participating in the Network Contract DES could be a PCN member (like any other non-practice provider, i.e. not a Core Network Practice) and therefore be party to a PCN's Network Agreement.
- 5.1.5. A practice may be a member of more than one PCN, for example where a practice provides services from a branch surgery and sub-contracts the delivery of PCN services and/or activities for that branch surgery to a different PCN, or where a practice is the nominated payee for two PCNs. In these examples, the practice would be a Core Network Practice of one PCN and a PCN member (i.e. non-Core Network Practice) of another PCN. Similarly, within the PCN ODS reference data, GPES and CQRS, practices will only be a Core Network Practice of one PCN.

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

- 5.1.6. A practice with one or more branch surgeries in different PCNs acknowledges that its list of patients will be associated with the PCN of which the practice is a Core Network Practice. For PCNs/practices intending to have a different PCN provide PCN services/ activities to a branch surgery, see section 6 for information about sub-contracting arrangements.

## **5.2 PCN organisational or Core Network Practice membership changes**

- 5.2.1. As outlined in section 2 above, a PCN may seek approval of a change to its Core Network Practice membership as part of the participation process following publication of the 2022/23 Network Contract DES Specification or an in-year variation. This change will be signed off as part of the process for practices confirming participation in the Network Contract DES, as outlined in section 2 of this guidance (and section 4.8 of the [Network Contract DES Specification](#)).
- 5.2.2. Changes to Core Network Practice membership of a PCN can only take place outside of this window in exceptional circumstances as set out in sections 6.6 to 6.9 of the Network Contract DES Specification and with the approval of the commissioner.
- 5.2.3. Commissioners should maintain accurate records of all PCN Core Network Practice membership approvals and rejections and will be required to demonstrate if requested, the rationale for their decision.
- 5.2.4. Where a PCN wishes to change its Clinical Director or nominated payee, it must follow the process as set out in sections 6.2 and 6.3 respectively of the Network Contract DES Specification.

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

- 5.3.1. Where changes to PCN membership or nominated payee have been approved by the commissioner, the commissioner must complete and submit the ODS Change Instruction Notice Form<sup>4</sup>. This form must be completed and submitted at the earliest opportunity and by no later than the last working day on or before the 14<sup>th</sup> day of each month, in order for the change to be actioned by the end of that month in the payment systems. In so doing, commissioners should have due regard to local payment arrangements and the timings implications of this when submitting an ODS Change Instruction Notice. Where the ODS Change Instruction Notice Form is not submitted by the monthly deadline, then changes will not take effect until 2 months later (payment reconciliations will be part of the automated process).

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

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

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

- 5.3.3. Each PCN will have a single commissioning relationship, regardless of whether the Core Network Practices of a PCN cross commissioner boundaries. In the event a PCN crosses commissioner boundaries, then the relevant commissioners must agree who will be the 'lead' commissioner for the PCN. The agreed 'lead' will be identified as such within both the PCN ODS reference data and subsequently within the relevant GP IT systems for payment processing. The identified lead commissioner will make payments to the relevant Nominated Payee in relation to the Network Contract DES. The lead commissioner and any other relevant commissioner must reconcile any funding allocation discrepancies between themselves and not via national GP payment systems.
- 5.3.4. Only a PCN's 'lead' commissioner will be able to instruct changes to the ODS reference data and by someone from within the primary care commissioning team.
- 5.3.5. The NHS Digital ODS Team is not able to distinguish between a delegated or non-delegated CCG. Where a Regional Team submits an ODS Change Instruction Notice, the assumption will be that this is due to the CCG not having delegated authority and/or that this has been agreed locally between the Regional Team and CCG. As such, it is the responsibility of the commissioners (Regional Team and/or CCG) to ensure that they have the authority to submit the ODS Change Instruction Notice, as it will have implications for payment system calculations and processing. Where a submission is made by a Regional Team, it will also need to be done by someone from within the primary care commissioning team.

## 5.4 Network Agreement

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

## 5.5 Recording agreements reached with local providers

- 5.5.1. In 2020/21, each PCN was required to agree with local community services providers, mental health providers and community pharmacy providers how they would work together. The collaboration agreements reached with these local providers must be documented in Schedule 7 of the PCN's Network Agreement.
- 5.5.2. As set out in the Network Contract DES Specification, PCNs must update Schedule 7 of their Network Agreement to set out:
  - a. the specifics of how the appropriate service requirements (those which require joint working with community services providers, community mental health providers and community pharmacy) under the Network Contract DES or other services deemed appropriate will be delivered through integrated working arrangements between PCNs and other providers; and
  - b. how providers will collaborate, including agreed communication channels, agreed representatives, and how any joint decisions will be taken.
- 5.5.3. Commissioners should use reasonable endeavours to facilitate the agreement of arrangements, or any subsequent amendment to the arrangements, between the local community services provider(s) and the PCN.

## 5.6 Clinical Director



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

### **Appointment of Clinical Director**

- 5.6.4. It will be the responsibility of the PCN to agree who their Clinical Director will be. The selection process will be for the PCN to determine but may include:
  - a. Election - nomination and voting;
  - b. Mutual agreement between the members;
  - c. Selection – via application and interview for example; or
  - d. Rotation within a fixed term (this could equally apply against the above processes).

### **Managing Conflicts of interest**

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

## **5.7 Data and analytics**

- 5.7.1. Each PCN is required to have in place appropriate data sharing and, where appropriate, data processing arrangements between members of the PCN and any sub-contractors as required. These arrangements must be in place prior to the start of the activity to which they relate. The [Data Sharing Agreements and Data Processing Agreement non-mandatory templates](#) are available for PCNs to use.
- 5.7.2. Where functionality is available, clinical data sharing for service delivery should be read/write access, so that a GP from any practice, and where required other PCN staff, can refer, order tests, and prescribe electronically and maintain a contemporaneous record for every patient.



- 5.7.3. PCNs should be routinely monitoring, sharing, and aggregating relevant data across the Core Network Practices. This is to allow for benchmarking of activity and the identification of:
- a. opportunities for improvement;
  - b. variation in access and service delivery; and
  - c. capacity and demand across the PCN population in order to review and manage appropriately.
- 5.7.4. The Calculating Quality and Reporting Service (CQRS) includes functionality to enable practice-level data for PCN Core Network Practices to be summed to PCN-level. PCN Core Network Practices and the lead commissioner will be able to review both PCN and practice-level data.
- 5.7.5. With regards to cross-boundary PCNs identified through the PCN ODS mapping data, reporting within CQRS will not enable PCN related data to be available to multiple commissioners. The commissioners will therefore need to work together and the 'lead CCG' – identified by the PCN ODS reference data - will be required to share all relevant PCN level data with the 'non-lead CCG' to support monitoring and payment information linked to the Network Contract DES. Providing the data is not patient identifiable – which for the purposes of the Network Contract DES it will not be – General Data Protection Regulation (GDPR) does not require a data sharing agreement to be in place between controllers.

## 5.8 Network Dashboard

- 5.8.1. The Network Dashboard was introduced during 2020/21 and will evolve each year, in line with feedback from users and the availability of new information to populate it. To access the Dashboard, please either [register](#) on the Insights Platform, or login in using your existing [Insights Platform account](#). A [user guide](#) is available to help navigate the dashboard.
- 5.8.2. The dashboard includes key metrics to allow every PCN to see the benefits it is achieving for its local community and patients and is intended to support local quality improvement. It will enable effective benchmarking between practices within PCNs, and between comparable PCNs, and will be accessible, on request, to all commissioners, providers and arms-length bodies working in health and social care.
- 5.8.3. These indicators will be displayed alongside contextual information for each PCN – for example the size, density and relative level of deprivation of their population.

## 6. Sub-contracting of network services

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

- 6.1.1. When a Core Network Practice of a PCN (PCN 1) is looking to sub-contract services/activities to a different PCN (PCN 2) for a proportion of their registered population (for example where it holds a single contract but delivers services from multiple sites, such as a branch surgery), PCN 1

should give careful consideration to how the patients - to whom PCN 2 will provide PCN services/activities - will be identified. This is particularly important where those patients are under a single registered list under a single primary medical services contract.

- 6.1.2. Identification of patients for whom PCN 2 will provide PCN services/activities may, for example, be the patients who usually access care at a GP practice site within PCN 1. The GP practice should also take care not to do anything that could mean that a cohort of registered patients were treated differently e.g. a GP practice should not tell specific patients that they can only access PCN services/activities from sites in PCN 2. This is important as the practice needs to ensure that it does not breach any of the practice's obligations to patients set out in its core primary medical services contract.
- 6.1.3. There are two main options for the sub-contracting of PCN services/activities:

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

- a. In this scenario, the practice will be a Core Network Practice of a PCN (PCN 1) and will be signed up to PCN 1's Network Agreement in the usual way. That Network Agreement will note that it has been agreed that another PCN (PCN 2) will provide PCN services/activities to certain patients of the relevant practice. It would be helpful for PCN 1's Network Agreement to set out the reasoning for this. The relevant practice will also sign the Network Agreement of PCN 2 as an "other member" (i.e. not as a Core Network Practice). The details of the sub-contracting arrangement - the financial/service delivery/workforce arrangements - would be set out in an additional schedule of PCN 2's Network Agreement.
- b. Careful consideration would need to be given to the role that the relevant practice has in PCN 2. The Network Agreement for PCN 2 would need to be clear on:
- i. setting out what requirements, if any, the relevant practice should be expected to deliver to facilitate the delivery of PCN services/activities to its patients. This might include agreed arrangements for communicating with patients and data sharing, for example;
  - ii. defining which matters of PCN 2 the relevant practice may have an interest/vote in; and
  - iii. whether there is any PCN 2 related information e.g. financial accounts, that it should not be party to.

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

- a. In this scenario, the relevant practice could enter into a separate sub-contract with one or more of the Core Network Practices of PCN 2 for the delivery of PCN services/activities. Both PCNs will need to reflect the sub-contracting arrangement in both Network Agreements. In this scenario, it would not be necessary for the relevant practice to sign the Network Agreement of PCN 2.
- 6.1.4. PCNs will need to carefully consider the pros and cons of each approach, bearing in mind the additional complexity that either of the sub-contracting arrangements may bring and ensure that the agreed position is set out in clear and unambiguous wording. In all cases, the sub-contracting

arrangements should include the ability to review/update the sub-contracting arrangements in light of any changes to the Network Contract DES Specification.

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

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

- 6.2.1. Following an amendment to GMS and PMS Regulations<sup>5</sup>, a sub-contractor to a practice or practices may be allowed to onward sub-contract a clinical matter that relates to the Network Contract DES. If, for example, practices have sub-contracted provision of clinical services to a GP federation, the sub-contract could now allow the GP federation to sub-contract the clinical services to another organisation with the prior written approval of the commissioner. The commissioner's approval will not unreasonably be withheld or delayed.
- 6.2.2. A sub-contractor to a practice or practice(s) will be allowed to onward sub-contract a non-clinical matter that relates to the Network Contract DES where the prior written approval of the commissioner is given. The commissioner's approval will not unreasonably be withheld or delayed.

## **7. Additional Roles Reimbursement Scheme**

### **7.1 Workforce planning and ongoing reporting**

- 7.1.1. Expanding the workforce is the top priority for primary care, and commissioners must support their PCNs to undertake recruitment under the Additional Roles Reimbursement Scheme to deliver this priority.
- 7.1.2. PCNs are required to plan their future workforce requirements in order to support claims under their Additional Roles Reimbursement Sum each year. As set out in the Network Contract DES Specification, each PCN is required to complete and return to the commissioner by 31 August 2022 the workforce planning template<sup>6</sup>, providing details of any updated recruitment plans for 2022/23 and by 31 October 2022 any updated indicative intentions through to 2023/24. The commissioner will confirm the plan with each PCN's Clinical Director and, once each plan is agreed, will share with NHS England Regional Teams by 30 September 2022 for 2022/23 plans, and by 30 November 2022 for indicative future plans.

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<sup>5</sup> The NHS (GMS Contracts and PMS Agreements) (Amendment) (No2) Regulations 2020: <https://www.legislation.gov.uk/uksi/2020/911/schedule/1/made?view=plain>

<sup>6</sup> This template will be available at <https://www.england.nhs.uk/gp/investment/gp-contract/>

- 7.1.3. The PCN may change these plans at any stage provided that such change is shared with the commissioner as this aids management of the redistribution of Additional Roles Reimbursement Scheme funding across all PCNs, as described in section 7.5 of the [Network Contract DES Specification](#).
- 7.1.4. PCNs working with their commissioners and their ICS are encouraged to have ongoing dialogue in relation to workforce strategies, to ensure these are consistent with broader ICS workforce strategies.
- 7.1.5. The commissioner must complete and return the six-monthly workforce report to [england.primarycareworkforce@nhs.net](mailto:england.primarycareworkforce@nhs.net). There are plans to develop an online template for future returns, and further details will be made available to commissioners in due course.
- 7.1.6. PCN Core Network Practices must record, on a monthly basis, within the National Workforce Reporting Service (NWRS) information on any staff employed or engaged through the Additional Roles Reimbursement Scheme.

### **System Support for PCNs**

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

## **7.2 Additional Roles Reimbursement Sum**

- 7.2.1. Each PCN will be allocated an Additional Roles Reimbursement sum each year, based upon the PCN's Contractor Weighted Population share of the total Additional Roles Reimbursement Scheme funding. The basis for weighting is the same as for global sum (i.e. Carr-Hill Formula). PCNs will be able to claim up to this maximum sum each year, in line with the rules set out in the Network Contract DES Specification.
- 7.2.2. Each PCN's Additional Roles Reimbursement Sum will use the Contractor Weighted Population<sup>7</sup> as at 1 January of the financial year preceding and be calculated as follows:

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<sup>7</sup> Contractor Weighted Population as defined in Annex A of the Statement of Financial Entitlements (SFE) taken as at 1 January of the financial year preceding. The SFE confirms that this is the number of patients arrived at by the Global Sum Allocation Formula.

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

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

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

## 7.3 Ready reckoner

7.3.1. A [ready reckoner](#) is available to support PCNs to calculate their indicative Additional Roles Reimbursement Sum based on their PCN Contractor Weighted Population. Table 1<sup>8</sup> sets out the indicative Additional Roles Reimbursement Sum allocations for different PCN sizes from 2022/23 to 2023/24.

7.3.2. For 2022/23 the Additional Roles Reimbursement Sum will be calculated using £16.696 multiplied by the PCN Contractor Weighted Population as at 1 January 2022. The 2022/23 figures in Table 1 are calculated using £16.696 per PCN Contractor Weighted Population. The figures for both years are calculated using the formula in section 7.2 and the January 2022 national population of 61,499,657.

**Table 1: Indicative Additional Roles Reimbursement Scheme Sum per PCN Contractor Weighted Population**

	2022/23	2023/24
Total National Workforce funding	£1,026,747,000	£1,412,011,000
PCN size (weighted)		
15,000	250,400	344,400
20,000	333,900	459,200
25,000	417,400	574,000
30,000	500,900	688,800
40,000	667,800	918,400
50,000	834,800	1,148,000
80,000	1,335,600	1,836,800
100,000	1,669,500	2,296,000
150,000	2,504,300	3,443,900

<sup>8</sup> For illustrative purposes, both national population and PCN size have been fixed in table 1 to give an indicative view of the funding current PCN population sizes will attract in future as they grow, on average, in line with the growth in the national population. The figures in table 1 do not include any subsequent uplifts that may be agreed to the Agenda for Change pay rates on which the maximum reimbursable sum is based. Figures are therefore subject to change to take this into account in future.

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

- 7.4.1. The Additional Roles Reimbursement Sum funding is only available to fund additional PCN workforce in line with the rules of the scheme.
- 7.4.2. NHS England expects the funding under the Additional Roles Reimbursement Scheme to be used in full, on the terms set out in the Network Contract DES Specification and in this guidance, in each year of the scheme.
- 7.4.3. As set out in the Network Contract DES Specification, each PCN is required to complete a workforce plan which commissioners will use to inform their estimation of likely unclaimed Additional Roles Reimbursement Scheme funding. Following this, commissioners will be required to follow the process for redistributing any unclaimed Additional Roles funding in line with the requirements and process as set out in the Network Contract DES Specification.
- 7.4.4. Any unused funding in a given financial year cannot be carried forward into subsequent years, and a PCN's entitlement to that funding in that year will therefore be lost.

## 7.5 Principle of additionality and baselines

- 7.5.1. To receive the associated funding through the Additional Roles Reimbursement Scheme, a PCN must show that the staff delivering health services for whom reimbursement is being claimed are additional and comply with the “principle of additionality” as set out in sections 7.2 of the Network Contract DES Specification. The additionality rule serves both to protect pre-existing local investment in primary care (e.g. by commissioners), as well as to expand capacity. It is not possible for Core Network Practices or commissioners to stop funding staff identified in the baseline exercise on the grounds that these could instead be funded through PCN reimbursement.
- 7.5.2. Core Network Practices and commissioners will be required to maintain existing funding for baseline staff levels measured as at 31 March 2019 against six of the reimbursable roles – clinical pharmacists, social prescribing link workers, first contact physiotherapists, physician associates, pharmacy technicians, and paramedics. The two baselines established during 2019 are as follows (further detail on how the baselines were established is available in the [2019/20 Additional Roles Reimbursement Scheme Guidance](#)):
  - a. A PCN baseline declared by the Core Network Practices of the PCN and agreed with the commissioner. It is comprised of the actual whole time equivalent (WTE) staff across these six reimbursable roles and funded by general practice as at 31 March 2019. The PCN baseline will be fixed until 31 March 2024.
  - b. A Clinical Commissioning Group (CCG) baseline declared by the CCG. It is comprised of the WTE patient facing or first contact time of staff across the six reimbursable roles deployed to support general practice



or primary medical care services - either in a specific practice or in the wider community - funded<sup>9</sup> by the CCG as at 31 March 2019 (regardless of whether funded due to direct CCG employment or through a contract). Any admin, travel, triage or other time directly related to patient care is included in the WTE. The commissioner is required to maintain funding for these baseline posts and will be subject to audit. Commissioners will be obliged to continue to fund baseline posts and will be subject to audit. All commissioners have been fully funded for GP contract costs in their primary medical services allocations. CCG baseline posts will have no bearing on PCN additionality claims.

- 7.5.3. These baselines will be monitored at a national level in line with the *NHS Long Term Plan* commitment that resources for primary medical and community services will increase in real terms by 2023/24 and rise as a share of the overall NHS budget.
- 7.5.4. The purpose of the baseline is to provide a fixed reference point against which additionality claims should be assessed. Thus, changes to baseline numbers will not be permitted. However, in the rare circumstances that it becomes apparent at a later date that the baseline was incorrect, the PCN Clinical Director and CCG Accountable Officer (or equivalent in the Integrated Commissioning Board) should agree and sign a new declaration confirming that the revised baseline reflects a true position. The changes to the baseline should be reflected, where appropriate, in the next quarterly NWRS and commissioner six-monthly returns.
- 7.5.5. The PCN and CCG baselines are fixed for five years. PCN reimbursement claims under the Additional Roles Reimbursement Scheme will be assessed against the PCN baseline only.
- 7.5.6. Practices are required to maintain the declared PCN baseline in order to meet the additionality rules under the Network Contract DES Additional Roles Reimbursement Scheme. Reimbursement claims under the Scheme will be assessed against the PCN baseline only. It should generally be assessed for individual workforce groups, rather than the total number of staff in the PCN baseline in all six reimbursable roles. However, with agreement from the commissioner, a PCN will be able to substitute between clinical pharmacists, first contact physiotherapists, physician associates and paramedics within the practice-funded PCN baseline posts as outlined in section 7.2.4 of the Network Contract DES Specification.
- 7.5.7. For the purposes of the Additional Roles Reimbursement Scheme claims, WTE is defined as 37.5 hours in line with Agenda for Change (AfC) Terms and Conditions, although this may vary for non-AfC posts. Where AfC does not apply, PCNs should calculate the relevant WTE according to the normal full-time hours for that role in the employing organisation with reimbursement being made on a pro-rata basis accordingly.

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



- 7.5.8. A PCN baseline will not be established for health and wellbeing coaches, care coordinators, dietitians, podiatrists, occupational therapists, nursing associates, trainee nursing associates, mental health practitioners (MHPs) advanced practitioners, **general practice assistants or digital and transformation leads**. While the PCN baseline will not include these roles, the additionality principles will still apply. A PCN claiming reimbursement in respect of these roles does so on the basis that it is for additional staff engaged or employed since 31 March 2019, and that the reimbursement is not being used to subsidise practice-funded roles that existed as at 31 March 2019.
- 7.5.9. Local agreements for the provision of MHPs (Adult and/or Child and Young Person MHPs) to a PCN must be additional over and above any:
- MHPs already employed by the secondary care provider of community mental health services to work as a member of, whether full-time or part-time, including on a rotational basis, a general practice or PCN's core multi-disciplinary team as at 31 January 2021; and
  - Improving Access to Psychological Therapies (IAPT) Practitioner already employed by the secondary care provider of community mental health services and working co-located within the relevant general practice as at 1 January 2021.
- 7.5.10. As set out in section 7.6.1 below, any clinical pharmacists who transferred to the PCN by either 31 March 2020 or transferred between 1 April 2021 to 30 September 2021, are exempt from the PCN baseline providing the post was included in the PCN baseline established on 31 March 2019. Similarly, as set out in section 7.6.2 any pharmacists (clinical pharmacists and pharmacy technicians) employed under the *Medicines Optimisation in Care Homes (MOCH) Scheme* who were included in the PCN baseline established on 31 March 2019 and who transferred by 30 September 2021 are exempt from the additionality rules.
- 7.5.11. Baseline posts occupied by fixed term appointed staff can be considered to be 'filled' only if they are part of a long-term arrangement, which must be in place for a minimum of six months or more. Equally, PCNs will only be eligible to claim reimbursement for additional posts to be occupied by staff on fixed-term contracts, if these are for a minimum period of six months or more, unless the purpose is to provide temporary cover (e.g. sickness or parental leave) for an individual employed through the Additional Roles Reimbursement Scheme. In these circumstances, PCNs will be able to claim up to the maximum reimbursement amount per WTE as set out in the Network Contract DES Specification for actual salary plus employer on-costs (NI and pension), pro-rata for the period of the contract of employment and relevant WTE.
- 7.5.12. The Additional Roles Reimbursement Scheme cannot distinguish between staff with different job descriptions e.g. a MSK physiotherapist is the same as a non-MSK physiotherapist for the purposes of the baseline and additionality, so long as both roles have an element of patient-facing or first contact care time in specific practices or in the wider neighbourhood or community.

## Changes to PCN baselines and staffing levels

- 7.5.13. It is expected that PCN staffing levels will change from time to time. PCNs will be required to notify commissioners at the earliest opportunity of any changes to staffing levels, which may affect the PCN's reimbursement entitlement. The mandatory [online claim portal](#) includes a section to notify commissioners of any changes.
- 7.5.14. The PCN should notify the commissioner that a member of staff who is in the PCN baseline or for which the PCN is claiming reimbursement will cease or has ceased to work for the PCN or (for PCN baseline roles) a Core Network Practice. Where possible, the PCN should notify the commissioner in advance of the member of staff's last day of employment (or the last day of the sub-contract where applicable) but no later than the last day of the calendar month in which the member of staff ceased to be employed/engaged.
- 7.5.15. Where a vacancy arises in a Core Network Practices' PCN baseline WTE, the PCN must apply an equivalent WTE reduction in their workforce funding under the Network Contract DES Additional Roles Reimbursement Scheme. This reduction will be applied from three months (a three-month grace period) after the date at which the vacancy arose and which resulted in the PCN baseline reduction. For example, if one WTE post becomes vacant in a PCN's baseline and is not recruited to within three months, the PCN must deduct one WTE from its reimbursement claim until such time as the PCN baseline vacancy is filled, in order to maintain the principle of reimbursement for additional workforce. Sections 7.2.3 and 10 of the Network Contract DES Specification provide further information.

## **7.6 Transfer of clinical pharmacists and pharmacy technicians**

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

- 7.6.1. Any clinical pharmacists who were in post as at 31 March 2019 under the *Clinical Pharmacist in General Practice Scheme* were required to transfer to the PCN by 31 March 2020 in order to be eligible for funding through the Additional Roles Reimbursement Scheme and to be exempt from the PCN baseline. A further opportunity was also then made available between 1 April 2021 and 30 September 2021 for any clinical pharmacists still employed under this scheme on 31 March 2021 to transfer and be eligible for funding through the Additional Roles Reimbursement Scheme. Practices are responsible for fully funding any clinical pharmacist posts which have not transferred after the tapering of the *Clinical Pharmacist in General Practice Scheme* funding.

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

- 7.6.2. For all pharmacists (clinical pharmacists and pharmacy technicians) employed under the *Medicines Optimisation in Care Homes (MOCH) Scheme*, transfer to the PCN must have taken place by no later than 31 March 2021. A further opportunity is available between 1 April 2021 and 30 September 2021 for any MOCH pharmacists still employed under this

scheme on 31 March 2021 to transfer and be eligible for funding through the Additional Roles Reimbursement Scheme.

- 7.6.3. Where MOCH pharmacists do not transfer, commissioners are required to align the priorities of the CCG commissioned MOCH team to that of the Enhanced Health in Care Homes service requirements outlined in section 8.3 the Network Contract DES Specification.

## 7.7 Additional Roles Reimbursement Scheme claims process

- 7.7.1. Commissioners should ensure that any staff for which reimbursement is being claimed meet the requirements set out in section 10 of the Network Contract DES Specification.
- 7.7.2. PCNs must use the mandatory [online claim portal](#) for all workforce reimbursement claims under the Additional Roles Reimbursement Scheme, in accordance with sections 10.1, 10.2 and 10.5 of the Network Contract DES Specification. Commissioners may ask PCNs for further evidence to support new workforce reimbursement claims, which may include:
- a. A signed contract of employment (can remove personal information where appropriate) clearly setting out the salary.
  - b. A contract/agreement with a provider for the provision of services.
  - c. A copy of a Network Agreement – if used as the basis for sub-contracting for services/staff.
- 7.7.3. In the event the practice(s) within the PCN decide to engage the services of staff reimbursable under the Additional Roles Reimbursement Scheme via a sub-contracting arrangement, the PCN will need to agree with the sub-contractor the relevant costs of the service while bearing in mind the scheme rules. The rules are that reimbursement can only be claimed for 100 per cent, or 50 per cent for mental health practitioners, of **actual salary plus employer on-costs (NI and pension)** up to the maximum amount for the relevant role, as outlined in the Network Contract DES Specification and within the PCNs overall Additional Roles Reimbursement Sum.
- 7.7.4. For social prescribing link workers engaged via a sub-contract to an organisation outside the PCN, and not directly employed, the reimbursement claim may include a contribution towards the additional costs charged by a sub-contractor for the delivery of social prescribing services. See section 10.1.11 below for details.
- 7.7.5. Commissioners should ensure that local processes are as straightforward as possible, with clear deadlines for submission of claims, and claims should be processed in a timely manner.
- 7.7.6. Reimbursement claims will be subject to validation and any suspicion that deliberate attempts have been made to subvert the additionality principles or to claim costs above and beyond those allowable, will result in a referral for investigation as potential fraud. PCNs may be asked as part of the validation process to re-confirm the position regarding the number of filled baseline posts at the point a reimbursement claim is made. They may also be asked

to provide copies of sub-contracting or Service Level Agreements where they are claiming for staff employed or supplied by a third party.

- 7.7.7. Reimbursement will apply up to the Additional Roles Reimbursement Scheme cap and applies to actual salary plus employer on-costs (NI and pension) only, not to additional hours or recruitment and retention premia agreed in addition.
- 7.7.8. Commissioners may claim back reimbursement monies where it becomes apparent that a PCN was not eligible to claim reimbursement under the Network Contract DES e.g. because it failed to declare a vacant baseline post.

## **8. Additional Roles Reimbursement Scheme Workforce**

### **8.1. Additional Roles**

- 8.1.1. A PCN may employ or engage any one or more of the reimbursable roles in accordance with the details set out in section 7 and section 10 of [the Network Contract DES Specification](#). Annex B of the Network Contract DES Specification sets out the minimum role requirements for each of the reimbursable roles from April 2022 and the associated requirements placed on PCNs.
- 8.1.2. This section provides additional information to support that included in the Network Contract DES and supporting materials available.

### **8.2. Role descriptions and terms and conditions**

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

### **8.3. Clinical pharmacists**

- 8.3.1. A minimum of 0.5 WTE should apply to the clinical pharmacists employed via the Network Contract DES **only if the clinical pharmacist is still enrolled on an approved 18-month training pathway or equivalent**. This is to ensure the clinical pharmacist is able to access timely national training and can deliver continuity of care whilst working across multiple providers within the PCN.

- 8.3.2. Clinical pharmacists being employed through the Network Contract DES funding will either be enrolled in or have qualified from an accredited training pathway that equips the pharmacist to be able to practise and prescribe safely and effectively in a primary care setting currently, the Clinical Pharmacist training pathway<sup>10,11</sup>) and in order to deliver the key responsibilities of the role. NHS England will be arranging a funding mechanism to allow all clinical pharmacists to access and complete an approved training pathway that equips the pharmacist to achieve this.
- 8.3.3. Upon completing the training pathway, the clinical pharmacist receives a 'Statement of Assessment and Progression' which details the learning undertaken and confirms the assessments they have passed. This documentation is available in both hardcopy and electronic format. In addition to this, evidence of training need for any current or future employer can be access through the protected section of the website of the learning provider, which captures the learning of the Clinical Pharmacists participating in their training.
- 8.3.4. This training requirement can be met with pre-existing qualifications / experience on the basis that it meets the learning objectives of the current approved training pathway funded by NHS England. The training will be modular and clinical pharmacists are only required to undertake the training they need to complete the portfolio requirements. This accreditation of prior learning should be undertaken by the supervising senior clinical pharmacist and Clinical Director for the PCN.

### **Supervision of Clinical Pharmacist**

- 8.3.5. All clinical pharmacists will be part of a professional clinical network and will always be clinically supervised by a senior clinical pharmacist and GP clinical supervisor. The following supervision must be in place for senior clinical pharmacists and clinical pharmacists:
- a. Each clinical pharmacist will receive a minimum of one supervision session per month by a senior clinical pharmacist<sup>12</sup>;
  - b. The senior clinical pharmacist will receive a minimum of one supervision session every three months by a GP clinical supervisor; and
  - c. All clinical pharmacists will have access to an assigned GP clinical supervisor for support and development.
- 8.3.6. The ratio of senior to junior clinical pharmacists should be up to one to five, and in all cases appropriate peer support and supervision must be in place.
- 8.3.7. Flexible and innovative approaches to the formation of clinical networks can be adopted and promoted to enhance collaboration/integration across healthcare interfaces.

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<sup>10</sup> CPPE Clinical Pharmacists in General Practice Training Pathway

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

<sup>11</sup> CPPE Medicines Optimisation in Care Homes Training Pathway

<https://www.cppe.ac.uk/career/moch/moch-training-pathway#navTop>

<sup>12</sup> This does not need to be a senior clinical pharmacist within the PCN but could be part of a wider local network, including from secondary care or another PCN.

## **Sub-contracted remote clinical pharmacy services under the ARRS clinical pharmacist role**

8.3.8 A PCN wishing to use an agency or alternative provider to access clinical pharmacy 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.

8.3.9 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.

8.3.10 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 whilst enrolled on an approved 18 month training pathway or equivalent.

8.3.11 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.

8.3.12 The commissioner and PCN must therefore be assured that all 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

## **8.4. MOCH pharmacists**

8.4.1. Where any MOCH pharmacists remain, PCNs will be expected to make operational use of the pharmacist's experience in relation to Care Homes as outlined in section 9.3 below and section 8.3 of the Network Contract DES Specification. This will include:



- a. supporting care homes with local policies and procedures, training, vaccinations and provide support for any challenges the home may have, including:
- b. ordering and storage of medicines to reduce waste
- c. supporting care planning and comprehensive geriatric assessments (CGA) structured medication reviews
- d. link-in to community services, acute trusts and mental health services
- e. supporting weekly care home rounds, working with the MDT
- f. working with the wider MDT (including external organisations) to support the delivery of Enhanced Health in Care Homes.

## 8.5. Further guidance and supporting information

8.5.1. Supporting guidance providing further information to help PCNs employ or engage Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Co-ordinators is available at:

- a. Social prescribing link workers - <https://www.england.nhs.uk/publication/social-prescribing-link-workers/>
- b. Health and Wellbeing Coaches - <https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/>
- c. Personalised Care Institute - <https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/>

8.5.2. PCNs employing or engaging one of the Allied Health Professionals must consider the qualifications, experience and capabilities when determining which job description is utilised for the role and considering the minimum role requirements set out in Annex B of the Network Contract DES Specification. Further information:

- a. on capabilities is available at (while this document refers to the MSK framework, the capabilities have been written for all AHPs): [https://www.csp.org.uk/system/files/musculoskeletal\\_framework2.pdf](https://www.csp.org.uk/system/files/musculoskeletal_framework2.pdf);
- b. <https://www.england.nhs.uk/ahp/ahps-in-primary-care-networks/>.

8.5.3. Each AHP employed or engaged by a PCN must have access to appropriate clinical supervision and an appropriate named individual for general advice and support daily.

8.5.4. A number of supporting materials are available in the Primary Care Networks Development Support section of the [FutureNHS Collaboration Platform](#).

8.5.5. During 2021/22, all Additional Roles will be made available for inclusion on Smartcards, to support accurate recording of Health Care Professional type in GP records. Further information will be provided in due course as to how these roles can be applied to Smartcards, for both new and existing employees.

8.5.6. Further guidance and resources to support the embedding of ARRS roles and the development of a multidisciplinary team are available at



<https://www.england.nhs.uk/gp/expanding-our-workforce/> and <https://future.nhs.uk/connect/ti/PCN/view?objectID=21555568>. These sites will be updated during 2022/23.

## 9. Service requirements

### 9.1. Current Extended Hours Access service and future Enhanced Access

- 9.1.1. Section 8.1 of the [Network Contract DES Specification](#) sets out the requirements for:
- a. delivery of the current extended hours access and undertaking the preparatory requirements for Enhanced Access from 1 April 2022 to 30 September 2022.
  - b. and delivery of Enhanced Access from 1 October 2022 onwards.
- 9.1.2. Where a practice has signed up to the Network Contract DES, it becomes contractually obliged to offer extended hours access, and from 1 October 2022 enhanced access, to its registered patients via the PCN (which can be delivered by the practice or sub-contracted). Therefore, all patients should have access to extended hours services from 1 April 2022, and then enhanced access services from October 2022, through the PCN, but it will be for the PCN to determine how that offer is made available to all its registered patients.
- 9.1.3. For extended hours access (until October 2022), the additional clinical appointments provided by a PCN are to be held at times that take account of patient's expressed preferences and are outside the hours that the PCN Core Network Practices' are required to provide as part of their primary medical services contracts. This means that if a Core Network Practice was required under a General Medical Services (GMS) contract to provide core services at its premises until 6:30pm, the additional clinical appointments could be provided after 6:30pm. If, however, another Core Network Practice in the PCN provided core services at its premises until 8pm, then:
- a. any additional clinical appointments provided after 6:30pm but before 8pm must not be provided at the later closing practice's premises (as these would not be additional hours appointments) but could be provided at the other practice's premises; and
  - b. a proportion of the additional clinical appointments must be provided after 8pm.
- 9.1.4. For enhanced access (from October 2022), the Network Standard Hours will cover 6.30pm-8pm during the week. As above, where a Core Network Practice is required under a General Medical Services (GMS) contract to provide core services at its premises after 6.30pm, the patients of that practice must also have access to enhanced access appointments, and the enhanced access appointments must be in addition to the appointments offered as part of that practice's core hours service offer.

- 9.1.5. Core Network Practices within a PCN are collectively responsible for the delivery of extended hours access and, from 1 October 2022, enhanced access. In the event the commissioner is not satisfied that a PCN is delivering the requirements in accordance with the Network Contract DES, then the commissioner may take action as set out in section 9 of the Network Contract DES Specification. If a commissioner determines to withhold payment<sup>13</sup>, the amount withheld will be an appropriate proportion of the extended hours access payment or enhanced access payment and the Core PCN funding payment.
- 9.1.6. PCNs have the flexibility to sub-contract extended hours access or enhanced access services to other providers in accordance with any sub-contracting provisions of the GP practices' primary medical services contracts.
- 9.1.7. The delivery of extended hours access through the Network Contract DES will be in addition to any CCG commissioned extended access services.
- 9.1.8. In relation to enhanced access, the Specification sets out the minimum universal requirements for PCNs to deliver. It is expected that, where areas already have additional patient services in place locally, commissioners will make arrangements for these to continue (and any changes would be subject to local engagement). Where current levels of capacity or funding as provided under the CCG Extended Access Service at 30 September 2022 exceed the minimum requirements for Enhanced Access set out in the Network Contract DES Specification, commissioners will be expected to ensure that these capacity and funding levels under the CCG Extended Access Service are maintained going forward

### **Preparatory requirements for implementation of Enhanced Access and requirements for delivery**

#### *Preparatory requirements from 1 April 2022 – 30 September 2022*

- 9.1.9. In preparation for Enhanced Access from October 2022, PCNs will be required to develop and agree with the commissioner an Enhanced Access Plan, in accordance with section 8 of the Network Contract DES Specification. PCNs and commissioners should consider what additional relevant information may be required to enable delivery of Enhanced Access. Further guidance will be provided.
- 9.1.10. PCNs and commissioners should be mindful of the following when developing and agreeing the Enhanced Access Plan:
- a. general practice services offered during the Network Standard Hours should include planned care appointments such as vaccinations and immunisations, screening, health checks and PCN services, reflecting the demand and preferences of the PCN's patient population;
  - b. a PCN's minimum number of appointments per week may:

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<sup>13</sup> Payment withheld in this context would be an appropriate proportion of the payments in relation to both extended hours access and Core PCN funding payments.

- i. be delivered concurrently where they exceed the Network Standard Hours; and/or
- ii. with agreement from the commissioner, a proportion may be delivered in continuous periods of at least 30 minutes outside of the Network Standard Hours to better meet the needs of the PCN's patients, for example, to:
  - provide appointments prior to 8am on weekday mornings or 9am on Saturday morning; or
  - provide appointments after 8.30pm on weekday evenings or 5.30pm on Saturday evenings;
- c. A PCN's Core Network Practices will have the ability to manage their collective capacity and workforce flexibility across Network Standard Hours and practices' core hours to best meet the needs of their population. By exception, a PCN and commissioner may agree that a proportion of capacity can be used to support management of demand during core hours, where this is regularly high;
- d. where a proportion of the minimum appointments are delivered outside of the Network Standard Hours, this does not mean that the Network Standard Hours may be reduced;
- e. In reviewing the PCNs' Enhanced Access Plans, the commissioner will need to ensure they form part of a cohesive ICS approach.

9.1.11. The following are key dates for development and approval of the Enhanced Access plan:

- a. 31 July 2022 – deadline for submission of draft Enhanced Access Plan to commissioner. The Enhanced Access plan must include the PCN's intentions in relation to the matters set out in section 8.1.15.b.i to 8.1.15.b.vi of the Network Contract DES Specification.
- b. 1 August 2022 to 31 August 2022 – period of co-operation in which the PCN and commissioner must work together to agree the Enhanced Access Plan.
- c. 31 August 2022 – deadline for commissioner to agree the final iteration of the Enhanced Access Plan.
- d. 1 October 2022 – PCNs required to commence delivery of Enhanced Access.

9.1.12. A non-exhaustive list of what would be considered a significant change to the Enhanced Access Plan is included in section 8.1.15.e of the Network Contract DES Specification. In general, where the service changes would require engagement with the PCN's patients, then a PCN should seek input from the commissioner at an early stage to agree whether this would constitute a significant change and require the Enhanced Access Plan to be updated.

*Delivery of Enhanced Access from 1 October 2022 onwards*

9.1.13. PCNs will need to deliver their agreed Enhanced Access plan from 1 October 2022. The requirements for providing Enhanced Access are set out in the Network Contract DES Specification. A package of implementation guidance is available here and will be further updated before 1 October 2022.

- 9.1.14. In delivering the Enhanced Access requirements, PCNs should ensure that the mix of services available and workforce used to deliver enhanced access appointments is reflective of patient need, as informed by the patient engagement undertaken in the preparation stage (April – October 2022).

### **Delivery models for PCN Extended Hours Access and Enhanced Access appointments**

- 9.1.15. It will be up to the PCN to determine the delivery model for extended hours access and enhanced access as part of the Network Agreement, but PCNs will need to ensure this service is offered to the entire PCN population. The exact model of delivery in each PCN may vary and could include:
- a. All practices in the PCN continuing to offer extended hours access, and after 1 October 2022 enhanced access, to its own registered list.
  - b. One practice undertaking the majority of the extended hours access or enhanced access provision for the PCN's population, with other practices participating less frequently (but those practices' registered patients still having access to extended hours access or enhanced access at other sites).
  - c. One practice offering extended hours access or enhanced access to its own registered list and the other practices sub-contracting delivery for their respective patients.
  - d. The PCN subcontracting delivery as a whole or elements of the service to another provider for its collective population. A PCN may decide to sub-contract delivery of Enhanced Access and if doing so this must have due regard to the requirements set out in the statutory regulations or directions that underpin each Core Network Practice's primary medical services contracts in relation to sub-contracting, as set out in section 5.6 of the of the Network Contract DES Specification.
- 9.1.16. Irrespective of the delivery model, the PCN should ensure that all network patients have access to a comparable extended and enhanced access service offer. PCNs should ensure that any sub-contracting arrangements are in accordance with any sub-contracting provisions of the Core Network Practices' primary medical services contracts.

### **Funding for the Extended Hours Access and Enhanced Access in the Network Contract DES**

- 9.1.17. The part- year funding under the Network Contract DES from 1 April 2022 to 30 September 2022 equates to £0.720 per registered patient. On top of this payment of £0.720 per registered patient through the Network Contract DES, practices will receive within their global sum payments around £0.25 per patient to cover the expansion in delivery to 100 per cent of patients. Taken together, the two amounts would total a payment of approximately £0.97 (£0.720 plus £0.25) per registered patient over the course of 1 April 2022 – 30 September 2022 – and continue to receive the £0.50 per annum from October 2022 (i.e. the £0.25 balance of the £0.50 from October 2022 to March 2023 and approximately £0.50 per annum thereafter).
- 9.1.18. This funding is in addition to funding the practice may already receive from the CCG for delivering their commissioned extended access services

between April 2022 to 30 September 2022.

- 9.1.19. For Enhanced Access from 01 October 2022 to 31 March 2023, payments under the Network Contract DES will be made using PCN Adjusted Populations, which are based on the CCG Primary Medical Care weighted populations. The formula used to calculate these populations includes a 15% adjustment to recognise inequalities and unmet need, and the same Adjusted Populations are used for the calculation for the number of minutes which PCNs are required to provide in Enhanced Access (60 mins per 1000 population, based on the PCN Adjusted Population). The practice-level Adjusted Populations are available here.
- 9.1.20. PCNs can view their Enhanced Access funding here or in the [GP contract ready reckoner](#).
- 9.1.21. The recurrent global sum payments as referenced in 9.1.17 will continue.

## 9.2. Medication Reviews and Medicines Optimisation

- 9.2.1. Further guidance related to the implementation and delivery of requirements relating to this service have been published<sup>14</sup>. The Network Contract DES Specification sets out that PCNs must have due regard to that separate guidance in delivery of the service requirements.

### Recording of SMRs on GP IT systems

- 9.2.2. The relevant SMR codes must be used to record the occurrence of a SMR and follow up appointments. The relevant SMR codes are available in the supporting Business Rules<sup>15</sup>.

### Additional metrics and outcomes

- 9.2.3. PCN rates of prescription of high-carbon inhalers and medicines of low priority will be displayed in the Network Dashboard. Metrics on prescribing quality for anti-microbials and drugs that potentially cause dependency, as well as a wider patient outcome measurement, are being considered and will be informed by future developments, such as the implementation of Public Health England's (PHE) report into prescribed medicines<sup>16</sup>. Once finalised, measures of prescribing quality will be displayed on the new Network Dashboard. In the meantime, the Network Dashboard will link to existing data on prescribing rates of relevant drugs hosted by the NHS Business Services Authority (NHS BSA) and Open Prescribing. Further detail will be contained in the standalone [guidance](#) document.

## 9.3. Enhanced Health in Care Homes

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<sup>14</sup> <https://www.england.nhs.uk/publication/structured-medication-reviews-and-medicines-optimisation-2021-22/>

<sup>15</sup> Network Contract DES related Business Rules are published by NHS Digital under the relevant years '[Enhanced Services, Vaccinations and Immunisations and Core Contract components](#)' page.

<sup>16</sup> <https://www.gov.uk/government/publications/prescribed-medicines-review-report>

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

- 9.3.1. The Network Contract DES and requirements for relevant providers of community physical and mental health services within the NHS Standard Contract establish a consistent, national, model for the Enhanced Health in Care Homes (EHCH) service. Commissioners, PCNs and other providers should consider these requirements as a minimum standard. The Enhanced Health in Care Homes requirements remain of vital importance during the COVID-19 pandemic, to support the organisation and delivery of a coordinated service to care home residents, many of whom will be at very high risk of a severe negative impact (directly or indirectly) from COVID-19. Good practice is described in the [EHCH Framework](#) which will support implementation of a mature EHCH service.

### Definition of Care Home

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

### Alignment of Care Homes to PCNs

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



- c. What contracts are already held between commissioner and practices to provide support to the home, or directly between the home and practices
- d. Existing relationships between care homes and practices.

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

### **Delivery plan with local partners**

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

### **Supporting re-registration of patients**

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

### **Further guidance**

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

## **9.4. Early Cancer Diagnosis**

9.4.1. Primary care has a vital role to play in system-wide improvement efforts to increase the proportion of cancers diagnosed early, supporting the NHS Long Term Plan ambition to diagnose 75% of cancers at stages 1 and 2 by 2028. The ECD service requirements for PCNs seek to improve referral practice and screening uptake through network level activity. Further guidance related to the implementation and delivery of requirements relating to the PCN service, including guidance on the appropriate management of suspected cancer referrals during the COVID-19 pandemic, is [available here](#).

## **9.5. Social prescribing service**



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

## 9.6. Cardiovascular Disease (CVD) Prevention and Diagnosis

- 9.6.1. CVD is the leading cause of death worldwide and is strongly associated with health inequalities (the most deprived quintile of the population is four times more likely to die from CVD than the least deprived). Hypertension is the most prevalent risk factor, and the focus of this service in 2021/22 which from April 2022, will be expanded to incorporate detection and management of atrial fibrillation (AF) and addressing cholesterol in the context of CVD risk, including detection and management of familial hypercholesterolaemia (FH).
- 9.6.2. Further guidance related to the implementation and delivery of requirements relating to this PCN service is available [here](#).

## 9.7. Tackling Neighbourhood Health Inequalities (TNHI)

- 9.7.1. Since October 2021, PCNs have been required to improve delivery of annual learning disability health checks and action plans for patients over 14, improve recording of patients with a severe mental illness and delivery of comprehensive physical health checks, record the ethnicity of all PCN registered patients (where provided) and appoint a health inequalities lead for the PCN.
- 9.7.2. PCNs will have met further milestones in December 2021 and February 2022 to identify a population experiencing inequality in health provision and/or outcomes, agree with the commissioner an approach to engagement and tackling the unmet needs of the population, and from 1 March 2022 begin ongoing delivery of its planned intervention. This requirement continues through 2022/23.
- 9.7.3. [Best practice guidance](#) has been published to help inform and support implementation and delivery of these requirements is available [here](#).

## 9.8. Anticipatory Care

9.8.1 There are new requirements around Anticipatory Care for 2022/23. ICSs have lead responsibility for the co-ordination of Anticipatory Care but PCNs will need to contribute to ICS-led conversations on the local development and implementation of Anticipatory Care working with other providers with whom Anticipatory Care will be delivered jointly.

## 9.9. Personalised Care

9.9.1 There are new requirements around Personalised Care for 2022/23. PCNs must work with commissioners to improve their social prescribing programme and their use of shared decision making, and keep the effectiveness of those measures under review. Full details are in the Network Contract DES Specification.

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

### 10.1. Financial entitlements

- 10.1.1. Financial entitlements under the Network Contract DES reflect a blended payment as set out in section 10 of the [Network Contract DES Specification](#).
- 10.1.2. Table 2 provides a summary of the Network Contract DES financial entitlements payable to the PCNs nominated payee. All Network Contract DES payments are inclusive of VAT, where VAT is applicable.

Table 2: Summary of Network Contract DES financial entitlements

Payment details and allocation	Amount	Allocations	Payment timings
Core PCN funding	£1.50 per registered patient <sup>17</sup> per year (equating to £0.125 per patient per month).	CCG core programme allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Clinical Director contribution	£0.736 per registered patient <sup>17</sup> per year (equating to £0.061 per patient per month).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Staff reimbursements	Actual salary plus employer on-costs (NI and pension) to the maximum per WTE <sup>18</sup> amounts <sup>19</sup> as outlined in Network Contract DES Specification. For the London Region PCNs, inner and outer maximum reimbursable	PMC allocations	Monthly in arrears by the last day of the month following the month in which the payment relates and taking into account local payment arrangements. Payment claimable following start of employment.

<sup>17</sup> Based on the patient numbers as at 1 January immediately preceding the financial year. The 1 **January 2022** patient figures are used for the **2022/23** financial year.

<sup>18</sup> WTE is usually 37.5 hours in line with Agenda for Change (AfC) Terms and Conditions, although this may vary for non-AfC posts. Where AfC does not apply, PCNs should calculate the relevant WTE according to the normal full-time hours for that role in the employing organisation with reimbursement being made on a pro-rata basis accordingly.

<sup>19</sup> The annual maximum amounts for 2022/23 as outlined in the Network Contract DES are to be pro-rated on the proportion of the year that an individual is in post.

Payment details and allocation	Amount	Allocations	Payment timings
	rates apply in accordance with the Network Contract DES Specification.		
Extended hours access from 1 April 2022 to 30 September 2022	£0.720 per registered patient <sup>17</sup> (equating to £0.120 per patient per month).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Enhanced Access	The Enhanced Access payment for the period 01 October 2022 to 31 March 2023 is calculated as £3.764 multiplied by the PCN's Adjusted Population <sup>20</sup> (equating to £0.627 per PCN Adjusted Population per month).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements
Care home premium	£120 per bed per year (equating to £10 per bed per month).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Investment and Impact Fund (IIF)	Amount payable dependant on achievement.	PMC allocations	See paragraph 10.1.3 below
Leadership and management payment	£0.699 multiplied by PCN Adjusted Population <sup>20</sup> (equating to £0.058 per adjusted patient per month) where PCN Adjusted Population is based on the ICS primary medical care allocation.	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
PCN Capacity and Access Support Payment	The Capacity and Access Support Payment for the period 1 October 2022 to 31 March 2023 is calculated £0.602 per PCN Adjusted Population as at 1 January 2022 for the six months October 2022 to March 2023, (which equates to £0.100 per PCN Adjusted Population per month over these six months).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.

10.1.3. The details on how the IIF operates and associated payments can be found in Section 10.6 and Annexes C and D of the [Network Contract DES Specification](#) and the separate IIF guidance<sup>21</sup>.

<sup>20</sup> The PCN Adjusted Population as at 1 January 2022.

<sup>21</sup> <https://www.england.nhs.uk/publication/investment-and-impact-fund-2021-22-implementation-guidance/>

10.1.4. Payments due to the PCN nominated payee for Core PCN Funding, Clinical Director, Care Home Premium and Leadership and Management Payment will be payable in 12 equal monthly instalments and paid no later than the last day of the month in which the payments apply. For a Previously Approved PCN with membership changes and a new proposed PCN, these payments will be made no later than the end of the month in which participation of all Core Network Practices of that PCN has been confirmed, taking into account local payment arrangements. Where an ODS Change Instruction Notice needs to be submitted, this must be by the last working day on or before the 14<sup>th</sup> day of any month and where it is submitted after this time, the change and payment will not take effect until the end of the following month.

10.1.5. Extended Hours Access payments will be payable in 6 equal monthly instalments from April to September 2022 and made by the commissioner no later than the last day of the month in which the payments apply and taking into account local payment arrangements.

Enhanced Access payments will be payable in 6 equal monthly instalments from October 2022 to March 2023 and paid no later than the last day of the month in which the payments apply.

PCN Capacity and Access Support Payments will be payable in 6 equal monthly instalments from October 2022 to March 2023 and paid no later than the last day of the month in which the payments apply.

10.1.6. Where the PCN is a Previously Approved PCN and the first payment is paid after April 2022, the first payment (except for Enhanced Access) will be backdated to include payments due from 1 April 2022. Where the PCN is a new proposed PCN after 1 April 2022, the PCN will only be entitled to receive payments for the months for which it delivers the requirements of the Network Contract DES. Refer to section 10.3 for further information on how payment calculations for 2022/23 will be managed.

10.1.7. The Core PCN Funding payment (ie the £1.50 per head payment) and all other Network Contract DES Payments – plus the Network Participation payment – will be payable from the commissioner's Primary Care Medical allocations from 2022.23. .

10.1.8. Additional Role Reimbursement Scheme payments will be made monthly in arrears following the start of employment or commencement of service provision. The nominated payee will be required to submit the relevant monthly claims using the [online claim portal](#). Commissioners will make the relevant payments to the nominated payee no later than the last day of the month following the month to which the payment relates and taking into account local payment arrangements.

## **Network Participation Payment**

- 10.1.9. In addition to the payments made to the PCN's nominated payee under the terms of the Network Contract DES, practices participating in the Network Contract DES will be entitled to the Network Participation Payment (NPP) - as set out in the General Medical Services Statement of Financial Entitlements and Network Contract DES Specification. This payment is £1.761 per weighted patient per year, equating to £0.147 per patient per month. The numbers of weighted patients are based on the Contractor Weighted Population taken as at quarter 4 immediately preceding the financial year (i.e. at 1 January in the preceding financial year). For example, the 2022/23 contractor weighted population figure will be that for quarter 4 in the 2022/23 financial year i.e. at 1 January 2022.
- 10.1.10. The NPP will be paid monthly in arrears on or before the last day of the month following the month in which the payment relates (i.e. payment for April will be made on or before the end of May). Where a practice is a Core Network Practice of a Previously Approved PCN and the first payment is paid after April 2022, the first payment will be backdated to include payments due from 1 April 2022. Where a practice is a Core Network Practice of a new proposed PCN after 1 April 2022, the practice will only be entitled to receive the NPP for the months for which it is actively participating in the Network Contract DES. Refer to section 10.3 below for further information on how payment calculations for 2022/23 will be managed.

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

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

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

- 10.2.1. The following paragraphs in the [Network Contract DES Specification](#) set out the factual points regarding who can hold the Network Contract DES and be the nominated payee:
- a. Paragraph 2.2.10 – “the “**Nominated Payee**” refers to a practice or organisation that receives payment (**on behalf of the PCN**) of the applicable financial entitlement set out in this Network Contract DES Specification.”
  - b. Paragraph 10.1.1 – “A practice participating in the Network Contract DES acknowledges that payments made under the Network Contract DES are dependent on the Core Network Practices of a PCN working together to deliver the requirements of this Network Contract DES.”

- c. Paragraph 10.1.6 – “The commissioner must ensure that payments due to a PCN set out in this Network Contract DES are made into the bank account of the Nominated Payee. The PCN must inform the commissioner of the relevant payment details of its Nominated Payee. The PCN will include in the Network Agreement the details of arrangements with the Nominated Payee and may indicate the basis on which the Nominated Payee receives the payments on behalf of the other practices, e.g. as an agent or trustee.”
- 10.2.2. The nominated payee must be party to the PCN’s Network Agreement. This is because the Network Agreement forms the legal agreement between the constitute members of the PCN. It will set out how the PCN has agreed to use the DES funding to support delivery and how the PCN has agreed the funding will be apportioned between the members within the PCN.
- 10.2.3. Unlike the requirements over who can hold the Network Contract DES, the nominated payee does not have to hold a registered list and be delivering an essential primary medical services contract. The nominated payee must, however, be party to the Network Agreement.
- 10.2.4. An APMS provider (including a provider who holds a hybrid NHS Standard Contract that is delivering primary medical care services under a Schedule 2L arrangement) can therefore be a nominated payee, even if they do not hold the Network Contract DES. As such, it is possible that a GP Federation could be nominated as the payee if all the Core Network Practices of the PCN agree. It also means that the same GP Federation could be nominated to be the payee for more than one PCN.

### 10.3. Network Contract DES Payments

#### Automated payment arrangements through PCSE Online

- 10.3.1. Five PCN payment calculations – the Core PCN Funding, Clinical Director, Leadership and Management, Care Home Bed Premium, Enhanced Access (replacing Extended Hours Access from 1<sup>st</sup> October 2022) are **automated** via the PCSE Online.
- 10.3.2. The NPP will be processed directly by PCSE Online and paid directly to GP Practices from 1<sup>st</sup> November 2022.

PCSE Online will calculate these **six** payments using the PCN ODS reference data towards the end of each month. Commissioners should ensure that any changes to the PCN ODS reference data are submitted using the PCN ODS Change Instruction Notice<sup>22</sup> by the last working day on or before the 14<sup>th</sup> day of each month, so as to ensure the changes take effect prior to the PCSE Online payment calculation date. **These changes will take effect in the subsequent month.** In the event a PCN ODS Change Instruction Notice is completed after the 14<sup>th</sup> day of a month, then changes

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<sup>22</sup> The PCN ODS Change Instruction Notice is available [here](#).



will not take effect until 2 months later (payment reconciliations will be part of the process).

### Additional payment information

10.3.3. A PCN is required to use the national mandatory [online claim portal](#) for all workforce claims. This claim form is to be completed and submitted on a monthly basis in accordance with the instructions from the commissioner. Commissioners are to inform PCNs as soon as possible where claim forms should be returned to. As of 1 April 2021, the portal will be the only way to claim reimbursement under the Additional Roles Reimbursement Scheme.

10.3.4. The Additional Roles Reimbursement Scheme (ARRS) portal will have a direct link to the PCSE payment system. The roll-out plan is phased and will commence from the 3<sup>rd</sup> October 2022. The National Primary Care MDT Workforce team will be working with their regional workforce leads to manage this transition.

PCNs will continue to use the manual contract variation template submitting to PCSE in respect of ARRS with the new pay codes until they have migrated across to the automated process.

### Any nominated payee

10.3.5. Work has been completed to support the introduction of 'any nominated payee'. This allows for a non-GP provider to be a PCN's nominated payee and/or for a separate bank account to be link to the PCN ODS code.

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

10.3.6. Table 3 sets out the relevant subject and finance system codes that commissioners will be required to use to support all payments under the 2022/23 Network Contract DES.

**Table 3: National subjective and finance system codes for Network Contract DES payments**

Payments	Paycode	Paycode description	Subjective Code
Core Funding PCN	NCDSUP	NCD Core Funding	521610ZE
Leadership and management payment	NCDLEP	NCD Leadership Payment	52161418
Clinical Director contribution (population-based payments)	NCDCDR	NCD Clinical Director	521610YE
Care home premium	NCDCHP	NCD Care Home Premium	5216108G

Extended hours access (22/23). This will be replaced by Enhanced Access on 1 <sup>st</sup> October 2022	NCDEHA	NCD Extended Hours Access	521610UN
Enhanced access-2022-23. To commence on 1 <sup>st</sup> October 2022	NCDENA	NCD Enhanced Access	521610B9
IIF Aspiration Payment	NCDASP	NCD IIF aspiration	5216108H
IIF Achievement Payment	NCDACH	NCD IIF achievement	5216108I
PCN Capacity and Access Support Payment	NCDCAS	NCD Capacity and Access Support Payment	52161436

From 1<sup>st</sup> November 2022, Network Participation Payments will continue to be paid to GP practices and not to a PCN.

Payments	Paycode	Paycode description	Subjective Code	APMS/ GMS/ PMS
Network Participation Payment	DESPRA	DES Participation in the PCN	521610XO	A
	DESPRG		521610XW	G
	DESPRP		521610YD	P

#### ARRS/Staff Reimbursement Scheme:

ARRS payments should continue to be paid via the previous method using the current GPP paycodes, with payments made to the lead GP Practice. Once ICBs move across to the automated ARRS solution, they will need to change to using the new ARRS paycodes with payments made direct to the PCN. This will be communicated directly with the ICBs as part of the national roll-out.

Paycodes pre transfer to PCN automated solution (instruction via GPP and paid to lead GP Practice):

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
Staff reimbursements	CPHARA	A	C&M-APMS PCN DES Clin Pharmacist	521610UD
	CPHARG	G	C&M-GMS PCN DES Clin Pharmacist	521610UE
	CPHARP	P	C&M-PMS PCN DES Clin Pharmacist	521610UO
	SPRESA	A	C&M-APMS PCN DES Soc Prescribing	521610VD
	SPRESG	G	C&M-GMS PCN DES Soc Prescribing	521610VE
	SPRESP	P	C&M-PMS PCN DES Soc Prescribing	521610VI
	PHYSIA	A	C&M-APMS PCN DES Physiotherapist	521610VO
	PHYSIG	G	C&M-GMS PCN DES Physiotherapist	521610WD
	PHYSIP	P	C&M-PMS PCN DES Physiotherapist	521610WE
	PASSOA	A	C&M-APMS PCN DES	521610WI

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
			Physician Assoc	
	PASSOG	G	C&M-GMS PCN DES Physician Assoc	521610WO
	PASSOP	P	C&M-PMS PCN DES Physician Assoc	521610XA
	DIETIA	A	C&M-APMS PCN DES Dieticians	5216108A
	DIETIG	G	C&M-GMS PCN DES Dieticians	
	DIETIP	P	C&M-PMS PCN DES Dieticians	
	PHARTA	A	C&M-APMS PCN DES Pharmacy technicians	5216108B
	PHARTG	G	C&M-GMS PCN DES Pharmacy technicians	
	PHARTP	P	C&M-PMS PCN DES Pharmacy technicians	
	PODIAA	A	C&M-APMS PCN DES Podiatrist	5216108C
	PODIAG	G	C&M-GMS PCN DES Podiatrist	
	PODIAP	P	C&M-PMS PCN DES Podiatrist	
	OCCTHA	A	C&M-APMS PCN DES Occupational Therapists	5216108D
	OCCTHG	G	C&M-GMS PCN DES Occupational Therapists	
	OCCTHP	P	C&M-PMS PCN DES Occupational Therapists	
	HWELLA	A	C&M-APMS PCN DES Health and Wellbeing Coach	5216108E
	HWELLG	G	C&M-GMS PCN DES Health and Wellbeing Coach	
	HWELLP	P	C&M-PMS PCN DES Health and Wellbeing Coach	
	CARECA	A	C&M-APMS PCN DES Care Coordinator	5216108F
	CARECG	G	C&M-GMS PCN DES Care Coordinator	
	CARECP	P	C&M-PMS PCN DES Care Coordinator	
	HOMRRA	A	C&M-APMS PCN DES Home/RR paramedic	521610XD
	HOMRRG	G	C&M-GMS PCN DES Home/RR paramedic	521610XE
	HOMRRP	P	C&M-PMS PCN DES Home/RR paramedic	521610XI
	NURSAA	A	C&M-APMS PCN DES Nursing Associate	5216108L
	NURSAG	G	C&M-GMS PCN DES Nursing Associate	
	NURSAP	P	C&M-PMS PCN DES Nursing Associate	
	TNURSA	A	C&M-APMS PCN DES Trainee Nursing Associate	5216108M
	TNURSG	G	C&M-GMS PCN DES Trainee Nursing Associate	
	TNURSP	P	C&M-PMS PCN DES Trainee Nursing Associate	
	CPHAPA	A	C&M-APMS PCN DES Clinical Pharmacist Advanced Practitioner	5216107S
	CPHAPG	G	C&M-GMS PCN DES Clinical Pharmacist Advanced Practitioner	

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
	CPHAPP	P	C&M-PMS PCN DES Clinical Pharmacist Advanced Practitioner	
	PHYAPA	A	C&M-APMS PCN DES Physiotherapist Advanced Practitioner	5216107T
	PHYAPG	G	C&M-GMS PCN DES Physiotherapist Advanced Practitioner	
	PHYAPP	P	C&M-PMS PCN DES Physiotherapist Advanced Practitioner	
	DIEAPA	A	C&M-APMS PCN DES Dietician Advanced Practitioner	5216107U
	DIEAPG	G	C&M-GMS PCN DES Dietician Advanced Practitioner	
	DIEAPP	P	C&M-PMS PCN DES Dietician Advanced Practitioner	
	PODAPA	A	C&M-APMS PCN DES Podiatrist Advanced Practitioner	5216107V
	PODAPG	G	C&M-GMS PCN DES Podiatrist Advanced Practitioner	
	PODAPP	P	C&M-PMS PCN DES Podiatrist Advanced Practitioner	
	OCTAPA	A	C&M-APMS PCN DES Occupational Therapist Advanced Practitioner	5216107W
	OCTAPG	G	C&M-GMS PCN DES Occupational Therapist Advanced Practitioner	
	OCTAPP	P	C&M-PMS PCN DES Occupational Therapist Advanced Practitioner	
	PARAPA	A	C&M-APMS PCN DES Paramedic Advanced Practitioner	5216107X
	PARAPG	G	C&M-GMS PCN DES Paramedic Advanced Practitioner	
	PARAPP	P	C&M-PMS PCN DES Paramedic Advanced Practitioner	
	ADMHPA	A	C&M-APMS PCN DES Adult Mental Health Practitioner	5216107Y
	ADMHPG	G	C&M-GMS PCN DES Adult Mental Health Practitioner	
	ADMHPP	P	C&M-PMS PCN DES Adult Mental Health Practitioner	
	CYPMHA	A	C&M-APMS PCN DES CYP Mental Health Practitioner	5216107Z
	CYPMHG	G	C&M-GMS PCN DES CYP Mental Health Practitioner	
	CYPMHP	P	C&M-PMS PCN DES CYP Mental Health Practitioner	
	DATLEA	A	APMS NCD Digital and Transformation Lead	52161435
	DATLEG	G	GMS NCD Digital and Transformation Lead	
	DATLEP	P	PMS NCD Digital and Transformation Lead	
	GPASSA	A	APMS NCD General Practice Assistant	52161437
	GPASSG	G	GMS NCD General Practice Assistant	
	GPASSP	P	PMS NCD General Practice Assistant	

New ARRS paycodes (to be utilised following migration to the automated payment solution to ARRS and made direct to the PCN):

Payments	Paycode	Paycode description	Subjective Code
Staff reimbursements	NCDPHR	NCD Clinical Pharmacist	521610UD
	NCDSPH	NCD Social Prescribing Link Worker	521610VD
	NCDPHY	NCD Physiotherapist	521610VO
	NCDPAS	NCD Physician Associate	521610WI
	NCDDIT	NCD Dietician	5216108A
	NCDPTC	NCD Pharmacy Technician	5216108B
	NCDPOD	NCD Podiatrist	5216108C
	NCDOTH	NCD Occupational Therapist	5216108D
	NCDHWC	NCD Health and Wellbeing Coach	5216108E
	NCDCCO	NCD Care Coordinator	5216108F
	NCDPAR	NCD Paramedic	521610XD
	NCDNAS	NCD Nursing Associate	5216108L
	NCDTNA	NCD Trainee Nursing Associate	5216108M
	NCDCPA	NCD Clinical Pharmacist Advanced Practitioner	5216107S
	NCDPAP	NCD Physiotherapist Advanced Practitioner	5216107T
	NCDDAP	NCD Dietician Advanced Practitioner	5216107U
	NCDPOA	NCD Podiatrist Advanced Practitioner	5216107V
	NCDOCT	NCD Occupational Therapist Advanced Practitioner	5216107W
	NCDPPR	NCD Paramedic Advanced Practitioner	5216107X
	NCDMHP	NCD Adult Mental Health Practitioner	5216107Y
	NCDCYP	NCD CYP Mental Health Practitioner	5216107Z
	NCDGPA	NCD General Practice Assistant	52161437
NCDDTR	NCD Digital and Transformation Lead	52161435	

## Payment considerations

- 10.3.7. The following sets out a couple of considerations for commissioners and networks with regards to who is nominated the payee and how payments will be processed:
- a. The nominated payee must be party to the Network Agreement (this could mean party to more than one Network Agreement if it is a GP Federation).
  - b. There are VAT considerations for the PCN if the APMS provider (e.g. GP Federation) charges any commission for their services in being the nominated payee. These charges would not be reimbursed by commissioners and would remain a liability for the PCN to manage. Further information on VAT is available in the [Network Contract DES and VAT Information Note](#).

### 3. Frequently Asked Questions

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

NHS England  
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