NHS England

Draft Network Contract DES 2025/26

Part B Guidance: Non-clinical

1 April 2025

Publication reference: PRN01903

Contents

1. Introduction

1.1. The Network Contract Directed Enhanced Service (DES) was introduced during 2019. For 2025/26, the Network Contract DES Directions comes into force on 1 April 2025 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. NHS England has announced a number of changes to the Network Contract DES for 2025/26, as set out in Changes to the GP Contract in 2025/26. The Network Contract DES and this guidance reflect those changes.

1.3. This 'Part B guidance' provides supporting information for commissioners and practices on non-clinical DES delivery requirements. There is also 'Part A guidance' which outlines good practice for delivery of the clinical service requirements and can be found here.

1.4. This guidance does not take precedence over the Network Contract DES Specification.

1.5. This part B guidance uses defined terms indicated by an initial capital letter. The definitions of these terms are as set out in the Network Contract DES unless a definition is expressly stated within this guidance.

2. Participation in the Network Contract DES

2.1 Participation process

2.1.1. From 1 April 2025 onwards, all Core Network Practices of Previously Approved PCNs will automatically participate in the 2025/26 and any 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 Contact DES Variation. For the 2025/26 Network Contract DES, this opt-out and opt-in window will apply until 30 April 2025 and allows for:

a. Core Network Practices to opt-out of the 2025/26 Network Contract DES following automatic participation; or

b. Non-participating practices wishing to participate to opt-in to the 2025/26

c. 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 2025/26 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 2025 or in the case of a Network Contract DES Variation, by the 30th 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 of 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. Ensure each PCN Network Area supports 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, which 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)[1].

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 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[2] are provided to patients of the non-DES practice in accordance with the timescales for these services/activities:

a. the service requirements as listed at sections 8.1-8.5 of the Network Contract DES Specification; and

b. the Enhanced Access requirements as listed at section 8.6 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;

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.

[1] Where the PCN has formed as a legal entity, the local agreement could be made directly with the PCN.
[2] The list outlines the 2025/26 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.

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 NHS England.

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 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 / arrangements will need to account for amendment of list sizes in all systems and will not be supported by either the General Practice Extraction Service (GPES) or the Calculating Quality Reporting Service (CQRS). Commissioners will be required to manage these out-with of these systems.

4.2.2. 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.

4.2.3. 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.

4.2.4. 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.

4.2.5. 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[3]. 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.

[3] 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.

5.1.2. 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 commissioner 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 ICSs.

5.1.3. From a contractual perspective, a primary medical services provider who holds:

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 services contracts will be able to have each of those contracts varied to include the Network Contract DES and each practice will be a Core Network Practice of the relevant PCN(s).

5.1.4. A practice not participating in the Network Contract DES could be a PCN member (like any other non-practice provider, i.e. not a Core Network Practice) and therefore be party to a PCN's Network Agreement.

5.1.5. A practice may be a member of more than one PCN, for example where a practice provides services from a branch surgery and sub-contracts the delivery of PCN services and/or activities for that branch surgery to a different PCN, or where a practice is the nominated payee for two PCNs. In these examples, the practice would be a Core Network Practice of one PCN and a PCN member (i.e. non-Core Network Practice) of another PCN. Similarly, within the PCN ODS reference data, GPES and CQRS, practices will only be a Core Network Practice of one PCN.

5.1.6. A practice with one or more branch surgeries in different PCNs acknowledges that its list of patients will be associated with the PCN of which the practice is a Core

Network Practice. For PCNs/practices intending to have a different PCN provide PCN services/ activities to a branch surgery, see section 6 for information about sub-contracting arrangements.

5.2 PCN 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 2025/26 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[4]. If the instruction for the new PCN is given to ODS (via the PCN ODS Change Instruction Notice) prior to the last working day on or before the 14th of the month, then the PCN change will take effect in the next month's statement. If the instruction is not provided prior to the last working day on or before the 14th of the month, then the PCN must wait until the month after the next to be included in the statements (in the case of late notification, it will be down to commissioners to make a decision on how payments are made for the part month and proceeding month where relevant). The new PCN changes submitted to ODS will be reflected in systems in accordance with these timelines. 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 two months later. The relevant

[4] The PCN ODS Change Instruction Notice is available here.

systems will be updated with the instructed changes via automated notification processes. If the PCN has its own bank account to receive payment, please state the PCN 'U' code and name below. If a practice/provider receives payment on behalf of the PCN, please state their ODS code and name below.

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

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

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

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 Working with local providers

5.5.1. A PCN must work with other PCNs, local community services providers, mental health providers, community pharmacy providers and other relevant health and social care delivery partners in the best interests of patient care. This includes developing and fostering strong relationships with leaders and commissioners to successfully manage the health and care needs of the populations they serve.

5.5.2. 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 needs of the PCN's patients. 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) 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. In 2025/26 it has been updated to focus on co-ordination of service delivery, effective allocation of resources, supporting transformation towards Modern General Practice and supporting the PCN's role in the development of Integrated Neighbourhood Teams.

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).

5.6.5. The PCN must ensure that any changes to the Clinical Director are recorded in the PCN module of the National Workforce Reporting Service (NWRS).

Managing Conflicts of interest

5.6.6. 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 Agreement and Data Processing Agreement non-mandatory templates have been updated for 2025/26 to reflect updated legislative references and requirements and 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.

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[5]

[5] NHS England's template subcontract for the provision of services related to the Network Contract DES

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[6], 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.

[6] The NHS (GMS Contracts and PMS Agreements) (Amendment) (No2) Regulations 2020:

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 October 2025 a workforce plan, providing details of any updated recruitment plans for 2025/26. 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 November 2025.

7.1.3. PCNs working with their commissioners are encouraged to have ongoing dialogue in relation to workforce strategies, to ensure these are consistent with broader ICS workforce strategies.

7.1.4. PCNs must record, on a monthly basis, within the PCN Module of the National Workforce Reporting Service (NWRS) information on any staff employed or engaged through the Additional Roles Reimbursement Scheme.

7.1.5. PCNs are required to record and submit any data required by NHS England for the purposes of the NHS England Workforce Collection (known as the "Workforce Minimum Dataset"). This includes ARRS roles agreed with the ICB in line with the provisions in section 7.3 of the Network Contract DES Specification.

7.1.6. The data needs to be appropriately coded, reviewed and updated in line with agreed standards set out in guidance[7] published by NHS England, and made available for collection at least monthly, using the data entry module on the National Workforce Reporting Service (NWRS).

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 co-ordinate and run 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] https://digital.nhs.uk/data-and-information/areas-of-interest/workforce/national-workforce-reporting-service-nwrs/guidance

7.2 Additional Roles Reimbursement Sum

7.2.1. Each PCN will be notified of Additional Roles Reimbursement maximum entitlement 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 the 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[8] as at 1 January of the financial year preceding and be calculated as follows:

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

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[9] is available to support PCNs to calculate their indicative Additional Roles Reimbursement Sum based on their PCN Contractor Weighted Population. Table 1 set out the indicative Additional Roles Reimbursement Sum allocations for different PCN sizes in 2025/26 for the ARRS scheme.

7.3.2. For 2025/26 the Additional Roles Reimbursement Sum will be calculated using £26.631 multiplied by the PCN Contractor Weighted Population as at 1 January 2025, calculated using the formula in section 7.2 and the January 2025 national population of 62,923,806.

Table 1: Indicative Additional Roles Reimbursement Scheme Sum per PCN Contractor Weighted Population for 2025/26

[8] 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.

[9] https://www.england.nhs.uk/publication/general-medical-services-gms-and-primary-care-network-pcn-income-ready-reckoner-from-1-april-2024/

	2025/26
Total National Workforce funding	£1,697,045,000
PCN Contractor Weighted Population	
15,000	£399,500
20,000	£532,600
25,000	£665,800
30,000	£798,900
40,000	£1,065,200
50,000	£1,331,600
80,000	£2,130,500
100,000	£2,663,100
150,000	£3,994,700

7.4 Principle of additionality and baselines

7.4.1. 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.

7.4.2. 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 2026

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[10] 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.

These baselines will be monitored at a national level.

7.4.3. 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 ICB Accountable Officer should agree and sign a new declaration confirming that the revised baseline reflects a true position. The changes to the baseline should be reflected, where appropriate, in the next quarterly NWRS and commissioner six-monthly returns.

7.4.4. The PCN and ICB baselines are fixed until the end of 2025/26. PCN reimbursement claims under the Additional Roles Reimbursement Scheme will be assessed against the PCN baseline only.

7.4.5. 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 roles covered by the baseline. 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.

7.4.6. 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

[10] The six reimbursable roles funded include those directly employed by the CCG.

employing organisation with reimbursement being made on a pro-rata basis accordingly.

7.4.7. A PCN baseline will not be established for general medical practitioners, health and wellbeing coaches, care coordinators, dietitians, podiatrists, occupational therapists, nursing associates, student nursing associates (previously trainee nursing associates), mental health practitioners (MHPs), advanced practitioners (including advanced practitioner nurses), general practice assistants, digital and transformation leads, apprentice physician associates, enhanced practice nurses, new to general practice nurses, experienced general practice nurses, consultant nurses primary care, healthcare support workers or other direct patient care staff (excluding those set out in paragraph 7.4.2). 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.

7.4.8. 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:

a. 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

b. Improving Access to Psychological Therapies (IAPT) / Talking Therapies Practitioners 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.

7.4.9. As set out in section 7.5.1 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 7.5.2 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.

7.4.10. Baseline posts occupied by fixed term appointed staff can be considered to be 'filled' only if they are part of a long-term arrangement, which must be in place for a minimum of six months or more. Equally, PCNs will only be eligible to claim reimbursement for additional posts to be occupied by staff on fixed-term contracts, if these are for a minimum period of six months or more, unless the purpose is to provide temporary cover (e.g. sickness or parental leave) for an individual employed through the Additional Roles Reimbursement Scheme or they are a General Medical Practitioner employed or engaged in a permanent role for less than six months. 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.

7.4.11. The Additional Roles Reimbursement Scheme cannot distinguish between staff with different job descriptions e.g. a MSK physiotherapist is the same as a non-MSK physiotherapist for the purposes of the baseline and additionality, so long as both roles have an element of patient-facing or first contact care time in specific practices or in the wider neighbourhood or community.

7.4.12. The Additional Role Reimbursement Scheme does not apply to General Medical Practitioners who were previously substantively employed as a General Medical Practitioner in general practice. This is in order to ensure that practices will not be able to move existing general medical practitioners (funded from practice contract funding) into the Additional Role Reimbursement Scheme, upholding the principles of additionality. Commissioners will have local discretion to determine if a General Medical Practitioner has or has not been substantively employed in general practice previously, depending on the specific circumstances, e.g. short-term cover provided by a General Medical Practitioner in a practice previously would not count as substantive employment.

7.4.13. The Additional Roles Reimbursement Scheme does not apply to General Medical Practitioners who are beyond the second anniversary of their certificate of completion of training, issued by the General Medical Council, at the start of their employment or engagement. Once employed or engaged, General Medical Practitioners can continue to be reimbursed past the second anniversary of their certificate of completion of training.

7.4.14. The Additional Roles Reimbursement Scheme does not apply to either new to general practice nurses or experienced general practice nurses who have held a post in the PCN or any practice within the PCN, within the past 12 months, unless the nurse is being recruited to a specialist or more senior nursing role.

Changes to PCN baselines and staffing levels

7.4.15. 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.

7.4.16. 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.

7.4.17. 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.

7.5 Transfer of clinical pharmacists and pharmacy technicians

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

7.5.1. 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

7.5.2. 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 was made 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.

7.5.3. 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. 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:

iv. ordering and storage of medicines to reduce waste;

v. supporting care planning and comprehensive geriatric assessments (CGA) structured medication reviews;

vi. link-in to community services, acute trusts and mental health services;

vii. supporting weekly care home rounds, working with the MDT; and

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

7.6 Additional Roles Reimbursement Scheme claims process

7.6.1. 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.

7.6.2. 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.

7.6.3. 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.

7.6.4. 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 10.1.10 below for details.

7.6.5. 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.

7.6.6. 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.

7.6.7. 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.

7.6.8. 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 2025 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 (other than General Medical Practitioners) 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/job plans 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.

8.2.4. PCNs are able to employ staff directly or engage them via a contract of service with a third-party organisation. Where staff are engaged via third parties, these services may operate over a larger footprint than the PCN and may include the 'pooling' of funding from multiple PCNs. For example, two PCNs may each choose to commission a digital and transformation service from a third-party provider by contributing funding for one FTE. This funding could cover staff working at different bands. The team then employed by the provider may then deliver services for each PCN.

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[11,12]) 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.

[11] CPPE Clinical Pharmacists in General Practice Training Pathway https://www.cppe.ac.uk/career/clinical-pharmacists-in-general-practice-education#navTop

[12] CPPE Medicines Optimisation in Care Homes Training Pathway https://www.cppe.ac.uk/career/moch/moch-training-pathway#navTop

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 / advanced practice pharmacist and Clinical Director for the PCN.

Supervision of clinical pharmacists

8.3.5. All clinical pharmacists will be part of a professional clinical network and will always be clinically supervised by a senior clinical / advanced practice pharmacist and GP clinical supervisor. The following supervision must be in place for senior clinical / advanced practice pharmacists and clinical pharmacists:

a. Each clinical pharmacist will receive a minimum of one supervision session per month by a senior clinical / advanced practice pharmacist[13];

b. The senior clinical / advanced practice pharmacist will receive a minimum of one supervision session every three months by a GP clinical supervisor; and

c. All clinical / advanced practice pharmacists will have access to an assigned GP clinical supervisor for support and development.

8.3.6. The ratio of senior / advanced practice 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.

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):

[13] 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.

- 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; and
- 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 Other direct patient care roles

8.4.1. From within the allocated Additional Roles Reimbursement Sum, a PCN may also recruit other direct patient care, non-nurse, and non- doctor MDT roles, if agreed with the Commissioner. The Network Contract describes the responsibilities of commissioners in considering these roles, and the type of assurances they may seek from PCNs in doing so. Other considerations that support the recruitment of new roles:

a. The NWRS was updated for the 2024/25 Network Contract to reflect roles that PCNs have told us they may want to recruit. The general `DPC other` code should be used if there is no relevant role available in NWRS. Where `DPC other` is to be used, PCNs should inform their ICB which role has been

recruited and ICBs should share these roles with their regional workforce lead. National teams will amend NWRS as needed based on this information.

b. Where a PCN recruits an ARRS role using the provision above, it should use the newly created `Other Direct Patient Care` category when making a claim for reimbursement via the PCN Monthly Claims Portal.

Further guidance and supporting information

8.4.2. 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 - NHS England » Supported self-management: health coaching guide

c. Personalised Care Institute - https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

8.4.3. A number of supporting materials are available in the Primary Care Networks Development Support section of the FutureNHS Collaboration Platform and the MDT workforce section of the NHSE website.

8.5 General Medical Practitioner

8.5.1 Annex B of the Network Contract DES Specification does not provide for specific role responsibilities for General Medical Practitioners, except that, any offer of employment or engagement made to a General Medical Practitioner must be made on terms and conditions which are no less favourable than those contained in the document entitled “Model terms and conditions of service for a salaried general practitioner employed by a GMS practice”[14] .

8.5.2. Where a General Medical Practitioner is to be engaged or employed by a PCN they must be, at the time of engagement or employment, within two years of the date of their certificate of completion of training (CCT), issued by the General Medical Council.

9. Service requirements

9.1 Core PCN Service Requirements

[14] https://www.nhsemployers.org/system/files/2021-06/TCS-GP-GMS-150409.pdf

9.1.1. The Network Contract DES specifies that a PCN has four key functions:

a. co-ordinate, organise and deploy shared resources to support and improve resilience and care delivery[15] at both PCN and practice level;

b. improve health outcomes for its patients through effective population health management and reducing health inequalities;

c. target resource and efforts in the most effective way to meet patient need, which includes delivering proactive care; and

d. collaborate with non-GP providers to provide better care, as part of an integrated neighbourhood team.

9.1.2. PCNs choosing to provide some practice services (such as vaccination and immunisation, or provision of personally administered items) must comply with additional requirements and make provision for equitable redistribution of funding as appropriate.

9.1.3. As set out in the Specification, where Core Practice Networks within a PCN intend to collaboratively deliver vaccinations, the PCN must ensure that the Network Agreement has been varied to include a schedule (and a clause referring to that schedule) that explains the governance arrangements associated with that delivery. The objective is to ensure it is clear that vaccines are not inadvertently unlawfully supplied by one practice to another. The schedule must make clear that where a practice has procured vaccines itself or ordered vaccine from central supplies, that same practice is responsible for the vaccination activity even where that practice uses staff from other Core Network Practices to administer its vaccines and/or where the patients are from other Core Network Practices.

9.1.4. Some vaccinations attract an item of service fee, and that fee will be paid in accordance with the Statement of Financial Entitlements or relevant enhanced service specifications. If a practice is administering its vaccines to patients of other Core Network Practices, the newly inserted schedule of the Network Agreement should make clear how the income from vaccination activity is distributed.

9.1.5. If one or more practice is providing personally administered items (PAIs) to PCN patients who are not their registered patients, this payment will also be paid in accordance with the Statement of Financial Entitlements. Under the terms of the SFE a practice may submit a claim for payment with prescriptions appended and receive payment for provision of PAI to patients registered with other practices, so long as they are within the same commissioner area. Practices claiming payment

[15] This may also include PCNs delivering practice-level contractual requirements such as vaccinations, screening and health checks, provision of personally administered items, QOF and IIF-related activity during core hours. PCNs delivering vaccinations must document their arrangement in Schedule 8 of their Network Agreement.

should note the claims would count (accrue) as prescriptions within the total count that determines the level of discount deduction incurred as set out in Annex G of the SFE.

9.1.6. The Network Contract DES also includes a requirement to provide Enhanced Access which is unchanged for 2025/26.

9.1.7. Details on service requirements is not in this part B guidance document and can be found in the accompanying part A guidance document.

10. Financial entitlements, nominated payee and payment information

10.1 Financial entitlements

10.1.1. Financial entitlements under the Network Contract DES reflect a blended payment as set out in section 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 (1 April 2025-31 March 2026)

Payment details and allocation	Amount	Allocations	Payment timings
Core PCN funding	£2.999 per patient[16] per year[17].	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[18] amounts[19] as outlined in	PMC allocations	Monthly in arrears by the last day of the month following the month in which the payment relates and

[16] Based on the patient numbers as at 1 January immediately preceding the financial year. The 1 January 2025 patient figures are used for the 2025/26 financial year.

[17] £2.266 being multiplied by the PCN registered list size as at 1 January 2025 and £0.733 multiplied by PCN Adjusted Population as at 1 January 2025. This combines the funding that was previously labelled as Core PCN Funding, Clinical Director Payment and PCN Leadership and Management Payment

[18] 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.

[19] The annual maximum amounts for 2025/26 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
	Network Contract DES Specification. For the London Region PCNs, inner and outer maximum reimbursable rates apply (for General Medical Practitioners, only, a London weighting applies) in accordance with the Network Contract DES Specification.		taking into account local payment arrangements. Payment claimable following start of employment.
Enhanced Access	The Enhanced Access payment is calculated as £8.427 per year multiplied by the PCN's Adjusted Population.	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	£130.253 per bed per year.	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
PCN Capacity and Access Support Payment	The Capacity and Access Support Payment is calculated as £3.208 per year multiplied by the PCN's Adjusted Population	PMC allocations	Monthly in arrears by the last day of the month in which the payment applies and taking into account the timing of 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.

10.1.4. Payments due to the PCN nominated payee for Core PCN Funding, Care Home Premium, Enhanced Access Payment and Capacity and Access Support 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. If the instruction for the new PCN is given to ODS (via the PCN ODS Change Instruction Notice) prior to the last working day on or before the 14th of the month, then the PCN change will take affect in the next month's statement. If the instruction is not provided prior to the last working day on or before the 14th of the month, then the PCN must wait until the month after the next to be included in the statements (in the case of late notification, it will be down to commissioners to make a decision on how payments are made for the part month and proceeding month where relevant). The new PCN changes submitted to ODS will be reflected in systems in accordance with these timelines.

10.1.5. 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

10.1.6. 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. 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 2025/26 contractor weighted population figure will be that for quarter 4 in the 2024/25 financial year i.e. at 1 January 2025.

10.1.7. The NPP will be paid monthly in arrears on or before the last day of the month following the month in which the payment 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 2025, the first payment will be backdated to include payments due from 1 April 2025. Where a practice is a Core Network Practice of a new proposed PCN after 1 April 2025, 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 2025/26 will be managed.

Capacity and Access Payment

10.1.8. For 2025/26 the Capacity and Access Payment (CAP) has total available funding of £292m. The CAP is designed to support and incentivise PCNs to focus on improving

access for patients. Contractual requirements are set out in the 2025/26 Network Contract DES Specification.

10.1.9. The Capacity and Access Payment consists of two parts:

a. 70% of funding (£204m) makes up the Capacity and Access Support Payment and will be paid to PCNs, proportionally to their Adjusted Population[20], in 12 equal payments over the 2025/26 financial year[21] and

b. 30% of the funding (£88m) makes up the Capacity and Access Improvement Payments and part or all of this will be paid to PCNs based on the Network Clinical Director certifying that all practices have met all conditions subject to the commissioner being satisfied that the improvement(s) has been achieved as part of post-payment validation. The maximum a PCN could earn is £1.375 multiplied by the PCN's Adjusted Population as of 1 January 2025.

Further details of the Capacity and Access Improvement Payments are set out in section 11 below.

Sub-contracted social prescribing service

10.1.10. For social prescribing services sub-contracted by a PCN to another provider, a 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 PCN, practice or organisation that receives payment of the applicable financial entitlement set out in this Network Contract DES Specification".

[20] PCN Adjusted Population is a weighted population figure derived from the CCG primary medical care allocation formula.
[21] Full details in the Network Contract DES 25/26 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. Four PCN payment calculations – the Core PCN Funding, Care Home Bed Premium, Enhanced Access and Capacity and Access Support are automated via the PCSE Online.

10.3.2. The NPP will be processed directly by PCSE Online and paid directly to participating GP Practices.

10.3.3. PCSE Online will calculate these four payments using the PCN ODS reference data towards the end of each month. Commissioners should ensure that any changes to the PCN ODS reference data are submitted using the PCN ODS Change Instruction

Notice[22] by the last working day on or before the 14th day of each month, so as to ensure the changes take effect prior to the PCSE Online payment calculation date. These changes will take effect in the subsequent month. If the instruction for the new PCN is given to ODS (via the PCN ODS Change Instruction Notice) prior to the last working day on or before the 14th of the month, then the PCN change will take effect in the next month's statement. If the instruction is not provided prior to the last working day on or before the 14th of the month, then the PCN must wait until the month after the next to be included in the statements (in the case of late notification, it will be down to commissioners to make a decision on how payments are made for the part month and proceeding month where relevant). The new PCN changes submitted to ODS will be reflected in systems in accordance with these timelines

Additional payment information

10.3.4. Commissioners should use the manual PCN Variation Template to instruct approved ARRS claims for payment via PCSE Online. Claims should still be submitted to the online ARRS claims portal by the PCN and reviewed by the Commissioner. In order to instruct that the claim is ready for payment, ICBs will need to complete the PCN Variation Template. Primary Care Support England's PCN Variation Template User Guide provides support for managing a PCNs monthly payment schedule through PCSE online.

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 2025/26 Network Contract DES.

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

Payments	Paycode	Paycode description	Subjective Code
PCN Support Payment	NCDSUP	NCD Support Payment	5216108K
Care home premium	NCDCHP	NCD Care Home Premium	5216108G

[22] The PCN ODS Change Instruction Notice is available here.

Enhanced access payment.	NCDENA	NCD Enhanced Access	521610B9
IIF Achievement Payment	NCDACH	NCD IIF achievement	5216108I

From 1st 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.

Paycodes (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

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
	PASSOA	A	C&M-APMS PCN DES Physician Assoc	521610WI
	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	

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
	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	

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
	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	
	PNDPCG		C&M-PCN Other Direct Patient Care	52161444
	PNENG		C&M-PCN Enhanced Nurse	52161445
	NCDCAS		NCD Capacity and Access Support Payments	52161436
	NCDCAI		NCD PCN Capacity and Access Imp	5216108N
	NCDHSW		PCN DES Healthcare Supp Wrks	52161474
	NCDNGN		PCN DES New to Gen Pract Nurse	52161475
	NCDEGN		PCN DES Exprncd GPrac Nrse	52161476
	NCDCNP		PCN DES Consultnt Nrs PCar	52161477

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.

11. Capacity and Access Payment

11.1 Introduction

11.1.1. This section provides guidance for PCNs to utilise and commissioners to allocate the Capacity and Access Payment (CAP) in 2025/26. The aim of the CAP funding is to support PCNs with making improvements to patient access and to move to Modern General Practice.

11.1.2. The CAP is worth £292m and consists of two parts:

a. National Capacity and Access Support Payment (CASP): 70% of funding (£204m) will be flexible in focus to improve access for patients and paid unconditionally to PCNs, proportionally to their Adjusted Population1, in 12 equal payments over the 2025/26 financial year, an average of ~£13,354/month/PCN; and

b. Local Capacity and Access Improvement Payments (CAIPs): part or all of 30% of the funding (£88m). This will be paid to PCNs in 2025/26 based on the PCN's progress in implementing the Modern General Practice (MGP) model[23] and specifically in delivering against the two priority domains (see table 1 in section 11 for further detail). The maximum a PCN could earn is £1.375 multiplied by the PCN's Adjusted Population as of 1 January 2025.

11.2 National Capacity and Access Support Payment (CASP)

[23] NHS England » Modern general practice model

11.2.1. The National Capacity and Access Support Payment (CASP) can be utilised flexibly by PCNs to improve access to general practice for patients. It can be used to support network level activities in a broad range of ways, for example:

a. implementing Modern General Practice, including enhancing care navigation processes and redesign of workflow (supported by the use of common digital tools across a PCN),

b. enabling PCN and Core Network Practice teams to participate in a facilitated conversation using the Support Level Framework[24] (SLF). This useful tool, developed with general practices, helps practices to identify priorities for improvement, understand what support is needed and facilitates the development of a focused and personalised improvement action plan,

c. enabling PCN and Core Network Practices to participate in the national general practice improvement programme and/or other local support offers, for example to backfill staff time for participation,

d. supporting and optimising available staff and capacity, such as backfill for clinical supervision of Additional Roles Reimbursement Scheme (ARRS) staff,

e. improving delivery of care to people living in care homes as required in the Network Contract DES, or

f. supporting the delivery and coordination of care continuity by Core Network Practices and benchmarking for service improvement purposes.

11.2.2. A range of support is available to PCNs to help them in making improvements to take forward the changes to implement Modern General Practice. This support includes the national General Practice Improvement Programme (GPIP) and local support offers. Commissioners should commit to providing support where required for PCNs to make improvements.

11.2.3. Furthermore, networks are encouraged to extract and review relevant data to support access improvements, particularly data from telephony systems, GP websites, online consultation tools and appointment books to improve understanding and management of demand. This would include continuing to review the telephony data extraction of which started in October 2024.

11.3 Local Capacity and Access Improvement Payments (CAIP)

[24] https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/support-level-framework/

11.3.1. The Local Capacity and Access Improvement Payment (CAIP) focuses specifically on implementing two domains of the Modern General Practice model[25]:

- Risk stratification to support continuity of care; and
- Support implementation of modern general practice model.

11.3.2. The following components of Modern General Practice need to be in place in every practice, and to be confirmed as such by the network Clinical Director and the constituent practices, for the full funding to be paid.

Table 1: Assessment criteria

MGP priority domain	All PCN practices to have following components in place and these continue to remain in place
1) Risk stratification to support continuity of care	☐ Using the intelligence provided by digital risk stratification tools, PCNs should risk stratify their patients in accordance with need, including to identify those that would benefit most from continuity of care (with a named GP, where appropriate)
2) Supporting modern general practice access	☐ Digital telephony data is routinely used to support capacity/demand service planning and quality improvement discussions.* ☐ Consistent approach to care navigation and triage so there is parity between online, face to face and telephone access, including collection of structured information for walk-in and telephone requests. ☐ The approach should include asking patients their preference to wait for a preferred clinician if appropriate, for continuity. ☐ Online consultation (OC) is available for patients to make administrative and clinical requests at least during core hours.

* Where a practice is currently unable to adopt better digital telephony that is capable of enabling any of the components linked to this MGP priority domain, for example because exit costs from a current contract are prohibitively high, and this has been agreed in writing by the commissioner, the “better digital telephony" MGP priority domain (or "improvement" as referred to in the Network Contract DES Specification) will be deemed to have been achieved if the PCN has agreed with the

[25] https://www.england.nhs.uk/gp/national-general-practice-improvement-programme/modern-general-practice-model/

commissioner a clear and deliverable plan to implement an appropriate digital telephony solution.

11.4 CAIP allocation process and audit

11.4.1. The available CAIP funding should be apportioned between the two modern general practice priority domains in a two-to-one ratio, with "supporting modern general practice" representing the larger weighting, such that 100% of funding can only be received if achievement is demonstrated across both areas, and by all practices within a PCN.

11.4.2. Constituent practices should confirm their position against the domains to their PCN Clinical Director. Once the PCN Clinical Director has confirmed that the practices are implementing all listed components for a domain the PCN Clinical Director will notify the ICB through submission of the CAIP payment form.

11.4.3. Each PCN can only claim funding for each component of CAIP once and these claims do not need to be simultaneous. This means there are two opportunities for the PCN to claim for CAIP in-year. The funding for each component cannot be awarded as a partial payment and once awarded, must be pro-rated over the remaining months of the financial year as set out in the Network Contract DES Specification.

11.4.4. The commissioner must make payments no later than the last day of the second month following the month to which the payment relates and taking into account local payment arrangements (for example, a payment relating to April 2025 is to be made on or by the end June 2025). Funding will be released no later than 30 June 2026.

11.4.5. Once a network has claimed funding for a domain of CAIP, the commissioner will update a national tracker to indicate this. This will be submitted to NHS England within a week of the last day of every quarter by e-mailing it to england.pccsdeliveryunit@nhs.net.

11.4.6. NHS England will audit a sample of CAIP payments made in 2025/26 to ensure that payments have been made in line with this guidance. This will include a reconciliation of Clinical Director submissions, ICB payments and national data sets which can be used to verify the implementation of the listed components.

11.4.7. PCNs and member practices should take an improvement approach to the implementation of modern general practice. Commissioners should support PCNs, and practices as needed to take forward improvement priorities.

12. Investment and Impact Fund

12.1 Introduction

12.1.1. The Investment and Impact Fund (IIF) forms part of the Network Contract Directed Enhanced Service (DES). It supports primary care networks (PCNs) to deliver high quality care to their population, as well as supporting the delivery of priority objectives articulated in the NHS Long Term Plan and in Investment and Evolution; a five-year GP contract framework to implement the NHS Long Term Plan.

12.1.2. The IIF for 2025/26 has been redesigned to focus on two national clinical priorities, while at the same time providing general practice and PCNs with the time, funding, and flexibility to ensure patients can access good and timely care.

12.1.3. The IIF for 2025/26 contains two indicators worth up to a maximum £13 million. The remaining IIF-committed funding for 2025/26 has been put into the Capacity and Access Support Payment and the Capacity and Access Improvement Payments, which has total available funding of £292m.

12.1.4. This document provides guidance on the IIF Indicators for 2025/26. Information on how performance and achievement will be calculated is included, and should be read alongside the relevant sections of the 2025/26 Network Contract DES specification (Sections 10.6 and Annexes C and D). For indicators sourced from the GP Extraction Service (GPES), the business rules provide full details of how the indicators are constructed from information in GP systems. For Indicators that are not sourced from GPES, more technical details are provided (or links provided for) in this guidance. In addition, CQRS guidance provides details on the submission and reporting of data for all indicators.

12.2 Structure of the IIF

12.2.1. This section introduces the key elements regarding the IIF in 2025/26:

- Domains, areas, and indicators
- Indicator structure, performance, exclusions and exceptions (personalised care adjustments)
- Achievement points
- Achievement payments, prevalence adjustment and list size adjustment
- Monitoring IIF performance

12.3 Indicators

12.3.1. There are two indicators in the 2025/26 IIF. They are set out in the summary table below, along with respective start dates for each indicator.

2025/26 indicators

Area	Indicators
Tackling health inequalities	**HI03:** Percentage of patients on the Learning Disability register (as defined in the SFE) aged 14 or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan in addition to a recording of ethnicity.
Cancer	**CAN04:** The proportion of patients who have had a lower gastrointestinal urgent suspected cancer referral in the reporting year where at least one urgent suspected cancer referral was accompanied by a faecal immunochemical test result, with the result recorded in the 21 days leading up to the referral.

12.4 Indicator structure and performance calculation

12.4.1. Both indicators in 2025/26 IIF can be classed as 'standard quantitative' and are constructed from the ratio of a numerator and denominator. This represents the indicator performance (Performance X = Numerator (N)/Denominator (D)).

12.4.2. For both indicators a higher indicator value means better performance.

12.4.3. The denominator of each indicator is the target cohort for the intervention in question. In 2025/26 IIF, the target cohort for all indicators is a count of eligible patients or interventions (e.g. medications) delivered to a set of eligible patients. For example, for indicator HI03 the target cohort is people on the Learning Disability Register aged 14 and over, as defined in the SFE.

12.5 Exclusions and Exceptions (Personalised Care Adjustments)

12.5.1. Exclusions may be applied to some indicators, removing patients, and any services or interventions they receive, from the denominator for that indicator. Exclusions are applied prior to assessment of 'success' and are therefore removed even if action or intervention that the IIF indicator seeks to reward has happened. The exact

circumstances in which Exclusions apply to IIF indicators are provided in the tables below.

12.5.2. Personalised care adjustments (PCAs), previously known as 'Exceptions', are applicable to both indicators, removing patients, and any services or interventions they receive, from the denominator for that indicator – unless the action or intervention being incentivised by the indicator has occurred, in which case they will be retained. The exact circumstances in which PCAs apply to IIF indicators are provided in the tables below.

12.5.3. An example of how PCAs would be applied to CAN04 is as follows: A PCN has 400 people who had a lower gastrointestinal urgent suspected cancer referrals, of which 240 received a faecal immunochemical test. If a practice's clinical system records that 20 of the 400 eligible patients were offered a faecal immunochemical test but refused and it was also deemed clinically inappropriate to administer a faecal immunochemical test to a further 20, then PCN performance in relation to indicator CAN02 would be 66.7% (= 240/360), not 60% (= 240/400).

12.6 Achievement points

12.6.1. The IIF Indicators are points-based. For 2025/26, each PCN can achieve a maximum of 58 IIF points and the value of a point will be £198.00 (adjusted for list size and prevalence – see paragraphs 12.7.1 - 12.7.2). Each indicator is worth a specific number of points.

12.6.2. The points a PCN can achieve for standard quantitative indicators will depend on how their performance relates to an upper performance threshold and a lower performance threshold.

12.6.3. The upper performance threshold is based on clinical or other expert opinion concerning good practice. Reflecting the aim of reducing unwarranted variation, the lower performance threshold for each indicator has typically been set with reference to the 40th centile of baseline performance (where baseline data is available).

12.6.4. If a PCN's performance for an indicator is better than or equal to the upper performance threshold, it will achieve all the points available for that indicator; if a PCN's performance is worse than or equal to the lower performance threshold, it will achieve zero points; and if performance is between the upper and lower thresholds, it will achieve some but not all of the points available for that indicator. Consider a hypothetical indicator worth 50 points with an upwards desired direction, a lower performance threshold of 50% and an upper performance threshold of 75%. Then, two IIF points are achieved for every percentage point improvement in performance between the lower and upper threshold (50 points/ (75%-50%) = 2 points per percentage point). If a PCN's performance is 70%, it will achieve 40 of the 50

available achievement points – because 70% is 4/5ths of the way from 50% (the lower performance threshold) to 75% (the upper performance threshold).

12.7 Achievement payments

12.7.1. For each indicator, a PCN's achievement payment equals its achievement points multiplied by the value of an IIF point (£198.00 in 2025/26), multiplied by a 'list size adjustment', and by a 'prevalence adjustment'. The value of an IIF point will be subject to annual revision.

12.7.2. The purpose of the prevalence adjustment and list size adjustment is to more closely relate PCN payments to the effort that a PCN must undertake to achieve IIF points. The points-based system means that, for any indicator, every PCN will achieve the same number of points for a given 'absolute' level of performance. However, differences in prevalence and in list size mean that PCNs may have to make different levels of effort to achieve a given percentage point (absolute) improvement in performance e.g. to improve from 50% to 60% performance. Annex A explains how applying a prevalence adjustment and a list size adjustment takes account of these differences.

12.7.3. In 2025/26, PCNs are entitled to one type of payment associated with the IIF indicators: a Total Indicator Achievement Payment which is the sum of achievement payments for each indicator (as defined above). To be eligible to receive a Total Indicator Achievement payment, a PCN must comply with the conditions set out in the 2025/26 Network Contract DES specification (section 10.6.10). Crucially, the PCN must provide a simple written commitment to their commissioner that any money earned through the IIF indicators 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.

12.8 Monitoring IIF Indicator performance

12.8.1. Each PCN is able to monitor its indicative performance against IIF indicators in both CQRS and on a dashboard available on FutureNHS[26].

12.9 Tackling health inequalities area

12.9.1. The social and economic environment in which we are born, grow up, live, work and age, as well as the decisions we make for ourselves, have a significant impact on our health. The imbalance in outcomes and different experiences of healthcare services between different groups, communities and regions is well documented. IIF indicators in the tackling health inequalities area are designed to help to ensure that

[26] https://future.nhs.uk/PrimaryCareDataHub/groupHome

everyone gets access to the care they need and focus interventions on groups who experience health inequalities.

HI03: Percentage of patients on the Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan in addition to a recording of ethnicity	
Rationale for inclusion	People with a learning disability being identified on their local register with a recording of their ethnicity, having an annual health check and a health action plan is vital to tackle the causes of morbidity and the 42% (LeDer 2022) of avoidable deaths (as defined by the OECD)in people with a learning disability.
Indicator type	Standard Quantitative
Running period	1 April 2025 – 31 March 2026
Denominator	Number of patients on the Learning Disability register as defined in the SFE aged 14 years or over.
Numerator	Of the denominator, the number who received a learning disability Annual Health Check and have a completed Health Action Plan in addition to a recording of ethnicity.
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	Patient refused the offer of a learning disability health check or a health action plan.
Desired direction	Upwards
Thresholds	60% (LT), 80% (UT)
Points	36

HI03: Percentage of patients on the Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan in addition to a recording of ethnicity	
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	People with a learning disability are at a higher risk than the general population of treatable and preventable conditions including diabetes type 2, constipation, respiratory and cardiovascular disease. People are less likely to access screening services leading to later diagnosis and poorer outcomes of treatable conditions including cancer. People are more likely to be admitted to hospital with ambulatory care conditions and have longer stays once admitted. The 2022 LeDeR report found the median age of death for people with a learning disability was 62.9 years. A report by the Race and health observatory found the average of death of people with a learning disability from a minority ethnic community was 34. The learning disability annual health check provides an opportunity to take an holistic, personalised overview of the health of the patient, raising awareness of preventative services, identify emerging risks and issues, improve health literacy and develop or maintain a productive relationship between Primary care and the patient (and carers where appropriate). The purpose of the health action plan is to support the ongoing health of the patient – working with them to identify health goals and support them to be a proactive participant in their health and care. Data for

HI03: Percentage of patients on the Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan in addition to a recording of ethnicity	
	2023/24 showed that there was an average 3.25% disparity between people who had received an Annual Health Check and those who received a Health Action Plan as a consequence. Reports commissioned by NHS England regarding Annual Health Check delivery suggested that many of the people consulted with had not received a physical copy of a Health Action Plan following their Annual Health Check. A copy of the health action plan should be provided to the patient in accordance with the NHS Accessible communication standard and in line with recorded reasonable adjustments. An accurate recording of ethnicity will provide even greater insight into potential health risks. NICE Quality Standard 187 provides the quality standard for learning disability health checks. All checks should be auditable against this standard. This IIF indicator supplements the item of service payment (£140 at the time of publishing this guidance) for annual Learning Disability health checks, which is paid as an Enhanced Service. In providing the annual health check, clinicians are reminded that discussing the Health Action Plan is an essential component of the check and integral to its overall efficacy. Patients should leave their health check with a copy, which meets the NHS Accessible communication standard, of the action plan discussed, to support them in managing their health and wellbeing. The IIF supports case identification by employing a prevalence adjustment and list

HI03: Percentage of patients on the Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan in addition to a recording of ethnicity	
	size adjustment to Achievement Payments. The combined effect of these adjustments is to make a PCN's earning ability in respect of indicator HI-01 proportional to the number of patients on the learning disability register. Further details of these adjustments are provided in Annex A. In recognition of concerns raised about patients inappropriately added to the learning disability register as a result of an associated diagnosis and SNOMED coding, a removal code will be available – PCNs must assure themselves patients cannot be erroneously removed. PCAs are available if the patient refuses the offer of a learning disability health check or a health action plan. GPs are reminded that in order for a patient to refuse, their capacity should be assessed using the Mental Capacity Act framework. Where the individual does not have capacity a best interest process should be followed. Further Information • NHS England: Learning Disability Annual Health Checks • Mencap charity: Leaflets and resources to encourage people to take up an annual health check • Contact (charity): Annual health checks: Factsheet for parents • Annual Health Checks and people with learning disabilities guidance includes evidence for an annual heath check and further resources including videos on how to complete an annual health check. • NDTI resources

HI03: Percentage of patients on the Learning Disability register aged 14 years or over, who received a learning disability Annual Health Check and have a completed Health Action Plan in addition to a recording of ethnicity	
	• Learning from Lives and deaths (LeDeR) • Race Health Observatory "We deserve better"

12.10 Cancer area

12.10.1. IIF

12.10.2.

CAN04 The proportion of patients who have had a lower gastrointestinal urgent suspected cancer referral in the reporting year where at least one urgent suspected cancer referral was accompanied by a faecal immunochemical test result, with the result recorded in the 21 days leading up to the referral.	
Rationale for inclusion	Comprehensive use of FIT in NG12 patients is critical to improving bowel cancer survival in England, ensuring patients on the lower GI pathway can be diagnosed promptly and that available colonoscopy capacity is used in the most effective way. The risk of colorectal cancer in those with a negative result, a normal examination and full blood count is <0.1%. This is lower than the general population risk. In August 2023, NICE published guidance on using FIT to guide colorectal cancer pathway referral in primary care. This guidance recommends that all adults with symptoms of a suspected colorectal cancer diagnosis be offered a FIT test in primary care, except those with an anal/rectal mass or anal ulceration, and that those with a result of at least 10 micrograms of haemoglobin per gram of faeces are

CAN04 The proportion of patients who have had a lower gastrointestinal urgent suspected cancer referral in the reporting year where at least one urgent suspected cancer referral was accompanied by a faecal immunochemical test result, with the result recorded in the 21 days leading up to the referral.	
	referred on a Lower GI urgent suspected cancer pathway.
Indicator type	Standard Quantitative
Running period	1 April 2025 – 31 March 2026
Denominator	The number of patients who have had a lower gastrointestinal urgent suspected cancer referral in the reporting year.
Numerator	Of the denominator, those where at least one urgent suspected cancer referral was accompanied by a faecal immunochemical test result, with the result recorded in the 21 days leading up to the referral.
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	Provision of faecal immunochemical test kit declined. Patients with anal ulceration or with anal or rectal masses.
Desired direction	Upwards
Thresholds	65% (LT), 80% (UT)
Points	22
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes

Additional information	All GPs are expected to implement the recommendations set out in NICE DG56 guidance. The guidance recommends the use of FIT in primary care for patients presenting with all NG12 suspected colorectal cancer symptoms. The implementation of FIT in primary care has had a positive impact on lower GI referral volumes. Recent data has shown that referrals for all cancers are 2.3% above the pre-pandemic trend, while lower GI referrals are 14.1% below the trend. At the same time, there has been an increase in the proportion of lower GI urgent suspected cancer referrals that result in a cancer diagnosis, and no significant change to the trend in lower GI detection rates. This suggests that FIT is supporting the most appropriate patients to be referred for colonoscopy. There are a number of steps a PCN may take to ensure that FIT is implemented across all practices: • Encouraging patient uptake of FIT: Make sure the patient is aware of the importance of completing a FIT test and returning it as quickly as possible. Cancer Research UK has materials to support patient uptake available on their website. • Working closely with secondary care: Utilise e-RS pre-referral specialist advice (or 'advice and guidance') where it is unclear if a patient requires an urgent referral based on their FIT result and symptoms. • LGI urgent cancer forms: Include FIT results on the LGI Urgent Suspected Cancer referral form so that it can be used by LGI triage teams to determine the appropriate onward pathway for the patient. FIT kits should be commissioned locally through ICBs. Where there are supply issues that are unable to be resolved locally via ICBs or Cancer Alliances, PCNs should contact england.pcn.fitsupply@nhs.net for support from the National Cancer Team at NHS England.

13. Annex A: Prevalence adjustment and list size adjustment

A.1 This annex explains why a prevalence adjustment and list size adjustment are applied when calculating IIF Indicator achievement payments, as well as explaining how they are calculated. Further details about calculation of these adjustments are provided in Annex C of the 2025/26 Network Contract DES specification.

Prevalence adjustment

A.2 Prevalence refers to the percentage of a population affected by a given disease or condition. We use this concept to define a generalised 'prevalence' concept for every IIF indicator, equal to a prevalence numerator divided by the number of registered patients at the PCN. The prevalence numerator will usually, but not always, be equal to the indicator denominator (the denominator may be a count of eligible patients or a count of interventions e.g. medications delivered to a set of eligible patients). For instance, for indicator HI03 prevalence is equal to the percentage of a PCN's patients who are on the Learning Disability register (as defined in the SFE) and aged 14 years or over.

A.3 Consider two PCNs that are identical other than one has twice as many patients on the Learning Disability register aged 14 years or over. This would mean that PCN has to deliver twice as many interventions (a learning disability Annual Health Check, a completed Health Action Plan and a recording of ethnicity) to earn the same number of points. Applying a prevalence adjustment compensates that PCN for the extra effort required to earn a given number of points (i.e. achieve a given percentage point improvement in performance).

A.4 The prevalence adjustment for an indicator is equal to PCN prevalence divided by national prevalence. For instance, if 0.5% of the residents of England registered at practices signed up to the Network Contract DES are on the Learning Disability register and aged 14 years or over, then a PCN with 0.75% of registered patients on the Learning Disability register and aged 14 years or over would have a prevalence adjustment of 1.5 – that is, it would be paid 50% more for each additional achievement point than an otherwise identical PCN with a prevalence equal to the national average prevalence.

A.5 As well as making payments more proportional to effort, applying a prevalence adjustment also encourages appropriate case finding for indicators whose denominator is under the control of the PCN. Consider HI03, where the denominator is the number of patients on the learning disability register aged 14 and over. PCNs and their constituent practices are responsible for adding patients to this register. The prevalence adjustment encourages efforts to identify patients with a Learning Disability and to add them to the register, as case finding increases earnings ability.

List size adjustment

A.6 The list size adjustment is based on a similar principle to the prevalence adjustment. If two PCNs are identical (including having identical prevalence for every IIF indicator) other than one has double the list size, that PCN would have to change its treatment of twice as many patients to earn the same number of points. The list size adjustment compensates larger PCNs for this situation by making the payment per achievement point proportional to list size.

A.7 Formally, the list size adjustment for a PCN is equal to the PCN list size divided by the national average PCN list size (i.e. the total number of patients registered that are a Core Network Practices that are part of a PCN, divided by the total number of PCNs). Thus, if the national average PCN list size is 49,000 and a PCN has 98,000 patients, that PCN's list size adjustment would be 2. In other words, that PCN would be paid twice as much for each additional achievement point as an otherwise identical PCN with a list size equal to the national average.

Summary

A.8 The net effect of applying a prevalence adjustment (for Quantitative indicators) and a list size adjustment is to make payment proportional to the amount of activity undertaken (e.g. number of patients treated). The effort required to deliver one unit of activity is not fixed, but may vary according to patient demographics, socio-economic status and other characteristics. Likewise, there may be economies of scale, so that treating 200 patients does not require twice as much effort as treating 100 patients. Thus, applying a prevalence adjustment and a list size adjustment does not ensure an exact correspondence between effort and reward, but does bring the two closer together.