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Network contract directed enhanced service

Frequently asked questions 2022/23

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1. Introduction

The Network Contract Directed Enhanced Service (DES) was introduced during 2019 and will remain in place until at least 31 March 2024. For 2022/23, the Network Contract DES Directions come into force on 1 April 2022 and the requirements on practices and Primary Care Networks (PCNs), as outlined in the Network Contract DES specification, will apply from that date.

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

2. General FAQs

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

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

a. Network Contract DES Specification: PCN Requirements and Entitlements 2022/23
b. Network Contract DES Guidance for 2022/23 in England
c. Network Contract DES Participation and Notification of Change Form
d. Network Contract DES Additional Roles Reimbursement Scheme Claims Portal
e. Network Contract DES Network Agreement and Schedules
f. Data Sharing and Data Processing Agreements
g. Investment and Impact Fund Guidance 2022/23
h. Framework for Enhanced Health in Care Homes
i. Early Cancer Diagnosis Guidance
j. Structured Medication Reviews and Medicines Optimisation Guidance
k. Cardiovascular Disease (CVD) Prevention and Diagnosis Supplementary Guidance
l. Personalised Care Guidance
m. Anticipatory Care Guidance
n. Workforce planning template 2022/23 will be available here when published.

In addition to the above documents, practices and commissioners should be aware of the cover note published alongside the above documents.

2.2 Once a practice has agreed to participate in the Network Contract DES for 2022/23, can they then later opt out?

After 30 April 2022, a core network practice cannot end its participation in the Network Contract DES except as set out in section 4.9.7 of the Network Contract DES Specification, namely in situations where this is as a result of:

a. expiry or termination of the core network practices primary medical services contract

b. an irreparable breakdown in relationships or an expulsion

c. commissioner consent due to merger or split of a core network practice

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

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

2.3 Can the core network practice membership of a PCN change during the year?

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

- exceptional circumstances within which the PCN's core network practice membership may need to change after 31 May 2022 participation deadline

or

- a newly formed practice joins a PCN.

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

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

A practice participating in the Network Contract DES for 2022/23 will automatically participate in any subsequent year's Network Contract DES and any variation that may take place in-year prior to the 31 March 2023, unless it opts out in accordance with section 4.9 of the Network Contract DES Specification. This means that unless a practice chooses to opt out of the subsequent Network Contract DES or in-year variation during the relevant period, they will be auto-enrolled into the updated Network Contract DES.

2.5 Can PCNs merge at any point during the year?

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

2.6 Where there is a PCN split that leaves one PCN with a population of below 30k, what options are available to commissioners?

Section 6 of the Network Contract DES Specification sets out the requirements in this situation and, where the remaining practices in the PCN do not then meet the minimum PCN criteria set out in section 5 (and a population of 30k would not meet the minimum criteria unless allowed for rurality reasons), then the PCN cannot be confirmed by the commissioner and the Core Network Practices would need to join another PCN(s) to continue to be signed up to the Network Contract DES.. Commissioners should offer support to local discussions about membership changes. PCNs will need to ensure that they are following any relevant arrangements as set out in their Network Agreement.

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

Any decisions about the legal entity or form of a PCN and the potential implications for that form is a matter for the PCN and local commissioners and where appropriate they should seek independent advice on how best to proceed.

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

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

Locums would not provide the oversight and continuity that a clinical director needs to be able to deliver the role requirements of a clinical director, as set out in the Network Contract DES Specification for 2021/22. See section 5.3. of the Network Contract DES Specification for further information.

2.9 Where Clinical Directors are approaching the end of the term set out in the Network Agreement, and wish to remain in position, will this need to go to member practices for re-election?

Section 5.6.4 of the Network Contract DES Guidance sets out the process for appointment of the clinical director and as such it is at the discretion of the PCN, subject to the appointment details set out in Schedule 1 of the Network Agreement, whether they would choose to rotate that position or leave it with the incumbent.

2.10 How should specialist services, such as those for homeless populations and those providing special allocation schemes, link to PCNs?

We would want patients who receive such services to be able to access the services that PCN's are required to provide including the new workforce arrangements. We recognise that some pragmatism at local levels may be required to enable this to take place.

3. Additional Roles Reimbursement Scheme (ARRS)

3.1 General

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

WTE is usually 37.5 hours in line with Agenda for Change (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.

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

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

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

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

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

3.1.4 Can PCN staff employed via the Additional Roles Reimbursement Scheme (ARRS) continue to support the COVID-19 vaccination programme between October 2022 and April 2023 (phase 5)?

Yes, PCN staff employed via the ARRS may continue to support the COVID-19 vaccination programme between October 2022 and April 2023 and remain eligible for reimbursement. However, this is only on the basis that they are doing so alongside their ARRS role and continue to deliver the requirements for their role as set out in Annex B of the Network Contract DES. For the avoidance of doubt, this means that any ARRS staff may not be fully or wholly deployed to work within a COVID-19 vaccination clinic and remain eligible for reimbursement.

3.1.5 Has an uplift been applied to the ARRS?

From 1 April 2022 – 30 September 2022, the maximum reimbursement rates for each role under the ARRS of the Network Contract DES remained the same as for

the period October 2021- March 2022. They were then uplifted from 1 October 2022 to match the agreed uplift to Agenda for Change (AfC) payscales.

This change does not affect the overall value of a PCN's ARRS sum. The ARRS rates are based on a weighted average of the Agenda for Change pay scale. While the Network Contract DES sets out the overarching rules for reimbursement, a PCN will need to determine what the actual salaries are for their additional roles. The overall value of the ARRS in 2022/23 is in excess of £1billion.

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

Not while 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 while working across multiple providers within the PCN. Once the clinical pharmacist has completed that training pathway or equivalent, the 0.5 WTE minimum no longer applies.

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

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

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

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

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

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

A consistent approach to the clinical pharmacist(s) working with the PCN through a service agreement would be expected, with clinical pharmacist(s) working with the PCN's existing MDT to ensure they can consistently support and complement the existing workforce. For example, service provision by a different individual every shift would not fulfil the requirements listed above. The Network Contract DES requires clinical pharmacists employed or engaged through the Additional Roles Reimbursement Scheme to be for a minimum of 0.5 WTE whilst enrolled on an approved 18 month training pathway or equivalent.

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

The commissioner and PCN must therefore be assured that 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.

3.1.9 Can staff be self employed and still be claimed for via the ARRS?

As set out in Section 5.6 of the Network Contract DES Specification, PCNs are able to either engage or employ roles to deliver PCN services as part of the Additional Roles Reimbursement Scheme (ARRS). Therefore, the PCN would be allowed to engage any appropriate role on a self-employed basis via a provision of service agreement, subject to any applicable off-payroll working rules. To ensure long-term stability for the PCN and its patients, Section 7.4 of the same document

specifies that all ARRS roles must be recruited for a minimum of six months, unless the purpose is to provide temporary cover (e.g. sickness or parental leave). This applies whether the roles are directly employed or engaged via a service contract from a third party. In order to be eligible for reimbursement under the Network Contract DES, the PCN must submit the claim for the role though the Additional Roles Reimbursement Scheme claim form, and record it on NWRS. Claims are only eligible for reimbursement through the ARRS if the individual is able to meet the requirements set out in the appropriate role outline of the Network Contract DES Specification and meet all appropriate training and qualification criteria.

3.1.10 Can PCNs employ staff as apprentices to one of the identified roles and claim for these roles under the Additional Roles Reimbursement Scheme?

Apprenticeships aren't included for any roles under the Additional Roles Reimbursement Scheme and these would need to be funded wholly by the practice/PCN should you wish to employ such a role. Only those roles set out in the Network Contract DES Specification are eligible for reimbursement under the Additional Roles Reimbursement Scheme. Apprenticeships aren't included for any roles under the Additional Roles Reimbursement Scheme and these would need to be funded wholly by the practice/PCN should you wish to employ such a role.

3.1.11 Can PCNs employ staff using zero hours contracts and claim for these via the Additional Roles Reimbursement Scheme?

For any staff employed or engaged via the Additional Roles Reimbursement Scheme, the PCN must ensure that all aspects of the role outline (Annex B-Minimum Role Requirements) are delivered. Moreover, a consistent approach to the role working with the PCN would be expected, with that person working with the PCN's existing MDT to ensure they can consistently support and complement the existing workforce. 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", which on the face of it a "zero hours" arrangement would fall under, would not be eligible for reimbursement.

The commissioner and PCN must therefore be assured that the requirements of the Network Contract DES are being met in full for a role to be eligible for reimbursement.

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

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

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

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

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

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

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

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

Any hours worked on any other duties not related to their PCN role, including those related to their partnership duties, are not eligible for reimbursement and must be

covered/paid out with of the DES arrangement. As such, the claim for reimbursement through ARRS will need to be pro-rata to the relevant WTE hours the individual spends working in their PCN role and delivering the requirements outlined in the DES.

3.2 Baseline and additionality

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

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

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

No. This is the only exception and commissioners will not be required to continue to fund clinical pharmacist or pharmacy technician posts on the national schemes that have transferred to PCNs.

3.2.3 How will changes to PCN core network practice membership be taken into account in relation to the PCN baseline?

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

3.3 Reimbursement claims

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

PCNs will need to claim on a monthly basis for all staff recruited or engaged via ARRS using the national online claim portal.

3.3.2 Is the reimbursement, once claimed, guaranteed?

Once claimed, PCNs will be entitled to continue to receive reimbursement on an ongoing basis as part of their Additional Roles Reimbursement Sum so long as they continue to meet the requirements set out as part of the Network Contract DES, which will exist until at least 31 March 2024.

As set out in Investment and Evolution: Update to the GP contract agreement 2020/21 – 2023/24, staff employed or engaged through ARRS will be considered as part of the core general practice cost base beyond 2023/24.

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

There is no automatic right within ARRS for additional funding to cover sickness and parental leave. However, the PCN would continue to be reimbursed during parental and sick leave, in line with the relevant employment contract provisions (ie as salary is reduced as appropriate then the level of reimbursement also would be reduced), as they have employment costs associated with this absence and it is then up to the PCN as to whether they employ temporary cover or not.

This may be an additional expense on top of the employer's responsibility to pay for parental and sickness absence, but the PCN would only be able to claim for the WTE that was 'absent'.

As set out in the section 7.4.1 of the Network Contract DES Specification and section 7.5 of the Network Contract DES Guidance, if a PCN has available funding within their Additional Roles Reimbursement Sum, they may claim reimbursement for a temporary contract (including funding below six months if necessary) if this is to enable provision of cover for sickness or parental leave.

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

For clinical pharmacists, it is not possible to offer temporary staff access to the NHS England commissioned training pathway or independent prescribing training. As

such, PCNs will need to ensure the clinical pharmacist providing the cover has completed the required training.

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

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

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

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

The maximum reimbursement amount is to apply on a pro-rata basis on the proportion of the year that an individual is in post ie the annual figure would equate to a monthly maximum reimbursement amount for 1 WTE (37.5 hours under the DES).

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

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

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

When a vacancy occurs within one of the reimbursable roles in the PCN baseline, this has eligibility implications for claims being made under ARRS, regardless of who (eg which core network practice) employs the vacant post within the PCN baseline.

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

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

3.3.8 Can the PCN claim reimbursement for a proportion of a 1 WTE for the reimbursable roles to allow the individuals to work across multiple settings eg the PCN and a CCG?

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

With regards to clinical pharmacists, a minimum of 0.5 WTE applies to clinical pharmacists employed or engaged via the Network Contract DES whilst enrolled on an approved 18 month training pathway or equivalent so as to ensure the clinical pharmacist is able to access timely national training and can deliver continuity of care while working across multiple providers within the PCN.

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

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

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

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

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

4. Financial entitlements and payment arrangements

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

Section 10 of the Network Contract DES Specification and section 10 of the Network Contract DES Guidance provide details of financial entitlements and payment arrangements in 2022/23.

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

The PCN's core network practices must all agree who the nominated payee is, and commissioners must ensure the nominated payee information is included in the PCN ODS data.

4.3 Can a GP Federation be a PCN's nominated payee?

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

- The GP Federation will need to be party to the Network Agreement and the Network Agreement will need to clearly set out the agreement on the financial arrangements.
- In 2022/23 payments will not be able to be made via PCSE Online, if the nominated payee is not setup in this system (this is most likely the case for any GP Federation). GP Federations, who are the nominated payee, will

need to invoice for payment using the Tradeshift process (see section 10.3 of the Network Contract DES Guidance).

- In the event a GP Federation charges a commission to the PCN, there may be VAT considerations and these charges will not be reimbursed by the commissioner.

Commissioners should be mindful that:

- Payments must be made to the single nominated payee
- In 2022/23, commissioners will be required to make payments to the non-GP providers using local payment arrangements.
- Commissioners will be required to use the relevant national subjective and other finance system codes and provide any information as required to support national reporting of primary medical services expenditure.
- Commissioners will need to ensure relevant financial reporting information is provided to NHS England to monitor spend against the Network Contract DES – specifically where payments are not being made via NHAIS or PCSE Online.

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

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

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

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

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

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

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

The Network Participation Payment will be automated via CQRS - see question **Error! Reference source not found.**. In the event a practice no longer participates in the Network Contract DES, then the payments would need to be stopped.

4.8 Do PCNs have to use the national Additional Roles Reimbursement Scheme Portal Claim Form?

Yes, PCNs are required to use the mandatory online claim portal to submit reimbursement claims under ARRS.

4.9 What level of verification is required for ARRS claims?

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

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

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

5. Network Contract DES service requirements

5.1 Enhanced Health in Care Homes

5.1.1 What is a care home under the Network Contract DES, and which homes are in and out of the scope of the service?

For the EHCH requirements, a 'care home' is defined as a Care Quality Commission (CQC) registered care home service, with or without nursing. Whether each home is included in the scope of the service will be determined by its registration with CQC, which can be found in the CQC's 'care home directory with filters', which is updated monthly here. All CQC-registered care homes with or without nursing are in the scope of the service.

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

For the purposes of the EHCH service requirements in the Network Contract DES specification, a 'care home' is defined as a CQC-registered care home service, with or without nursing. Whether each home is included in the scope of the service will be determined by its registration with CQC. All care homes in this directory are in the scope of the EHCH service, although a PCN and commissioner may agree that certain 'care home' registered beds are outside of the scope of the EHCH service – for example a registers.

The EHCH service requirements apply equally to people who self-fund their care and to people whose care is funded by the NHS or their local authority. It is equally applicable to care homes for people with learning disabilities and/or mental health needs and should not be interpreted as only pertaining to care homes for older people. However, secure mental health units are not in scope. This scope also applies to the payment of the care homes premium.

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

Under the EHCH service in the DES, each care home should be aligned to a single PCN, with residents supported to re-register with practices in that PCN. Patients may choose not to re-register. In supporting patients to re-register with a practice in the aligned PCN, care homes, PCNs and commissioners must clearly communicate the benefits offered under the EHCH service, and ensure that the patient understands that they will not receive the service if they choose not to re-register.

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

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

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

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

5.1.5 What is the care home premium?

The care home premium describes a payment that PCNs are entitled to, to support delivery of the EHCH service to patients in care homes. PCNs will be paid £120 per bed per year on a recurrent basis for beds within care homes that they are aligned to.

Funding for the care home premium is included in CCG primary medical care allocations. The funding level has been based on CQC data on registered care home beds in England and will be payable to PCNs in accordance with section 10.4 of the Network Contract DES Specification once commissioners have agreed:

a. the alignment of care homes to PCNs

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

5.2 Structured medication reviews (SMRs)

5.2.1 Who can undertake SMRs?

SMRs can be undertaken by appropriately trained clinicians. PCNs must ensure that only appropriately trained clinicians working within their sphere of competence

should undertake SMRs. These professionals will need to have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop these skills and should be able to take a holistic view of a patient's medication.

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

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

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

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

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

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

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

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

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

SMRs should be offered to all patients identified and prioritised within the groups listed in the DES service requirements, using appropriate tools. However, the service requirements also state that the actual number of SMRs offered by a PCN will be determined and limited by its clinical pharmacist capacity, as long as that PCN demonstrates all reasonable on-going efforts to maximise that capacity.

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

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

5.2.6 How long should each SMR take, along with preparation time?

We advise that SMRs are complex interventions that will naturally take longer than traditional medication reviews depending on the complexity of the patient and should vary in line with the needs of the individual. PCNs should allow for flexibility in appointment length for SMRs.

5.3 Cardiovascular Disease (CVD)

5.3.1 In the guidance for Familial Hypercholesterolaemia, what is meant by “referrals for further assessment”? Does the referral need to be to secondary care? What constitutes a referral for assessment can vary by area and by the lipid management pathways and services in place within the system.

Over time it is intended that there will be direct access to genetic testing for primary care. PCNs should consider whether referral to a lipid service may be needed, regardless of FH diagnosis, in patients with the a significantly abnormal lipid profile

(as indicated in the summary of national guidance for primary and secondary prevention of CVD). In the short term, most referrals for suspected FH are likely to be to lipid specialist services.

5.3.2 Do the people measuring blood pressure need to be clinically trained?

In a clinical or pharmacy setting, blood pressure measurement can be undertaken by anyone who has been suitably trained to do so. This may include non-clinical staff. If hypertension is suspected, further assessment by ambulatory or home blood pressure monitoring (HBPM or ABPM) should be arranged by a member of a practice nursing team, or by a community pharmacist. On review of the data, a diagnosis of hypertension would be confirmed by a GP or another appropriate health care professional.

5.3.3 Why does the DES say that statins should be considered for people with a QRISK score of 10% of higher, but the IIF says 20%?

The IIF incentivises providing support for the top layer of risk. However, it is still intended that people with a QRISK score of 10% and above should be reviewed in line with the summary of national guidance for primary and secondary prevention of CVD.

5.4 Early Cancer Diagnosis

5.4.1 Where can further information be found to support delivery of the early cancer diagnosis specification?

The Network Contract Directed Enhanced Service Early Cancer Diagnosis Support Pack sets out best practice guidance and resources to help inform and support implementation and delivery of the Network Contract DES requirements for Supporting Early Cancer Diagnosis.

5.4.2 Where can additional information be found to support delivery of service requirement 3: Work with its Core Network Practices to adopt and embed the requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer.

The Network Contract Directed Enhanced Service Early Cancer Diagnosis Support Pack sets out best practice guidance and resources to help inform and support

implementation and delivery of the Network Contract DES requirements for Supporting Early Cancer Diagnosis.

These details have been published alongside the Investment and Impact Fund Indicator:

· Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the seven days leading up to the referral, or in the fourteen days after the referral

This information can be found here.

5.4.3 Where can further information be found to support delivery of service requirement 4: focusing on prostate cancer, and informed by data provided by the local Cancer Alliance, develop and implement a plan to increase the proactive and opportunistic assessment of patients for a potential cancer diagnosis in population cohorts where referral rates have not recovered to their pre-pandemic baseline?

The Network Contract Directed Enhanced Service Early Cancer Diagnosis Support Pack sets out best practice guidance and resources to help inform and support implementation and delivery of the Network Contract DES requirements for Supporting Early Cancer Diagnosis.

Additional resources are also available to support delivery of service requirement 4. These resources are:

Clinical resources · Symptomatic guidance: NG12 · Asymptomatic guidance: Prostate Cancer Risk Management Programme · Gateway C Modules: Symptomatic and Metastatic Prostate Cancer · Best practice timed pathway: Prostate · Prostate Cancer UK's Consensus Statements on PSA testing · Prostate Cancer UK: Online learning

Patient resources · Prostate Cancer UK: Risk Checker · PSA testing and prostate cancer: advice for well men aged 50 and over · Information sheet for patients being referred with suspected prostate cancer

Patient information for your practice (accessible online and to order) · Know your prostate: A quick guide · 'The PSA test and prostate cancer: A quick guide' ·

‘Understanding the PSA test: A guide for men concerned about prostate cancer · Prostate cancer and other prostate problems: Information for black men · Display box: Prostate cancer: Information for black men

5.5 Personalised Care

5.5.1 Why was the Shared Decision Making (SDM) training requirement removed?

The training requirement was removed to assist with primary care network clinical staff capacity.

5.5.2 What does this mean for clinical staff?

Clinical staff no longer need to complete this training and there are no plans for it to form part of the specification for 2023/24. However, as these training courses can contribute to improvement plans for SDM practice and could be a helpful action to take where quality audits of patient experience of SDM indicate room for improvement, they are recommended resources for PCN clinical staff to complete. The SDM e-learning training provided by the PCI has consistently scored highly in terms of feedback.

5.5.3 Does removal of the mandatory SDM training have an impact on the requirement elsewhere for Health Education England (HEE) roadmaps and PCI modules?

No this does not have an impact. The requirement for HEE roadmaps remains part of credentials for Advanced Clinical Practitioners (ACP) working in primary care and is a separate policy requirement of the Network Contract DES[1].

6. Investment and Impact Fund (IIF)

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

The PCN Dashboard hosts a dedicated IIF page where indicative PCN performance against the IIF indicators can be viewed and it will be updated on a monthly basis.

[1] See Network Contract DES, B15.2 Multi-professional framework for advanced clinical practice in England

The data collection to inform these indicators relies on the relevant coding in GP IT systems.

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

The PCN Dashboard can now be accessed directly through NHS Applications, or by clicking here. Log in details for previous users of the PCN Dashboard or NHS Applications will remain the same. New users of the PCN Dashboard will need to register for an NHS Applications account here. Data on the dashboard is currently refreshed monthly. For new indicators introduced for 2022/23, these will not be available on the dashboard until summer 2022.

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

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

If a PCN believes that the underlying data for the PCN (or for one or more core network practices within the PCN) is incorrect in relation to an IIF indicator based on a data extract from GP systems, they should decline to declare their achievement and raise the discrepancy with their commissioner. The commissioner is able, at its sole discretion, to make manual adjustments to data if the PCN can explain to them why it is wrong.

Before doing this, PCNs should run a search on the core network practices' clinical systems to confirm their interpretation. The PCN should also check the business rules for the Network Contract DES service or GPES extract, which system suppliers use to construct GPES extract indicators.

The business rules state the 'code clusters' or 'reference sets' (collections of SNOMED codes) that are used to calculate IIF (and other Network Contract DES) indicators – they do not state the contents of these reference sets ie the actual SNOMED codes. The SNOMED codes contained within each reference set can be found in an accompanying spreadsheet that is published with the business rules.

If a PCN believes that its IIF indicator values for an indicator drawn from data sources other than GP systems is incorrect, they are advised to pursue the matter

via existing channels relating to those data sources. Further information about these channels is provided in IIF Guidance.

6.4 For some PCNs that have a specialised population (for example homeless, asylum seekers, special allocation schemes) it may be difficult to achieve the full target due to exceptions. Would there be an option for exceptional reporting for specialist populations?

The specific acceptable personalised care allowances (PCAs) are shown for each indicator in the IIF guidance. These don't cover specific populations and are for general use. There is no scope to remove patients other than via the exclusions or PCAs shown in the guidance.

6.5 What would happen if a PCN chooses not to declare their IIF achievement and wish to challenge the data on CQRS?

If a PCN disputes its achievement calculation, then it is for the PCN and commissioner to have dialogue to resolve the matter. The commissioner has the power to change the PCN's data (for GPES-derived indicators) if the PCN can provide supporting evidence. Once the PCN and commissioner reach agreement, the PCN will still be paid – though not by the 31 August payment deadline.

6.6 Are commissioners expected to carry out a post payment verification (PPV) process in relation to the IIF payments?

It is for commissioner to determine whether to conduct any investigative activities to ensure that the practice has achieved the points that it claims to have achieved – the Network Contract DES establishes that commissioners are entitled to undertake any such activities as they may deem necessary, but it does not mandate that they must occur. If it is about verifying that any earnings have been reinvested, commissioners should not take an onerous approach on this issue.

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

The PCN must provide a simple written commitment to their commissioner that any money earned through the IIF will be reinvested into additional workforce, additional primary medical services, and/or other areas of investment in a core network practice that support patient care (e.g. equipment or premises). The written

commitment does not have to detail the precise areas of spend, this is for PCNs to determine.

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

The following SNOMED code should be used:

- 871731000000106 | Referral to social prescribing service (procedure)

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

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

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

7. Enhanced Access

7.1 What are PCNs required to do from April 2022 to prepare for introducing enhanced access?

From 1st October 2022, PCNs will be required to provide Enhanced Access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays (which are referred to in the Network Contract DES Specification as “Network Standard Hours”).

From 1 April 2022, in preparation for delivery of the service, a PCN - working collaboratively with the commissioner - must produce an Enhanced Access Plan. The draft Enhanced Access Plan must be submitted to the commissioner for agreement on or before 31 July 2022, by the method the commissioner has indicated. The draft Enhanced Access Plan must set out how the PCN is planning to deliver Enhanced Access from October 2022.

Section 8.1.15 of the Network Contract DES Specification sets out the preparatory requirements.

From 01 April 2022 until 01 October 2022, PCNs will be required to deliver the extended hours access requirements, at which point this service will be replaced by the enhanced access service.

7.2 What are the differences between extended hours access and enhanced access and are PCNs required to provide extended hours as set out in the Network Contract DES in addition to the requirements of enhanced access?

The two services are separate and distinct with differing requirements and funding arrangements. From April 2022 until September 2022, PCNs will still need to deliver the extended hours commitments as set out from section 8.1.1 to 8.1.14 of the Network Contract DES Specification. The new enhanced access arrangements as set out from section 8.1.15 of the Network Contract DES Specification will come into force from 1st October but with preparatory work required from April to September.

7.3 Are PCNs able to utilise staff employed via ARRS in enhanced access services?

Yes, staff currently employed or engaged by PCNs and reimbursed through the ARRS may be utilised in the enhanced access period, as long as they are continuing to deliver all the requirements of the relevant role outline set out in the Network Contract DES Specification and are working as part of a multidisciplinary team to deliver that care across in hours and enhanced access.

7.4 Can you advise what will happen to GP Federations who may no longer hold an eligible contract to be a nominated payee for their PCN when the changes to enhanced access come into force?

The arrangements under the Network Contract DES continue to require that the nominated payee must hold a primary medical services contract. We are aware of the situation for GP Federation nominated payees and are working towards being able to continue this through any nominated payee arrangements.

7.5 Does this mean every practice has to be open evening and weekends?

The changes do not mean that every practice has to extend its opening hours. The service is at a PCN level and the approach to the time requirement is the same as it is now for the current Extended Hours access service under the DES and the CCG-commissioned Extended Access services combined, so there is already a workforce delivering this service. Where local EA services commissioned by CCGs are working well, PCNs can choose to sub-contract delivery of the EA requirements with the agreement of the commissioner.

Sundays are not a mandatory part of the new DES EA offer (they are currently part of the extended access service commissioned by CCGs). If there is patient demand for Sunday services, then following consultation there may be some offer on a Sunday in keeping with patient preference.

7.6 Do PCNs have to offer the full range of routine services?

It is up to the PCN to decide the mix of services which will be available during Enhanced Access, and how the workforce – including ARRS workforce – will be used to make full use of the MDT. This will form part of the PCN's Enhanced Access Plan, which should be informed by patient engagement to understand local need and will need to be agreed with the commissioner. The plan will also need to cover which premises will be used to deliver Enhanced Access.

7.7 Is the £6 per head being moved into the PCN DES, i.e. does that mean that PCNs will be paid £6 plus £1.44, making the new offer for enhanced access £7.44 per head?

The funding streams are being brought together to be paid to PCNs under the Network Contract DES, and the 2022/23 Network Contract DES Specification confirms how funding will be allocated. The updated Specification is available here, along with the 2022/23 ready reckoner, for PCNs to use to understand their funding.

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