NHS England

Network Contract DES

Contract specification 2026/27 – PCN requirements and entitlements

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Please be aware that all aspects of this service specification outline the requirements for this programme. As such, commissioners and practices should ensure they have read and understood all sections of this document as part of the implementation of this programme.

Practices are advised that to ensure they receive payment, particular attention should be paid to the payment and validation terms. Practices will need to ensure they understand and use the designated clinical codes as required to ensure payment.

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1. Introduction

1.1. The Network Contract Directed Enhanced Service (the "**Network Contract DES**") was first introduced in the Directed Enhanced Services Directions 2019.

1.2. The Network Contract DES placed obligations on practices and commissioners and granted various entitlements to practices with effect from 1 July 2019.

1.3. An objective of the Network Contract DES in 2019 was for primary medical services contractors to establish and develop Primary Care Networks ("**PCNs**"). A key aim for introducing PCNs was to build greater resilience and leverage the benefits of working at scale for practices. This remains a key aim, as does the objective for PCNs to forge closer links between practices, the broader health and care system and a diverse range of partners in their communities, including the voluntary sector and patient groups for the benefit of patients. Primary care networks form an important part of wider Integrated Neighbourhood Teams ("**INTs**").

1.4. The Network Contract DES forms part of a long-term, larger package of general practice contract reform originally set out in *Investment and Evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan* and subsequent updates.

1.5. This document sets out:

1.5.1. how commissioners must offer to primary medical services contractors the opportunity to participate in the Network Contract DES;

1.5.2. the eligibility requirements and process for primary medical services contractors to participate in the Network Contract DES; and

1.5.3. in relation to the Network Contract DES, the rights and obligations of:

a. primary medical services contractors that participate;

b. the PCNs of which they are members; and

c. commissioners,

for the financial year from 1 April 2026 to 31 March 2027.

1.6. This document has been updated since version 1 (2019/20) was agreed by NHS England and the British Medical Association's (BMA) General Practitioners Committee England (GPCE) (except where amended as part of a Local Variation Arrangement).

2. Commonly used terms

2.1. This document is referred to as the "**Network Contract DES Specification**".

2.2. In this Network Contract DES Specification:

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2.2.1. the "**Network Contract DES**" refers to the Network Contract DES for the financial year commencing 1 April 2026 and ending on 31 March 2027 unless expressly stated otherwise;

2.2.2. the "**Network Contract DES Variation**" refers to an in-year variation to the Network Contract DES during the period 1 April 2026 to 31 March 2027 issued on a national basis by NHS England;

2.2.3. a "**subsequent year's Network Contract DES**" refers to the Network Contract DES commencing on the 1 April 2027;

2.2.4. a "**practice**" refers to a primary medical services contractor;

2.2.5. a "**New Practice**" refers to a practice that is newly formed following the taking effect of a new primary medical services contract;

2.2.6. the "**commissioner**" refers to the organisation with responsibility for contract managing a practice and this will be an integrated care board (**ICB**) that carries out contract management of primary medical services contracts under delegated arrangements with NHS England;

2.2.7. the "**Network Agreement**" refers to the agreement entered into by practices (and potentially other organisations) that are members of a PCN and which incorporates the provisions that are required to be included in a network agreement[1] in accordance with section 5.1.2 d);

2.2.8. a "**Core Network Practice**" of a PCN has the same meaning as in a PCN's Network Agreement and refers to the practices that are members of a PCN who are responsible for delivering the requirements of the Network Contract DES in relation to that PCN;

2.2.9. a "**Previously Approved PCN**" refers to a PCN that was approved in the period commencing 1 July 2019 and ending on 31 March 2026;

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;

2.2.11. the "**Network Area**" refers to the area of a PCN as described in section 5.1.3;

2.2.12. a "**list of patients**" refers to the registered list of patients in respect of a practice that is maintained by NHS England in accordance with that practice's primary medical services contract;

2.2.13. the "**PCN's Patients**" refers collectively to the persons on the PCN's Core Network Practices' lists of patients;

[1] The Network Agreement and Schedule can be found at https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-network-agreement/

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2.2.14. the "**practice list size**" refers to the number of persons on the list of patients of the practice;

2.2.15. the "**PCN list size**" refers to the number of PCN Patients, which is the sum of all practice list sizes of the Core Network Practices of the PCN;

2.2.16. the **"Contractor Weighted Population"** refers to a practice's Contractor Registered Population (as calculated in accordance with the SFE regardless of whether the SFE applies to that practice and as calculated at the relevant date set out in the relevant section of this Network Contract DES Specification) adjusted by the Global Sum Allocation Formula set out in Annex B of the SFE;

2.2.17. the **"PCN Contractor Weighted Population"** refers to the PCN's Core Network Practices' collective Contractor Weighted Population;

2.2.18. **"Enhanced Access"** refers to the provision of services in the Network Standard Hours as set out in section 8 of this Network Contract DES;

2.2.19. **"Network Standard Hours"** refers to the hours of 6.30pm to 8pm Mondays to Fridays and 9am to 5pm on Saturdays;

2.2.20. the **"PCN Adjusted Population"** is a weighted population figure that is different to the PCN Contractor Weighted Population figure as it is derived from the ICB primary medical care allocation formula. Such a figure is periodically calculated and published for PCNs and commissioners;

2.2.21. the **"SFE"** is the General Medical Services Statement of Financial Entitlements Directions 2026 as amended from time to time;

2.2.22. "**INT**" means an Integrated Neighbourhood Team, which is formed when cross-sector teams come together, typically at a neighbourhood level to share responsibility for supporting the health and wellbeing of a community;

2.2.23. "**Additional Roles Reimbursement Scheme**" has the meaning explained in section 7.1.2;

2.2.24. "**Structured Medication Review**" means an evidence-based and comprehensive review of a patient's medication, that would normally be carried out by a clinical pharmacist or doctor, taking into account all aspects of the patient's health; and

2.2.25. "**Local Variation Arrangement**" means an arrangement under the Network Contract DES established by NHS England in accordance with section 4.10 following receipt of a Local Variation Arrangement Request, and set out in a Local Variation Notice, pursuant to which, for the period and for the Primary Care Network(s) and Core Network Practice(s) specified in the Local Variation Notice or, where applicable, confirmed in accordance with paragraph 4.10.6, specified sections of this Network Contract DES Specification are varied for local delivery,

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provided that a Local Variation Arrangement may vary only sections 7, 8 and 10.1 to 10.5 (inclusive).

3. Relationship between the Network Contract DES and the primary medical services contract

3.1. Where this Network Contract DES Specification sets out a requirement or obligation of a PCN, each Core Network Practice of a PCN is responsible for ensuring the requirement or obligation is carried out on behalf of that PCN.

3.2. A practice participating in the Network Contract DES must enter into a variation of its primary medical services contract to incorporate the provisions of this Network Contract DES Specification.

3.3. The provisions of this Network Contract DES Specification therefore become part of the practice's primary medical services contract.

3.4. Where a practice chooses not to participate in the Network Contract DES, this will not impact on the continuation of primary medical services under its primary medical services contract.

4. Eligibility for and participation in the Network Contract DES

4.1 Eligibility

4.1.1. A practice must satisfy each eligibility criteria below to be eligible to participate in the Network Contract DES:

a) the practice must hold a primary medical services contract;

b) the practice has a registered list of patients which means that persons are recorded in the registration system approved by NHS England as being registered with the practice; and

c) the practice's primary medical services contract must require the practice to offer in-hours (essential services) primary medical services.

4.2 Participation requirements

4.2.1. A Core Network Practice and the commissioner acknowledge that the Network Contract DES Specification 2025/26 contained a provision pursuant to which the Core Network Practices will automatically participate in the following year's Network Contract DES (which means the Network Contract DES commencing on 1 April 2026), unless the Core Network Practice chose to opt-out. A Core Network Practice that participates in this Network Contract DES (which means the Network Contract

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DES commencing on 1 April 2026) will automatically participate in any subsequent year's Network Contract DES, unless and until the Core Network Practice opts out. For the avoidance of doubt, this means that a Core Network Practice will be required to deliver the services in accordance with the subsequent Network Contract DES until the opt-out date.

4.2.2. Where a practice wishes to participate in the Network Contract DES or any Network Contract DES Variations, one of the situations below will apply. The practice, and where applicable the PCN, must identify the relevant situation and act in accordance with the appropriate sections:

a) If the practice is automatically participating in a Previously Approved PCN and there have been no changes to the PCN's Core Network Practices, the practices in the PCN must act in accordance with section 4.3;

b) If the practice is automatically participating, or wishes to participate, in a Previously Approved PCN and there will be changes to the identity of the PCN's Core Network Practices due to:

i. a Core Network Practice from another PCN joining; and/or

ii. a non-participating practice joining; and/or

iii. a New Practice joining; and/or

iv. a Core Network Practice opting out of participating;

then the PCN's Core Network Practices, joining practices and leaving practices must collectively act in accordance with section 4.4;

c) If the practice is either a New Practice or an existing practice and wishes to be a Core Network Practice of a newly proposed PCN, the practice must act in accordance with section 4.5; or

d) If the practice cannot identify a Previously Approved PCN or a newly proposed PCN that is willing to allow the practice to be a Core Network Practice under its Network Agreement, the practice must act in accordance with section 4.6.

4.2.3. A commissioner must ensure that any patients of a practice that is not participating in the Network Contract DES are covered by a PCN or alternative provider (for example through commissioning a local contractual arrangement). For the avoidance of doubt, subject to procurement rules, commissioners may not commission such a local contractual arrangement with any practice choosing not to participate in the Network Contract DES. Further information on commissioning PCN services for patients of non-participating practices is available in the Network Contract DES Guidance.

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4.2.4. Subject to sections 4.2.5 and 4.2.6, this Network Contract DES Specification will cease to have effect on:

a) 31 March 2027; or

b) where a Core Network Practice ceases to participate in the Network Contract pursuant to any provision of this Network Contract DES Specification, the date it is determined that the Core Network Practice ceases to participate in the Network Contract DES,

and the practice agrees that from the relevant date the practice's primary medical services contract will be deemed to have been varied to remove this incorporation of the Network Contract DES Specification.

4.2.5. Where NHS England issues a Network Contract DES Variation, a Core Network Practice will automatically participate in that variation unless the Core Network Practice follows the opt-out process which starts with notifying the commissioner of its intention to opt out of the Network Contract DES in accordance with section 4.9.5. Each practice that automatically participates must, as soon as practicable, enter into a written variation of its primary medical services contract with the commissioner to incorporate the Network Contract DES Variation and ensure the PCN's Network Agreement reflects the arrangements for delivery of the Network Contract DES Variation.

4.2.6. Unless expressly stated otherwise or by necessary implication, no term of this Network Contract DES Specification shall survive beyond 31 March 2027 or, if earlier, the date it is determined that a Core Network Practice ceases to participate in the Network Contract DES (as relevant).

4.3 Automatic participation in a Previously Approved PCN with no change in Core Network Practice membership

4.3.1. The Previously Approved PCN's Core Network Practices will automatically participate in the Network Contract DES and each practice must as soon as practicable:

a) enter into a written variation of its primary medical services contract with the commissioner that incorporates the provisions of this Network Contract DES Specification;

b) if the practice has been provided with access to the Calculating Quality Reporting Service ("**CQRS**"), indicate via CQRS that it is participating in the Network Contract DES; and

c) ensure the PCN's Network Agreement reflects the arrangements for delivery of the Network Contract DES.

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4.4 Participation in a Previously Approved PCN with changes in Core Network Practices

4.4.1. This section applies to Previously Approved PCNs with changes in their Core Network Practices due to any one or more of the following situations:

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.

and all practices acknowledge that as a result of any change to the Core Network Practices the participation in the Network Contract DES will be in accordance with this section 4.4.

4.4.2. The Previously Approved PCN's Core Network Practices will automatically participate in the Network Contract DES subject to sections 4.4.6, 4.4.8 and 4.4.9.

4.4.3. A Core Network Practice joining from another PCN will automatically participate in the Network Contract DES subject to sections 4.4.6, 4.4.8 and 4.4.9.

4.4.4. A New Practice may participate in the Network Contract DES at any time during the financial year and join a Previously Approved PCN subject to sections 4.4.6, 4.4.7, 4.4.8 and 4.4.9.

4.4.5. Where a Core Network Practice leaves a PCN during the opt-out period, the opting out practice must act in accordance with section 4.4.6 and 4.9. Sections 4.4.8 and 4.4.9 will apply to the remaining Core Network Practices in the PCN to enable the commissioner to determine the extent to which the PCN with its amended membership meets the criteria for a PCN and therefore whether the participation in the Network Contract DES of the remaining Core Network is confirmed.

4.4.6. All practices whether remaining, joining or leaving the PCN must complete a single form at Annex A and promptly submit it to the commissioner on or before 30 April 2026 and on or before the 30th calendar day following the date the Network Contract DES Variation is published. The form must be submitted by the method the commissioner has indicated and should be used to provide the information and include notification of:

a) the membership change that has occurred;

b) the reasons for the change pursuant to 4.4.1.

4.4.7. Where a New Practice wants to join a Previously Approved PCN outside of the periods pursuant to section 4.4.6, the PCN's Core Network Practices and the New Practice must complete a single form at Annex A and promptly submit it to the

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commissioner, by the method the commissioner had indicated and include notification of:

a) the membership change that has occurred;

b) the reasons for the change pursuant to 4.4.1.

4.4.8. Where the commissioner is satisfied that it has all required and necessary information, the commissioner will consider all information received including the extent to which the Previously Approved PCN meets the criteria for a PCN set out in section 5.1.2 and, as soon as practicable and in any event within one month of receipt of the notification, notify the practice(s) whether its participation in the Network Contract DES is confirmed.

4.4.9. Where the commissioner notifies the practice(s) that its participation, or continued participation, in the Network Contract DES:

a) is not confirmed, section 4.7 applies;

b) is confirmed, section 4.8 applies.

4.4.10. Where the commissioner consents to a change in the details of the Previously Approved PCN, the commissioner must:

a) complete the PCN ODS Change Instruction Notice[2], to indicate any changes to a PCN's membership and/or Nominated Payee and submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month; and

b) consider the list of care homes for which the PCN will have responsibility pursuant to section 8.4.2 and any required adjustment to care home allocations across PCNs within the area.

4.4.11. The practices in the PCN must:

a) update the PCN's Network Agreement accordingly to reflect the list of Core Network Practices;

b) confirm that all practices agree that payments under the Network Contract DES are made to the PCN's Nominated Payee; and

c) confirm that the PCN's Core Network Practices will have in place patient record sharing arrangements (as clinically required) and data sharing arrangements of the PCN, in line with data protection legislation and patient opt-out preferences, prior to the start of any service delivery under the Network Contract DES.

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

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4.5 New Practice or existing practice forming a new PCN

4.5.1. Where this section applies, the practice(s) must promptly provide the following information to the commissioner on or before 30 April 2026 and on or before the 30th day following the date the Network Contract DES Variation is published, using the form at Annex A:

a) the names and ODS codes[3] of the proposed PCN's Core Network Practices[4];

b) the number of the PCN's Patients as at 1 January 2026[5];

c) a map clearly marking the geographical area covered by the Network Area of the proposed PCN;

d) an initial Network Agreement – this requires completion of the proposed Core Network Practices' details in the front end of the Network Agreement and in Schedule 1, details of the Network Area, the Clinical Director and Nominated Payee (additional information in Schedule 1 relating to PCN meetings and decision-making may also be submitted but it is recognised that this may not have been fully agreed at the point of submission to the commissioner);

e) the Nominated Payee[6] and details of the relevant bank account that will receive funding on behalf of the PCN; and

f) the identity of the accountable Clinical Director,

the form must be submitted by the method the commissioner had indicated should be used to provide the information.

4.5.2. The practice must promptly provide to the commissioner any further information the commissioner requests in relation to the proposed PCN.

4.5.3. Where the commissioner is satisfied that it has all required and necessary information, the commissioner will consider all information received including the extent to which the proposed PCN meets the criteria for a PCN set out in section 5.1.2 and, as soon as practicable and in any event within one month of receipt of the notification, notify the practice whether its participation in the Network Contract DES is confirmed and whether the proposed PCN is approved.

4.5.4. Where the commissioner approves the PCN, the commissioner must:

[3] https://digital.nhs.uk/services/organisation-data-service

[4] This may be a single super practice.

[5] This can be obtained by aggregating the number of persons on the lists of patients for all Core Network Practices as recorded in the registration system approved by NHS England.

[6] Payment nomination would only apply where there is more than one primary medical care contractor in the PCN.

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a) complete the PCN ODS Change Instruction Notice[7] to indicate the details of the PCN and submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month;

b) indicate to the PCN and its Core Network Practices when they are required to commence delivery of the Network Contract DES and the date payments will be made, taking into account local payment arrangements; and

c) consider the list of care homes for which the PCN will have responsibility pursuant to section 8 and any required adjustment to care home allocations across PCNs within the area.

4.5.5. Where the commissioner notifies a practice that its participation in the Network Contract DES:

a) is not confirmed, section 4.7 applies;

b) is confirmed, section 4.8 applies.

4.6 Previously Approved PCNs or proposed PCN unwilling to accept a practice

4.6.1. Where this section applies to an existing practice, the practice must notify the commissioner by 30 April 2026 and on or before the 30th calendar day following the date the Network Contract DES Variation is published, that no Previously Approved PCN or proposed PCN is willing to enable the practice to be a Core Network Practice of the PCN. As a New Practice may be formed at any point between 1 April 2026 and 31 March 2027, the situation above may arise outside these periods in which case the New Practice can notify the commissioner of this situation at any point during the year.

4.6.2. The commissioner may require a PCN to include the practice as a Core Network Practice of that PCN. Where the commissioner is minded to require a PCN to do so, the commissioner must engage with the relevant LMC and, when making its determination, have regards to the views of the LMC. The commissioner acknowledges that the Core Network Practices of the PCN may already have submitted information and had their participation in the Network Contract DES confirmed at the point the commissioner is minded to require the PCN to include the practice as a Core Network Practice. If the commissioner requires a PCN to include the practice, the commissioner will consider this a change to the details of the PCN and consider any consequences of inclusion on the PCN and its Core Network Practices.

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

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4.6.3. Where the commissioner requires a PCN to include the practice as a Core Network Practice of that PCN:

a) the commissioner must inform that PCN on or before the 30th day following its determination that the PCN is required to include the practice as a Core Network Practice; and

b) each practice in the PCN to which the practice has been allocated will, as soon as practicable, and in any event within 30 days, after the commissioner informs them of its decision, take the necessary steps to enable the practice to become a Core Network Practice of the PCN including, but not limited, to varying the Network Agreement to include the practice.

4.6.4. As soon as practicable after the PCN has taken the necessary steps pursuant to section 4.6.3 b), the practice joining the PCN must provide the following information to the commissioner:

a) confirmation that the practice has signed an updated version of the PCN's Network Agreement;

b) confirmation that the practice is listed as a Core Network Practice in the PCN's Network Agreement;

c) confirmation that the practice agrees that payments under the Network Contract DES are made to the PCN's Nominated Payee;

d) confirmation that the practice will have in place patient record sharing arrangements (as clinically required) and data sharing arrangements of the PCN, in line with data protection legislation and patient opt-out preferences,[8] prior to the start of any service delivery under the Network Contract DES.

4.6.5. Where the commissioner is satisfied that it has all relevant and necessary information, the commissioner will as soon as practicable but in any event within five working days, taking into account the information that has been provided and the fact that the commissioner has required the PCN to include the practice in the PCN, notify the practice whether its participation in the Network Contract DES is confirmed.

4.6.6. Where, as a result of the commissioner's decision, there is a change in the details of the PCN, the commissioner must complete the PCN ODS Change Instruction Notice[9]. The commissioner must submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month.

[8] https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/how-we-look-after-your-health-and-care-information/your-information-choices/opting-out-of-sharing-your-confidential-patient-information

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

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4.6.7. Where the commissioner notifies a practice that its participation in the Network Contract DES:

a) is not confirmed, section 4.7 applies;

b) is confirmed, section 4.8 applies.

4.7 Participation not confirmed

4.7.1. Where the commissioner notifies a practice that its participation in the Network Contract DES is not confirmed:

a) the commissioner will explain to the practice the reasons for its decision;

b) the commissioner, the practice, and the relevant PCN if applicable must make every reasonable effort to communicate and co-operate with each other, and with the local LMC if relevant, with a view to enabling the commissioner to confirm the practice's participation in the Network Contract DES as soon as practicable;

c) if no agreement is reached after a reasonable timescale, the commissioner or the practice may refer the matter to the local NHS England team.

4.7.2. Where a local LMC is involved in the matter, the commissioner must work with the local LMC to support PCN development, addressing where appropriate issues that arise and seeking to maintain 100 per cent geographical coverage of PCNs.

4.7.3. If the commissioner notifies the practice that its participation in the Network Contract DES is confirmed, section 4.8 applies.

4.8 Confirmation of participation

4.8.1. Where a commissioner has confirmed a practice's participation in the Network Contract DES, the practice must, as soon as practicable:

a) enter into a written variation of its primary medical services contract with the commissioner that incorporates the provisions of this Network Contract DES Specification;

b) if the practice has been provided with access to CQRS, indicate via CQRS that it is participating in the Network Contract DES; and

c) ensure the PCN's Network Agreement reflects the arrangements for delivery of the Network Contract DES.

4.9 Opting out of participation or ending participation in year

4.9.1. There are three types of opt outs:

a) opt out of this Network Contract DES in accordance with section 4.9.4;

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b) opt out of the Network Contract DES in-year following the issue of a Network Contract DES Variation by NHS England in which case section 4.9.5 applies; and

c) opt out of any subsequent Network Contract DES (which means a Network Contract DES commencing on 1 April 2027) in accordance with section 4.9.6.

The circumstances in which each of the above can take place and the associated process are set out in sections 4.9.4, 4.9.5 and 4.9.6.

4.9.2. Where section 4.9.1a), 4.9.1 b) or 1.1.c) applies, the remaining Core Network Practices in the PCN will promptly discuss with the commissioner (and including the LMC, if relevant), the proposed date of opt out and the consequences of the opt out including:

a) whether the PCN with its amended membership meets the criteria for a PCN;

b) the likely consequences for the registered patients of the practice when that practice is no longer a Core Network Practice of the PCN;

c) changes to the Network Area;

d) any impact on the list of care homes for which the PCN will have responsibility pursuant to section 8.4 and any required adjustment to care home allocations across PCNs;

e) the effect on the financial entitlements of the PCN,

and the commissioner will determine the outcome of such matters.

4.9.3. With effect from the date agreed or, if not agreed, determined by the commissioner:

a) the opting out practice will no longer participate in the Network Contract DES;

b) in accordance with section 4.2.4b) the opting out practice's primary medical services contract will be deemed to have been varied to remove the incorporation of this Network Contract DES Specification;

c) the opting out practice will no longer be a Core Network Practice of the PCN; and

d) where the PCN remains approved, it must remove the opting out practice from the Network Agreement before any changes to the PCN, such as the Network Area, financial entitlements, etc. will take effect.

4.9.4. Opting out of this Network Contract DES

a) A Core Network Practice participating in the Network Contract DES may end its participation in this Network Contract DES by first notifying the commissioner prior to 30 April 2026 of its intention to opt out in accordance with section 4.4. Sections 4.4.8 and 4.4.9 will apply to the remaining Core Network Practices in

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the PCN to enable the commissioner to determine the extent to which the PCN with its amended membership meets the criteria for a PCN and therefore whether the participation in the Network Contract DES of the remaining Core Network is confirmed. As part of its consideration of the PCN, the commissioner will include the matters set out in section 4.9.2. Once the matters set out in section 4.9.2 are determined, section 4.9.3 will apply.

b) If a Core Network Practice does not notify the commissioner as set out in section 4.9.4, the Core Network Practice will continue to participate in this Network Contract DES. There is no option for the Core Network Practice to continue with a previous year's Network Contract DES Specification.

4.9.5. Opting out of an in-year Network Contract DES Variation

a) Where NHS England issues a Network Contract DES Variation, a Core Network Practice will automatically participate in that variation unless the Core Network Practice first notifies the commissioner of its intention to opt out of the Network Contract DES within 30 calendar days of the date of publication by NHS England of the Network Contract DES Variation.

b) If a Core Network Practice does not notify the commissioner in accordance with section 4.9.5 a), the Core Network Practice will automatically participate in the Network Contract DES Variation and the second sentence of section 4.2.5 will apply.

c) Where a Core Network Practice notifies the commissioner of its intention to opt out in accordance with section 4.9.5 a), section 4.9.2 will apply. Once the matters set out in section 4.9.2 are determined, section 4.9.3 will apply.

4.9.6. Opting out of any subsequent Network Contract DES

a) A Core Network Practice of a PCN may choose not to participate in any subsequent Network Contract DES (which means a Network Contract DES commencing on 1 April 2027) in which case that Core Network Practice must notify the commissioner of its intention to opt out and follow the process set out in any subsequent Network Contract DES Specification.

4.9.7. Ending participation in-year

a) There may be other situations, other than the opt out situations set out in section 4.9.1 in which a Core Network Practice's participation in the Network Contract DES, or its involvement in a PCN, may end:

i. expiry or termination of the Core Network Practice's primary medical services contract, in which case section 6.6 applies;

ii. there has been an irreparable breakdown in relationship or an expulsion, in which case section 6.7 applies;

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iii. the commissioner consents to a merger or split of the Core Network Practice, in which case section 6.8 applies;

iv. the commissioner determines that the Core Network Practice's participation in the Network Contract DES should cease in accordance with section 9.

b) Where a practice's participation in the Network Contract DES ends prior to 31 March 2027 as a result of any of the provisions of this Network Contract DES, then section 4.2.4 b) applies.

4.10 Local Variation Arrangements

4.10.1 A commissioner may submit to NHS England a written request for the establishment of a Local Variation Arrangement (a "Local Variation Arrangement Request") in accordance with paragraph 4.10.2.

4.10.2 A Local Variation Arrangement Request must:

a) identify the PCN(s) proposed to participate in the Local Variation Arrangement and either:

i) the Core Network Practice(s) proposed to participate in the Local Variation Arrangement; or

ii) where final evidence of participation is not yet available, the proposed participation threshold or other participation basis on which the request is made, together with such information as is available as to the proposed participating Core Network Practice(s);

b) identify the date from which the Local Variation Arrangement is proposed to apply (Local Variation Arrangements can only be proposed and approved for the current financial year);

c) specify the section(s) of this Network Contract DES Specification proposed to be varied, provided that a Local Variation Arrangement may vary only sections 7, 8 and 10.1 to 10.5 (inclusive);

d) specify the amendments to the PCN's Network Agreement that are proposed to be required for delivery of the Local Variation Arrangement;

e) set out the proposed interaction between the Local Variation Arrangement and any Network Contract DES Variation issued by NHS England during the period of the Local Variation Arrangement, including what is proposed to happen if a Network Contract DES Variation amends a section which is also proposed to be varied by the Local Variation Arrangement; and

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f) include the proposed variation wording and the rationale for the variations (including how the proposed variations support delivery of the Network Contract DES for the PCN's Patients)

4.10.3 NHS England may, upon receipt of a Local Variation Arrangement Request, request such further information relating to the proposed Local Variation Arrangement as appears to it to be reasonable and the commissioner must supply such information to NHS England promptly.

4.10.4 NHS England may, following consideration of a Local Variation Arrangement Request, decide whether to establish a Local Variation Arrangement or to establish a Local Variation Arrangement subject to conditions. NHS England may establish a Local Variation Arrangement only where the Local Variation Arrangement Request satisfies the criteria set out in the Network Contract DES Guidance.

4.10.5 Where NHS England decides to establish a Local Variation Arrangement, it must issue a written notice setting out the Local Variation Arrangement (a "Local Variation Notice"), which must:

g) identify the PCN(s) to which the Local Variation Arrangement applies and either:

i) the Core Network Practice(s) to which it applies; or

ii) where the final participating Core Network Practice(s) have not yet been confirmed, the proposed participation threshold or other participation basis by reference to which the Local Variation Arrangement is approved, pending confirmation of the final participating Core Network Practice(s) in accordance with paragraph 4.10.6;

h) specify the date from which it applies and the date (if any) on which it will cease to apply;

i) specify the interaction between the Local Variation Arrangement and any Network Contract DES Variation issued by NHS England during the period of the Local Variation Arrangement, including what is intended to happen if a Network Contract DES Variation amends a section which is also varied by the Local Variation Arrangement;

j) specify the section(s) of this Network Contract DES Specification which are varied by the Local Variation Arrangement and the manner in which they are to be varied, and specify any amendments to the PCN's Network Agreement that are required for delivery of the Local Variation Arrangement; and

k) specify any conditions which apply to the Local Variation Arrangement, including any condition which must be satisfied before it takes effect and any condition which must continue to be satisfied for so long as it remains in effect.

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4.10.6 Prior to the date upon which a Local Variation Arrangement is to take effect, the relevant commissioner must provide confirmation of the final participating Core Network Practice(s) and evidence that each such Core Network Practice has agreed to participate in the Local Variation Arrangement on the terms approved by NHS England.

4.10.7 If NHS England decides not to establish a Local Variation Arrangement, it must notify the commissioner in writing as soon as reasonably practicable and explain the reasons for its decision. Unless and until a Local Variation Notice is issued in accordance with paragraph 4.10.5, this Network Contract DES Specification shall apply without modification.

4.10.8 A Local Variation Arrangement must not vary any sections other than 7, 8 and 10.1 to 10.5 (inclusive) of this Network Contract DES Specification.

4.10.9 Where a Local Variation Arrangement is subject to conditions, it shall take effect only where any condition required for commencement is satisfied and shall remain in effect only for so long as any continuing condition remains satisfied. If a condition required for commencement is not satisfied, the Local Variation Arrangement shall not take effect. If a continuing condition ceases to be satisfied, the Local Variation Arrangement shall cease to have effect.

4.10.10 Where a Local Variation Arrangement applies to a Core Network Practice, that Core Network Practice must, as soon as practicable, enter into a written variation of its primary medical services contract with the commissioner to incorporate the Local Variation Notice and the modifications to this Network Contract DES Specification set out in the Local Variation Notice, for so long as the Local Variation Arrangement applies.

4.10.11 Where a Local Variation Arrangement applies to a PCN, the PCN must ensure that its Network Agreement is updated as soon as practicable to reflect the arrangements for delivery of the Local Variation Arrangement for so long as the Local Variation Arrangement applies.

4.10.12 Only the PCN(s) and Core Network Practice(s) identified in the Local Variation Notice are subject to the Local Variation Arrangement, except where the Local Variation Notice identifies a proposed participation threshold or other participation basis in accordance with paragraph 4.10.5(a)(ii), in which case the Local Variation Arrangement shall apply only to the PCN(s) and the Core Network Practice(s) confirmed in accordance with paragraph 4.10.6.

4.10.13 If and to the extent that a Network Contract DES Variation issued by NHS England during the period of a Local Variation Arrangement amends a section which is also varied by the Local Variation Arrangement and the Local Variation Notice does not specify the interaction required by paragraph 4.10.5(c), then from the effective date of the Network Contract DES Variation the Network Contract DES Variation shall prevail

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over the Local Variation Arrangement in respect of that provision unless and until NHS England issues an amended Local Variation Notice which expressly preserves the Local Variation Arrangement modification for the relevant PCN(s) and/or Core Network Practice(s).

5. PCN Organisational Requirements

5.1 Definition and criteria for a PCN

5.1.1. A PCN can be broadly defined as a practice or practices (and possibly other providers[10]) serving an identified Network Area with a minimum population of 30,000 people.

5.1.2. The criteria for a PCN are:

a) that the PCN has an identified Network Area that complies with the requirements set out in section 5.1.3;

b) that the PCN list size at 1 January 2026 is between 30,000 and 50,000 except that:

i. in exceptional circumstances, a commissioner may waive the 30,000 minimum PCN list size requirement where a PCN serves a natural community which has a low population density across a large rural and remote area; and

ii. a commissioner may waive the 50,000 maximum PCN list size requirement where it is satisfied that it is appropriate to do so. In such circumstances, the commissioner may require the Core Network Practices of the PCN to organise the PCN operationally into smaller neighbourhood teams that cover population sizes between 30,000 to 50,000 and the Core Network Practices will comply with such requirement. For the avoidance of doubt, the PCN will still be required to have one Nominated Payee;

c) that there is more than one Core Network Practice in the PCN except that there may only be one Core Network Practice if the commissioner is satisfied that this is appropriate having regard to all relevant factors. Where a PCN has only one Core Network Practice, the PCN must work with other providers as set out in section 8.5.1 to achieve the optimal benefits of PCN working;

d) that the PCN has a Nominated Payee;

[10] Examples of other providers - community (including community pharmacy, dentistry, optometry), voluntary, secondary care providers, social care - and GP providers who are not participating in the Network Contract DES.

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e) that the PCN has in place a Network Agreement signed by all PCNs members, that incorporates the mandatory provisions set out in the national template network agreement.[11,12]

f) that the PCN has at all times an accountable Clinical Director;

g) that the PCN has in place appropriate arrangements for patient record sharing in line with data protection legislation honouring patient opt-out preferences.[13,14]

5.1.3. The Network Area must:

a) satisfy the commissioner that the Network Area is sustainable for the future, taking account of how services are delivered by wider members of the PCN beyond the practices and with a view to the evolution of PCNs;

b) align with a footprint which would best support delivery of services to patients in the context of the relevant Integrated Care Board(ICB) strategy;

c) 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;

d) cover a geographically contiguous area;

e) 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 commissioner areas.

f) Where the commissioner, in partnership with the local authority, defines a neighbourhood around a natural community that does not fall within the PCN's Network Area, the PCN must work collaboratively with the commissioner to seek to achieve alignment between the Network Area, the list of PCN's Patients and that neighbourhood. This change is not intended to signal widespread

[11] 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.

[12] The Network Agreement template has been agreed between NHS England and GPC. The Network Agreement template can be found at https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-network-agreement/

[13] https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/how-we-look-after-your-health-and-care-information/your-information-choices/opting-out-of-sharing-your-confidential-patient-information

[14] Updated template data controller/data processer agreement and a template data controller/data controller agreement can be found at https://www.england.nhs.uk/gp/investment/gp-contract/network-contract-directed-enhanced-service-des/

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reconfiguration of PCNs. It is expected to apply only in limited circumstances and is designed as a pragmatic safety net where existing arrangements clearly do not reflect local communities.

5.1.4. Where a practice has one or more branch surgeries in different PCNs, the practice must ensure that it will be a Core Network Practice of only one PCN and a non-core member of the other PCN(s) within which the relevant branch surgeries are situated. The practice acknowledges that its list of patients will be associated with the PCN of which the practice is a Core Network Practice.

5.1.5. Where a PCN's Core Network Practices are situated within different commissioner areas, the relevant commissioners must agree which commissioner will be the 'lead' for the PCN and identified as such within 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.

5.2 General PCN organisational requirements

5.2.1. A PCN must ensure it remains compliant with the criteria of a PCN set out in section 5.1.2 at all times. A PCN must ensure its Network Agreement reflects the requirements of this Network Contract DES Specification.

5.2.2. Where a PCN is not compliant with the criteria of a PCN then, subject to any relevant processes set out in the Network Contract DES Specification, the commissioner may revoke the relevant Core Network Practice's participation in the Network Contact DES and section 1.1.b)4.2.4 b) will apply.

5.2.3. Where required by data protection legislation, a PCN must ensure each member of the PCN has in place appropriate data sharing arrangements and, if required, data processor arrangements[15], that are compliant with data protection legislation to support the delivery of all service requirements set out in this Network Contract DES prior to the provision of these services to patients.

5.2.4. A Previously Approved PCN must ensure that there is no interruption in provision of services in the transition from the previous year's Network Contract DES to this Network Contract DES. For the avoidance of doubt, this requires a Previously Approved PCN to provide all services under this Network Contract DES Specification from 1 April 2026.

[15] Updated optional data sharing agreement and data processing agreement can be found at https://www.england.nhs.uk/gp/investment/gp-contract/network-contract-directed-enhanced-service-des/

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5.2.5. The PCN acknowledges that where there are changes to the PCN's membership, confirmation of the Core Network Practices' participation in this Network Contract DES may not be received until after 1 April 2026. The PCN acknowledges that it must act in accordance with section 5.2.4 but the PCN acknowledges that section 10 sets out backdating of certain elements of the financial entitlements.

5.2.6. Except for a Network Contract DES Variation or a Local Variation Arrangement, a commissioner and a PCN must not vary this Network Contract DES Specification. For the avoidance of doubt, except as may be set out in a Network Contract DES Variation or a Local Variation Arrangement, a commissioner must not increase or reduce the requirements of the financial entitlements set out in this Network Contract DES Specification.

5.2.7. Where a commissioner commissions local services from the PCN that are supplemental to the Network Contract DES (referred to in this Network Contract DES Specification as "**Supplementary Network Services**")[16], the arrangements for such local Supplementary Network Services must not be included in a varied version of this Network Contract DES Specification and should instead be contained in a separate contractual arrangement. For the avoidance of doubt, a Local Variation Arrangement forms part of the Network Contract DES arrangements for the PCN(s) and/or Core Network Practice(s) to which it applies and is not a Supplementary Network Service for the purposes of this section.

5.3 PCN Clinical Director

5.3.1. A PCN must have in place a Clinical Director who is accountable, on behalf of member practices, for:

a) ensuring that the PCN delivers the requirements set out in this Network Contract DES for its registered population, including by:

i. effective allocation of funding and Additional Roles Reimbursement Scheme capacity across the Network to deliver the requirements of this Network Contract DES; and

b) working with local partners to support establishment of INTs and ensure PCN participation within its INT.

5.3.2. The Clinical Director must be:

a) a practicing clinician from within the PCN's Core Network Practices;

[16] Supplementary Network Services would be services commissioned locally, under separate arrangements and with additional resource, building on the foundation of the Network Contract DES. Further information regarding commissioning local services can be found in the Network Contract DES Guidance.

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b) able to undertake the responsibilities of the role and represent the needs of the PCN's patients;

c) able to develop relationships and work closely with other Clinical Directors, clinical leaders of other primary care, health and social care providers, local commissioners and LMCs.

5.3.3. A PCN must manage any conflicts of interest. A PCN must ensure that its Clinical Director takes a lead role in developing the PCN's conflict of interest arrangements, taking account of what is in the best interests of the PCN and its patients.

5.3.4. A PCN's appointment of a Clinical Director must follow a selection process either via appointment, election or both, details of which must be included in Schedule 1 of the Network Agreement.

5.4 Data, analytics and monitoring

5.4.1. A PCN must share non-clinical data between its members in certain circumstances. The data to be shared is the data required to:

a) support understanding and analysis of the population's needs;

b) support service delivery in line with local commissioner objectives; and

c) support compliance with the requirements of this Network Contract DES specification.

5.4.2. A PCN must determine appropriate timeframes for sharing of this data.

5.4.3. Where the functionality is available, a PCN should ensure that clinical data sharing for service delivery uses read/write access, so that relevant workforce from any practice can refer, order tests and prescribe electronically, and maintain a contemporaneous record for every patient.

5.4.4. A PCN must:

a) benchmark and identify opportunities for improvement;

b) identify variation in access, service delivery or gaps in population groups with highest needs; and

c) review capacity and demand management across the PCN, including sharing appointment and, where available, digital telephony data for the PCN to action (this could be achieved through using the GP workload tool or other similar tools), and the PCN must monitor, share and aggregate relevant data[17] across the Core Network Practices to enable it to carry out these requirements.

[17] Data sources include workload data, population data, appointment data, cost data, outcome data and patient experience data (e.g. friends and family test, GP patient survey).

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5.4.5. A commissioner and the wider system may support PCNs in the analysis of data.

5.4.6. Core Network Practices of a PCN must use the relevant SNOMED codes and other agreed approaches of capturing activity to support data collections for the indicators related to the Network Contract DES and other PCN activity.

5.4.7. The relevant SNOMED codes, as published in the supporting Business Rules[18], should be used within Core Network Practices' clinical systems to record activity as required under the Network Contract DES. Only those codes included in the supporting Business Rules will be acceptable to allow CQRS calculations. A PCN's Core Network Practices will therefore need to ensure that they use the relevant codes and if necessary, re-code patients. Further information is available in the Network Contract DES Guidance.

5.4.8. To support contract monitoring and PCN quality improvement efforts, a PCN's Core Network Practices agree to collection of data related to the Network Contract DES via the General Practice Extraction Service ("**GPES**") (or any subsequent replacement system), or other sources as required, and to manually input data into CQRS where required. The commissioner will monitor services and automated capitation payments as set out in the Specification will be made as via PCSE Online.

5.4.9. The PCN must 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 Additional Roles (as defined in section 7.1.2) agreed with the commissioner in accordance with section 7.3.2.

5.4.10. The PCN must appropriately code, review and update data required for the Workforce Minimum Dataset at least monthly, in accordance with the standards set out in guidance published by NHS England[19] and must make the data available for collection by submitting the data using the data entry module on the National Workforce Reporting Service ("**NWRS**")[20].

5.4.11. Core Network Practices and PCNs must participate in the General Practice Staff Survey ("**GPSS**"). The PCN must nominate a key contact who is responsible for providing the commissioner with the email addresses of all eligible PCN staff, so that they can be issued a personalised survey link. The PCN must ensure that the contact details supplied include the email addresses of staff employed by Core Network Practices, staff employed by the PCN (if applicable), and all Additional

[18] The applicable SNOMED codes are available in the relevant business rules under the relevant years 'Enhanced Services, Vaccinations and Immunisations and Core Contract components' page.

[19] https://digital.nhs.uk/data-and-information/areas-of-interest/workforce/national-workforce-reporting-service-nwrs/support

[20] https://datacollection.sdcs.digital.nhs.uk

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Roles, including where those Additional Roles are employed by third party organisations.

5.5 Patient engagement

5.5.1. A PCN must act in accordance with the requirements relating to patient engagement under the PCN's Core Network Practice's primary medical services contracts by:

a) engaging, liaising and communicating with the PCN's Patients in the most appropriate way;

b) informing and/or involving them in developing new services and changes related to service delivery; and

c) engaging with a range of communities, including 'seldom heard' groups.

5.5.2. A PCN must provide reasonable support and assistance to the commissioner in the performance of its duties[21] to engage patients in the provision of and/or reconfiguration of services where applicable to the PCN's Patients.

5.6 Sub-contracting arrangements

5.6.1. Where a PCN (or any one or more of its members which are practices) is considering sub-contracting arrangements related to the provision of services under the Network Contract DES[22], the PCN must have due regard to the requirements set out in the statutory regulations or directions that underpin each Core Network Practices' primary medical services contracts in relation to sub-contracting, which will also apply to any arrangements to sub-contract services under the Network Contract DES.

5.6.2. A PCN acknowledges that its members that are practices may be required under their primary medical services contract to notify the commissioner, in writing, of their intention to sub-contract as soon as reasonably practicable and before the date on which the sub-contracting arrangement is intended to begin.

5.6.3. A PCN (and its members that are practices) must make available on request from the commissioner any information relating to sub-contracting arrangements and reporting information relating to either the delivery of network services or the engagement of PCN staff, for which reimbursement is being claimed under the Network Contract DES.

5.6.4. Notwithstanding any provision to the contrary of a PCN Core Network Practices' primary medical services contract, a Core Network Practice may sub-contract any

[21] Sections 14Z36 and 14Z45 of the NHS Act 2006.

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

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of its rights or duties under the Network Contract DES in relation to non-clinical matters provided that the Core Network Practice obtains prior written approval from the commissioner (such approval to not be unreasonably withheld or delayed).

5.6.5. Where a Core Network Practice of a PCN has sub-contracted a non-clinical matter that relates to the Network Contract DES, the sub-contract may allow the sub-contractor to sub-contract the non-clinical matter provided that the Core Network Practice obtains prior written approval from the commissioner (and such approval will not be unreasonably withheld or delayed).

6. Changes to a PCN

6.1 Circumstances in which PCN changes can take place

6.1.1. A PCN acknowledges that:

a) it was approved; and

b) its Core Network Practices' participation in the Network Contract DES was confirmed,

on the basis of the information provided to the commissioner.

6.1.2. A PCN must ensure the information held by the commissioner in relation to its Previously Approved PCN is at all times accurate and up to date.

6.1.3. Where a PCN is minded to change that information, it must act in accordance with the appropriate section of this Network Contract DES Specification.

6.2 Clinical Director change

6.2.1. Where a PCN wishes to change its clinical director, it is required to notify the commissioner of the identity of the new clinical director as soon as reasonably practicable following the change.

6.3 Nominated Payee / PCN bank account change

6.3.1. A PCN must obtain the prior written consent of the commissioner to any change in the identity of its Nominated Payee.

6.3.2. The PCN must provide to the commissioner the identity of the organisation of the proposed Nominated Payee and provide such information as required by the commissioner.

6.3.3. Where the commissioner is satisfied that all necessary information has been provided:

a) it shall provide its written consent to the PCN; and

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b) complete the PCN ODS Change Instruction Notice[23].

6.3.4. The commissioner must also ensure this information aligns to the information contained within the relevant GP payment systems and where appropriate must notify PCSE of PCN bank account changes via the appropriate form[24]

6.3.5. The change will take effect on the first day of the month following the month in which the commissioner gave consent and completed the PCN ODS Change Instruction Notice provided that the commissioner submitted the notice by the last working day on or before the 14th day of that month. If submission was later in the month, the change will take effect on the first day of the month following the subsequent month.

6.4 Change in non-Core Network Practice members

6.4.1. Where a PCN changes its non-Core Network Practices members it is not required to notify the commissioner or obtain the commissioner's prior written consent, but it is required to ensure that its Network Agreement reflects the change of members.

6.5 Change in Core Network Practice members

6.5.1. A PCN acknowledges that a practice participating in the Network Contract DES cannot end its participation in the Network Contract DES except as set out in section 4.9. The process for changing Core Network Practice members is separate from the process of a practice ending its participation in the Network Contract DES but there may be situations in which a change is a result of a practice ending its participation.

6.5.2. Once a PCN has been approved in line with the process set out section 4.4 or section 4.9 if relevant, changes to Core Network Practices of the PCN will only be allowed in the exceptional circumstances set out in sections 6.6 to 6.9.

6.5.3. Where a PCN requests consent for a change to its Core Network Practices members due to one of the exceptional circumstances set out in sections 6.6 to 6.9, the PCN will act in accordance with the process set out in the relevant section. A PCN must obtain the prior written consent of the commissioner to any changes of its Core Network Practice members.

6.5.4. A commissioner must, as part of its consideration of the proposed change, ensure that the PCN will at all times satisfy the criteria of a PCN set out in section 5.1. If, the commissioner determines that a PCN does not satisfy the criteria, then the commissioner will allow a Core Network Practice of that PCN to join another Previously Approved PCN (subject to that PCN continuing to satisfy the criteria). If,

[23] The PCN ODS Change Instruction Notice is available here
[24] Change of bank account information - Primary Care Support England

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as a result of any of the circumstances listed in this section 6, a practice that was a Core Network Practice seeks to join a Previously Approved PCN but the Previously Approved PCN is unwilling to enable the practice to be a Core Network Practice of the PCN, then sections 4.6.2 to 4.6.7 apply. If a Core Network Practice cannot join a Previously Approved PCN then section 5.2.2 applies.

6.5.5. A PCN seeking to change its Core Network Practices members must provide to the commissioner details of its view of the impact (if any) of the change on the PCN's baseline for the Additional Roles Reimbursement Scheme[25]. As part of its consideration of the proposed change, the commissioner will seek to agree with the PCN the change (if any) to the PCN's baseline for the Additional Roles Reimbursement Scheme.

6.5.6. A PCN must promptly provide any information required by the commissioner in relation to the change in Core Network Practice membership.

6.5.7. The commissioner will record a PCN's Core Network Practice members via NHS England's Organisation Data Service ("**ODS**"). Where the commissioner consents to a change, the commissioner must, before the end of the month in which it gives consent, complete the PCN ODS Change Instruction Notice[26]. The commissioner must submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month. The commissioner must also ensure this information aligns to the information contained within the relevant GP payment systems. These relevant systems will be updated with the instructed changes via automated notification processes.

6.5.8. The change will take effect on the first day of the month following the month in which the commissioner gives consent and completes the PCN ODS Change Instruction Notice[27] provided that the commissioner submits the notice by the last working day on or before the 14th day of that month. If submission was later in the month, the change will take effect on the first day of the month following the subsequent month.

6.5.9. The PCN must ensure the Network Agreement is updated as soon as reasonably practicable following the change taking effect.

6.6 Change in Core Network Practice membership due to contract expiry/termination

6.6.1. Where the primary medical services contract of a Core Network Practice of a PCN expires or terminates for any reason prior to 31 March 2027, then that Core

[25] Refer to section 7.2 for details of baselines.
[26] The PCN ODS Change Instruction Notice is available here.
[27] The PCN ODS Change Instruction Notice is available here.

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Network Practice's participation in the Network Contract DES will cease from the date of expiry/termination. In such circumstances:

a) the Core Network Practices of a PCN must, as soon as they are aware of the possibility of a practice no longer being a Core Network Practice of the PCN, notify the commissioner.

b) The commissioner will consider the matter, including holding discussions with all practices within the PCN.

c) The commissioner will consider the consequences of the practice no longer being a Core Network Practice of the PCN. This will include:

   i. the likely consequences for the registered patients of the practice when that GP practice is no longer a Core Network Practice of the PCN;

   ii. the viability of the PCN including reference to the criteria of a PCN set out in section 5.1.2; and

   iii. the impact of any consequences on the financial entitlements set out in this Network Contract DES Specification.

   iv. The commissioner will, depending on the likely consequences and following any discussion with the LMC, determine the outcome of such matters including, if relevant, any changes to the information of the PCN such as changes to the Network Area and/or level of payments due to the PCN under this Network Contract DES specification.

6.6.2. The commissioner may, depending on the likely consequences and at its discretion, determine that where there is a significant influx of new patients registering with a Core Network Practice of a PCN, it is appropriate for payments that are based on practice list size or PCN list size to be based on practice list size or PCN list size as at a date that is more recent than 1 January 2026.

6.6.3. From the date of the expiry or termination of the relevant practice's primary medical services contract:

a) the practice will no longer participate in the Network Contract DES;

b) the practice will no longer be considered a Core Network Practice of the PCN;

c) the PCN must remove that practice from the Network Agreement with effect from that date; and

d) the commissioner must complete and submit the PCN ODS Change Instruction Notice[28].

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

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6.7 Change in Core Network Practice membership due to an irreparable breakdown in relationships or expulsion

6.7.1. Where there is an irreparable breakdown in relationships in respect of a Core Network Practice within a PCN such that the other members of the PCN are minded to expel the Core Network Practice from the PCN, the PCN must first notify the commissioner.

6.7.2. The commissioner will consider the matter, including holding discussions with all practices within the PCN.

6.7.3. The commissioner will consider the consequences of the practice being expelled from the PCN. This will include:

a) the likely consequences for the registered patients of the practice of that practice being expelled from the PCN, i.e. whether that practice can join another PCN;

b) the impact of any consequences on the financial entitlements of the Network Contract DES of the PCN which the practice would be expelled from and that of any PCN the practice may seek to join. It is acknowledged that for payments based on practice list size or PCN list size, the consequence of a practice being expelled from a PCN is likely to be a reduction in the level of payments made to a PCN;

c) the viability of the PCN including reference to the criteria of a PCN set out in section 5.1.2; and

d) any other relevant matters.

6.7.4. The commissioner will, having regard to the likely consequences and any discussion with the LMC, determine the outcome of such matters including whether it consents to any changes to the information of any affected PCN including but not limited to changes to the Core Network Practices, Network Area, Nominated Payee and/or level of payments.

6.7.5. Where, following the process set out in this Network Contract DES Specification, a Core Network Practice is expelled from a PCN, then, from the date the practice leaves the PCN:

a) the practice will no longer be considered a Core Network Practice of the PCN;

b) the PCN must remove that practice from the Network Agreement with effect from that date; and

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c) the commissioner must complete and submit the PCN ODS Change Instruction Notice[29].

6.8 Change in Core Network Practice membership due to practice merger/split

6.8.1. Where:

a) two or more Core Network Practices intend to merge and the resulting single practice intends to be a Core Network Practice of the same PCN; or

b) two or more practices intend to be formed from the split of a single Core Network Practice and the resulting practices intend to be Core Network Practices of the same PCN,

the PCN acknowledges that the prior written consent of the commissioner is required for both the merger/split and any resulting changes to the information of the PCN.

6.8.2. The commissioner will consider the application for merger or split and, as part of that consideration, will consider the consequences (if any) on the practice's or practices' membership of the PCN.

6.8.3. The commissioner may require any information from the New Practice formed from a merger/split as a result of the practice remaining with the PCN. The New practice formed from the merger/split will promptly provide such information to the commissioner, including where required with the other members of the PCN. The commissioner will consider this information before indicating to the New Practice whether its participation in the Network Contract DES is confirmed.

6.8.4. Where the commissioner consents to the type of change set out in section 6.8.1 the commissioner acknowledges that, for the purposes of this Network Contract DES, payments due under the Network Contract DES will continue to be made in accordance with this Network Contract DES Specification.

6.8.5. Where the commissioner consents to the type of change set out in section 6.8.1, the commissioner must, before the end of the month in which it gives consent, complete the PCN ODS Change Instruction Notice[30]. The commissioner must submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month. The commissioner must also ensure this information aligns to the information contained within the relevant GP payment systems.

6.8.6. Where:

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

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a) two or more Core Network Practices of a PCN intend to merge and the resulting single practice does not intend to be a Core Network Practice of the same PCN; or

b) two or more practices intend to be formed from the split of a single Core Network Practice and either one or both of the resulting practices do not intend to be Core Network Practices of the same PCN,

the PCN and the practices acknowledge that the prior written consent of the commissioner is required for both the merger/split and any resulting changes to the information of the PCN and any other related PCN.

6.8.7. The commissioner will consider the application for merger or split and, as part of that consideration, will consider the consequences on the practice's or practices' membership of the PCN or other PCNs.

6.8.8. The commissioner's consideration of the consequences of any merger/split on PCN membership will include:

a) the likely consequences for the registered patients of the practice(s);

b) the impact of any consequences on a PCN's financial entitlements due under this Network Contract DES Specification;

c) whether, if consent for the change was provided, any relevant PCN would satisfy the criteria for a PCN set out in section 5.1.2.

6.8.9. Where a Core Network Practice is subject to a split or a merger and:

a) the application of sections 6.8.1 to 6.8.8 in respect of splits or mergers would, in the reasonable opinion of the commissioner, lead to an inequitable result; or

b) the circumstances of the split or merger are such that sections 6.8.1 to 6.8.8 cannot be applied,

the commissioner will consider the resulting effect on the PCN as part of its consideration of the application for merger/split and make a determination on both matters.

6.8.10. Where the commissioner consents to any changes to the details of a PCN as a result of sections 6.8.8 or 6.8.9, the commissioner must complete the PCN ODS Change Instruction Notice[31]. The commissioner must submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month. The commissioner must also ensure this information aligns to the process contained within the relevant GP payment systems and that any required bank account changes are notified to PCSE via the appropriate form[32].

[31] The PCN ODS Change Instruction Notice is available here.
[32] Change of bank account information - Primary Care Support England

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6.9 Change in Core Network Practice membership due to a PCN merger

6.9.1. Where:

a) all Core Network Practices of two or more Previously Approved PCNs intend to merge to form a new PCN; or

b) all the Core Network Practices of two or more Previously Approved PCNs intend to merge via all the Core Network Practices of one Previously Approved PCN joining the other Previously Approved PCN,

the PCN acknowledges that the prior written consent of the commissioner is required for the merger and any resulting changes to the information of the new or surviving PCN.

6.9.2. A PCN seeking to change its Core Network Practices via a PCN merger must provide to the commissioner:

a) the names and ODS codes[33] of the proposed PCN's Core Network Practices[34];

b) the number of the PCN's Patients at 1 January 2026[35];

c) a map clearly marking the geographical area covered by the Network Area of the proposed PCN;

d) the Nominated Payee[36] and details of the relevant bank account that will receive funding on behalf of the PCN;

e) the identity of the accountable Clinical Director;

f) the list of care homes for which each PCN has responsibility pursuant to section 8; and

g) details of its view of the impact (if any) of the change on the PCN's baseline for the Additional Roles Reimbursement Scheme[37]. As part of its consideration of the proposed change, the commissioner will seek to agree with the PCN the change (if any) to the PCN's baseline for the Additional Roles Reimbursement Scheme.

6.9.3. The commissioner will consider the application for PCN merger and, as part of that consideration, will consider the consequences (if any) on the practice's or practices' membership of the PCN and the aligned care homes. A commissioner must, as part

[33] https://digital.nhs.uk/services/organisation-data-service

[34] This may be a single super practice.

[35] This can be obtained by aggregating the number of persons on the lists of patients for all Core Network Practices as recorded in the registration system approved by NHS England.

[36] Payment nomination would only apply where there is more than one primary medical care contractor in the PCN.

[37] Refer to section 7.2 for details of baselines.

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of its consideration of the proposed change, ensure that the PCN will at all times satisfy the criteria set out in section 5.1.

6.9.4. Where the commissioner consents to the type of change set out in section 6.9.1 the commissioner acknowledges that, for the purposes of this Network Contract DES, payments due under the Network Contract DES will continue to be made in accordance with this Network Contract DES Specification.

6.9.5. Where the commissioner consents to the type of change set out in section 6.9.1, the commissioner must, before the end of the month in which it gives consent, complete the PCN ODS Change Instruction Notice[38]. The commissioner must submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month. The commissioner must also ensure this information aligns to the information contained within the relevant GP payment systems.

6.9.6. The change will take effect on the first day of the month following the month in which the commissioner gives consent and completes the PCN ODS Change Instruction Notice[39] provided that the commissioner submits the notice by the last working day on or before the 14th day of that month. If submission was later in the month, the change will take effect on the first day of the month following the subsequent month.

6.9.7. The PCN must ensure and confirm prior to service delivery that the practices:

a) have signed a new or updated Network Agreement as soon as reasonably practicable following the change taking effect;

b) agree that payments under the Network Contract DES are made to the PCN's Nominated Payee;

c) will have in place patient record sharing arrangements (as clinically required) and data sharing arrangements of the PCN, in line with data protection legislation and patient opt-out preferences, prior to the start of any service delivery under the Network Contract DES;

d) have notified and engaged with any non-core members of the PCN accordingly,

and have updated any sub-contracting arrangements accordingly.

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

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7. Additional Roles Reimbursement Scheme

7.1 General

7.1.1. A PCN is entitled to funding as part of the Network Contract DES to support the recruitment of new additional staff to deliver health services.

7.1.2. The new additional staff recruited by a PCN or provided under contract as a service from a third-party organisation are referred to in this Network Contract DES Specification as "**Additional Roles**" and this element of the Network Contract DES is referred to as the "**Additional Roles Reimbursement Scheme**".

7.1.3. Where the Additional Role is provided by a third-party organisation under a contract of service:

a) the PCN must ensure that the specification of the service incorporates the requirements set out in Annex B;

b) any obligation in section 7.4.1 and Annex B of the PCN should be read as an obligation that the PCN must procure that the third-party organisation carries out that obligation.

7.2 Principle of additionality

7.2.1. To receive the associated funding, a PCN must show that the staff delivering health services for whom funding is requested, i.e. the Additional Roles, comply with the principle of "additionality". Sections 7.2.2 to 7.2.11 below set out how additionality is measured.

7.2.2. Additionality will be measured on a baseline of staff supporting a GP practice as taken at 31 March 2019 against six of the reimbursable staff roles – clinical pharmacists, social prescribing link workers, first contact physiotherapists, physician assistants (also known as physicians associates), pharmacy technicians and paramedics. Two baselines were established[40] during 2019 as follows:

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 at 31 March 2019. The PCN baseline will be fixed until 31 March 2027.

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

[40] See Network Contract DES: Additional Roles Reimbursement Scheme Guidance 2019/20 for further information.

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care services - either in a specific practice or in the wider community - funded[41] by the CCG at 31 March 2019 (regardless of whether funded due to direct CCG employment or through a contract). Any administration, 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 to ensure the funding is maintained.

7.2.3. Subject to section 7.2.4 below, a PCN's Core Network 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. In the event the PCN baseline reduces (meaning a vacancy arises in a Core Network Practice's baseline WTE) during the period 1 April 2020 to 31 March 2027, then the PCN will be subject to an equivalent WTE reduction in workforce funding under the Network Contract DES Additional Roles Reimbursement Scheme. The equivalent WTE reduction will be applicable from three months after the date at which the vacancy arose, resulting in a PCN baseline reduction, subject to the post not having been filled within this period and in accordance with section 10.

7.2.4. With the agreement of the commissioner, which will not be unreasonably withheld, a PCN will be able to substitute between clinical pharmacists, first contact physiotherapists, physician assistants (also known as physician associates) and paramedics within the PCN baseline. Where agreement to a substitution has taken place, the PCN will not be subject to an equivalent WTE reduction in workforce funding under the Network Contract DES Additional Roles Reimbursement Scheme.

7.2.5. A PCN is required to demonstrate that claims being made are for new additional staff roles beyond this baseline (including in future years, replacement as a result of staff turnover). The commissioner must be assured that claims meet the additionality principles above.

7.2.6. 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, advanced practitioners (including advanced practitioner nurses), general practice assistants, digital and transformation leads, apprentice physician assistants, enhanced practice nurses, new to general practice nurses, experienced general practice nurses, consultant nurses primary care, healthcare support workers, other direct patient care staff or other non-direct patient care staff (excluding those roles listed in section 7.2.2). While the PCN baseline will not include these roles, the additionality principles will still apply as per the additionality principles above. For the avoidance of doubt, this

[41] The six reimbursable roles funded include those directly employed by a commissioner or NHS England.

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means that a PCN acknowledges that where it claims reimbursement in respect of these roles, the PCN is confirming that:

a) the reimbursement is for additional staff engaged or employed since 31 March 2019 and:

   i. in the case of GPs, those to which section 7.3.8 of this Network Contract DES Specification applies;

   ii. in the case of new to general practice nurses, experienced general practice nurses, consultant nurses primary care and health support workers, then those engaged or employed since 1 April 2025, save where reimbursement is permitted under paragraph 7.3.9; and

b) the reimbursement is not being used to subsidise practice-funded roles that existed as at 31 March 2019 or:

   i. in the case of GPs, those for which a claim cannot be made as set out in section 7.3.8 of this Network Contract DES Specification; or

   ii. in the case of new to general practice nurses, experienced general practice nurses, consultant nurses primary care and health support workers, then those that existed prior to 1 April 2025, save where reimbursement is permitted under paragraph 7.3.9.

7.2.7. A failure to submit information or the provision of inaccurate workforce information is a breach of the Network Contract DES Specification and may result in commissioners withholding reimbursement pending further enquires in accordance with section 10.2. Reimbursement claims will be subject to validation and any suspicion that deliberate attempts have been made to subvert the additionality principles will result in a referral for investigation as potential fraud.

7.2.8. A PCN that engages new Additional Roles within the reimbursable roles after 31 March 2019 (i.e. above the baseline set and to meet additionality principles) will be eligible for reimbursement under the Network Contract DES, if those new Additional Roles are delivering the services across the PCN and if the PCN meets the requirements set out in this Network Contract DES specification.

7.2.9. Clinical pharmacists previously employed via the national *Clinical Pharmacist in General Practice Scheme* or those clinical pharmacists or pharmacy technicians employed via the *Medicines Optimisation in Care Homes Scheme* ("**MOCH**")[42] transferred to become PCN staff will be exempt from the additionality principles. For this exemption to apply:

[42] This will include any pharmacy technicians currently funded by ICBs.

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a) clinical pharmacists previously employed via the national *Clinical Pharmacist in General Practice Scheme* must have either:

   i. been in post on 31 March 2019 and been transferred to become PCN staff by 31 March 2020 in line with the requirements set out in this Network Contract DES Specification[43]; or

   ii. been in post on the scheme on 31 March 2021, become PCN staff by 30 September 2021 in line with the requirements set out in this Network Contract DES Specification, and the post be included in the PCN baseline established as at 31 March 2019, and

b) clinical pharmacists and pharmacy technicians previously employed under the MOCH Scheme, must have either:

   i. transferred no later than 31 March 2021 under the relevant requirements for clinical pharmacists or pharmacy technicians within the Network Contract DES Specification that applied to the period 1 April 2020 to 31 March 2021; or

   ii. been in post on the scheme on 31 March 2021, become PCN staff by 30 September 2021, and the post be included in the PCN baseline established as at 31 March 2019.

7.2.10. Where MOCH pharmacists did not transfer before 30 September 2021, the commissioner is required to align the work objectives of the CCG commissioned MOCH team to that of the Enhanced Health in Care Homes service requirements outlined in this Network Contract DES Specification.

7.2.11. The Additional Roles may be employed by a member of the PCN, or another body (e.g. GP Federation, voluntary sector provider, Local Authority or Trust). If the PCN chooses to commission the health services provided by the Additional Roles from another body, outside of the PCN, which therefore employs the staff, this does not change the general position that the PCN and its Core Network Practices are responsible for ensuring that the requirements of the Network Contract DES are delivered. The PCN is responsible for ensuring that all costs (including any applicable taxes which may include VAT) are met by one or other of the parties to any arrangements the PCN has for obtaining a health service from another body.

7.3 Additional Roles Reimbursement Sum

7.3.1. A PCN must act in accordance with the requirements set out in this section 7 in respect of the Additional Roles and the arrangements in section 10 to receive reimbursement from within a maximum allocated sum. This sum is referred to in this

[43] Full details on the transfer arrangements for clinical pharmacists is available in the 2019/20 Network Contract DES Guidance.

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Network Contract DES Specification as the "**Additional Roles Reimbursement Sum**".

7.3.2. From within the allocated Additional Roles Reimbursement Sum, a PCN may claim reimbursement for Additional Roles, in accordance with the terms set out in this section 7.3, section 10, and Tables 2, 3a, or 3b.

7.3.2-A From within the allocated Additional Roles Reimbursement Sum, the PCN may also recruit other direct patient care, non-nurse, and non-doctor Multi-Disciplinary Team ("**MDT**") roles, if agreed with the commissioner.

7.3.2-B When considering a role proposed by the PCN pursuant to section **Error! Reference source not found.**, a commissioner may require that the PCN provides information to assure the commissioner that the role:

a) is additional to those already working in the PCN's practices;

b) is demonstrably different to other roles available for reimbursement through the Additional Roles Reimbursement Scheme;

c) has a clear scope of practice and appropriate training to support its delivery;

d) fits with local care pathways/services and does not duplicate existing provision save where the PCN can demonstrate a clear local need for the role; and

e) is being reimbursed at a rate that is commensurate with its scope of practice up to a maximum Band 8c and where so required, the PCN will promptly provide such information to the commissioner. In considering requests for these roles, the commissioner should also consider local workforce supply, and methods to mitigate any issues caused by low supply of staff.

7.3.2-C From within the allocated Additional Roles Reimbursement Sum, the PCN may also recruit other non-direct patient care roles if agreed with the commissioner.

7.3.2-D When considering a role proposed by the PCN pursuant to section 7.3.2-C, a commissioner may require that the PCN provides information to assure the commissioner that the role:

a) is additional to those already working in PCN's practices;

b) is demonstrably different to other roles available for reimbursement through the Additional Roles Reimbursement Scheme;

c) has a clear scope of practice and appropriate training to support its delivery;

d) fits with local care pathways/services and does not duplicate existing provision save where the PCN can demonstrate a clear local need for the role; and

e) is being reimbursed at a rate that is commensurate with its scope of practice up to a maximum Band 8c and where so required, the PCN will promptly provide such information to the commissioner. In considering requests for these roles,

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the commissioner should also consider local workforce supply, and methods to mitigate any issues caused by low supply of staff.

7.3.3. A PCN may claim reimbursement for the adult mental health practitioner ("**MHP**") service from within the allocated Additional Roles Reimbursement Sum for 2026/27 and in accordance with the terms set out in this section 7.3, section 10 and Tables 3a and 3b. PCNs are able to claim:

- 50 per cent reimbursement for the first MHP recruited, with the remaining 50 per cent funded by the local community mental health provider; and
- up to 100 per cent reimbursement for subsequent MHPs, where there is a written agreement between the PCN's local community mental health provider and the PCN outlining this approach, the activities the MHP will support the relevant supervision arrangements, and the commissioner supports this arrangement.

7.3.4. In all instances, the adult MHPs will be employed or engaged under a suitable arrangement by the PCN's local community mental health provider which will provide the adult MHP service to the PCN in accordance with the local agreement to deliver the relevant service requirements set out in Annex B. All MHP roles will be expected to support community mental health transformation initiatives and patients with complex mental health needs.

7.3.5. There is no upper limit on numbers of adult MHPs that can be recruited, where the PCN and the PCN's local community mental health provider agree, with discussions supported by the commissioner's primary care and mental health teams.

7.3.6. The PCN and community mental health provider may additionally agree to the provision of a service to support children and young people's ("**CYP**") mental health. Where this is agreed locally, the PCN will be entitled to claim reimbursement, the level of which is to be agreed with the commissioner, for the provision of the CYP MHP service from within the allocated Additional Roles Reimbursement Sum and in accordance with the terms set out in this section 7.3, section 10 and Table 3b. Any one or more CYP MHP will be employed or engaged under a suitable arrangement by the PCN's local community mental health provider which will provide the CYP MHP service to the PCN in accordance with the local agreement.

7.3.7. A PCN may claim reimbursement for Advanced Practitioners from within the allocated Additional Roles Reimbursement Sum and in accordance with the terms set out in this section 7.3, and section 10.

7.3.8. A PCN may claim reimbursement for General Medical Practitioners from within the Additional Roles Reimbursement Sum and in accordance with the terms set out in this section 7.3, section 10 and Table 3c. A PCN may not claim reimbursement for

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a General Medical Practitioner who has been substantively employed as a General Medical Practitioner in a Core Network Practice of the PCN in the previous 12 months. That restriction does not apply where the General Medical Practitioner is transferring into the Additional Roles Reimbursement Scheme from a post which, immediately before that transfer, was funded through the Capacity and Access Payment under a previous year's Network Contract DES or through NHS England's PCN Test Site programme. A General Medical Practitioner is not considered to have been substantively employed if they were engaged or employed on a temporary basis (e.g. to cover maternity or sickness leave). Where the PCN has been claiming for General Medical Practitioners that complied with the claiming requirements for General Medical Practitioners set out in the previous year's Network Contract DES Specification, and the relevant General Medical Practitioner continues to be employed, the PCN can continue to claim in respect of that General Medical Practitioner.

7.3.9. A PCN may claim reimbursement for new to general practice nurses and experienced general practice nurses from within the Additional Roles Reimbursement Sum, and in accordance with the terms set out in this section 7.3, section 10 and Table 2. A PCN may not claim reimbursement for a new to general practice nurse or an experienced general practice nurse who has held a post in the PCN, or any practice within the PCN, within the previous 12 months, unless the new to general practice nurse or experienced general practice nurse is being recruited to a specialist or more senior nursing role. That restriction does not apply where the new to general practice nurse or experienced general practice nurse is transferring into the Additional Roles Reimbursement Scheme from a post which, immediately before that transfer, was funded through the Capacity and Access Payment under a previous year's Network Contract DES or through NHS England's PCN Test Site programme.

7.4 Additional Role requirements

7.4.1. To ensure satisfactory provision of health services, a PCN must comply with the following requirements in relation to any Additional Roles:

a) Additional Roles must:

i. be embedded within the PCN's Core Network Practices and be fully integrated within the multi-disciplinary team delivering healthcare services to patients;

ii. have access to other healthcare professionals, electronic 'live' and paper-based record systems of the PCN's Core Network Practices, as well as access to admin/office support and training and development as appropriate;

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iii. have access to appropriate clinical supervision and administrative support; and

iv. whether the arrangements are through direct employment or engaged via a service contract from a third party, they must be intended for a minimum of six months, unless the purpose is to provide temporary cover (e.g. sickness or parental leave) for an individual employed through the Additional Roles Reimbursement Scheme.

b) The PCN must consider the appropriateness of, and if considered appropriate, the PCN must (whichever is relevant) either carry out or input to, a review and appraisal process for Additional Roles.

c) The PCN must ensure that any Additional Roles comply with the minimum role requirements set out in Annex B of this Network Contract DES Specification to be eligible for the Additional Roles Reimbursement Sum. A PCN may build upon the requirements set out in Annex B of this Network Contract DES Specification in relation to any Additional Role job/service description.

d) The PCN must ensure the PCN's approach to deploying the Additional Roles is set out in the Network Agreement.

7.4.2. A PCN must inform the commissioner as soon as reasonably practicable where any change to its Additional Roles arrangements will have an impact on the payments being claimed (for example changes in WTE or new starters).

7.4.3. A PCN must record information on its Additional Roles, whether those Additional Roles are employed by the PCN itself or by another body, and including its Clinical Director, in the PCN module of the NWRS in line with the existing or updated requirements for general practice staff.

7.4.4. In accordance with section 5.4.11, a PCN must ensure that all Additional Roles are able to participate in the GPSS as required within section 5.4.11. Where an Additional Role is employed by a third-party organisation, the PCN must ensure that the employer provides the email address of that individual to the PCN's key contact, nominated in accordance with section 5.4.11, for the purpose of administering the survey.

7.5 PCN Additional Roles planning

7.5.1. By 31 October 2026, a PCN must complete and return to the commissioner a workforce plan in the form required by the commissioner, providing details of its updated plans for 2026/27.

7.5.2. The commissioner must explore different ways of supporting the PCN to implement the workforce plan through:

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a) offering staff support to the PCN to help with coordinating and undertaking recruitment and/or engagement exercises;

b) offering collective or batch recruitment across PCNs;

c) brokering arrangements to support full-time direct employment of staff by community partners, or to support rotational working across acute and community providers; and

d) ensuring the NHS workforce plans for the local system are helpful in supporting PCN's workforce plan.

7.6 Cover reimbursement arrangements for General Medical Practitioners employed via the Additional Role Reimbursement Scheme

7.6.1. Where a General Medical Practitioner is employed via the Additional Role Reimbursement Scheme:

a) they will have rights to time off for maternity leave, paternity leave, adoption leave, parental leave, neo-natal care leave, and shared parental leave, if they satisfy the relevant entitlement conditions under employment legislation for those types of leave;

b) if they qualify for it, be entitled to statutory sick pay for 28 weeks of absence on account of sickness in any three years;

c) if they are suspended from the medical performers list, they may be entitled to payments directly from NHS England. This is covered by a separate determination made under regulation 13(1) of the Performers Lists Regulations;

d) they may be entitled to take Prolonged Study Leave.

7.6.2. During any of the absences in section 7.6.1 any relevant payments may be made:

a) where the General Medical Practitioner is employed by a PCN member, in accordance with the applicable SFE; or

b) otherwise, where the General Medical Practitioner is employed by a Third-party Organisation (as defined in Annex E), and in respect of whom the SFE does not enable any right of payment, in accordance with Annex E.

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8. Service Requirements

8.1 Core PCN service requirements

8.1.1. A PCN has four key functions:

a) co-ordinate, organise and deploy shared resources to support and improve resilience and care delivery[44] 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.

8.1.2. The requirements for each of these functions are described in sections 8.1.3– 8.4.2 and in delivering them a PCN must have regard to associated guidance[45].

8.1.3. Where Core Practice Networks within a PCN intend to collaboratively deliver vaccinations, the PCN must ensure that the Network Agreement is varied to include

a. a new Clause 23A stating "Where the Core Network Practices intend to collaboratively deliver vaccinations, the Core Network Practices will comply with Schedule 8."; and

b. a new Schedule 8 that contains provisions that make clear the governance arrangements that apply to the collaborative delivery of vaccinations, and which are based on the notes set out in the template schedule provided here.

8.2 Supporting and improving resilience and care delivery

8.2.1. A PCN (led by the Clinical Director and as described in section 5.3 of this Network Contract DES Specification) must work with, and support, its Core Network Practices to improve the quality and effectiveness of its delivery of the Network Contract DES, whether components are delivered at PCN or practice level.

8.2.2. To achieve this, the PCN must continuously work to improve patient experience and the care that patients receive. This involves ensuring effective allocation of funding and Additional Roles Reimbursement Scheme capacity across the PCN as well as

[44] This could also include the PCN 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.

[45] https://www.england.nhs.uk/gp/investment/gp-contract/network-contract-directed-enhanced-service-des/

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supporting the effective configuration of practice capacity. It also involves supporting the application of peer-review and continuous improvement techniques across Core Network Practices.

8.3 Improving health outcomes and reducing health inequalities

8.3.1. A PCN must seek to improve health outcomes for its population using a data-driven approach and population health management techniques in line with guidance and the CORE20PLUS5 approach[46]. The approach must include, but is not limited to, the following activities:

a) use of insightful analytics, alongside improved data recording and use (including ethnicity), to target care and improve outcomes in populations groups where there is greatest opportunity;

b) working with partners, including community pharmacy, to proactively identify and manage CVD risk, hypertension and raised lipids in line with nationally agreed guidance and pathways;

c) in collaboration with partners, reviewing the quality of cancer referral practice against the recommendations of Nice Guideline 12 (suspected cancer, recognition and referral[47]), focusing on timely referral to support improved cancer survival. This should include building on current safety netting practice, including using electronic safety netting tools where appropriate to monitor patients with symptoms which could indicate cancer;

d) working with partners, including screening commissioning teams and providers, to improve uptake by proactively identifying those who are eligible but have not accessed NHS cancer screening programmes (inclusive of breast, cervical and bowel cancer screening), supporting opportunities to raise awareness and benefits, and understand the barriers to the programmes;

e) working to support uptake of the NHS lung cancer screening programme;

f) working with partners, including screening commissioning teams and providers, to improve uptake by proactively identifying those who are eligible for the NHS non-cancer screening programmes including; the diabetic eye screening programme, the abdominal aortic aneurysm screening programme and the antenatal and newborn screening programme, and sign posting to the service and communications available via the NHS App.

8.3.2. A PCN should actively seek to reduce health inequalities across its Core Network Practices in line with guidance and the CORE20PLUS5 approach. To address health inequalities, a PCN should work in partnership within local communities to

[46] NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people
[47] Overview | Suspected cancer: recognition and referral | Guidance | NICE

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deliver effective outreach and target care to address health inequalities that are amendable to primary care intervention.

8.4 Targeting resource and efforts

8.4.1. A PCN must contribute to the delivery of multi-disciplinary proactive care for complex patients at greatest risk of deterioration and hospital admission, by risk stratifying patients and offering care in accordance with the guidance[48]. This must be done as part of INTs, with the aim of reducing avoidable exacerbations of ill health, improving quality of care and patient experience, and reducing unnecessary hospital admission. A PCN should also use digital risk stratification tools, to identify those that would benefit most from continuity of care (with a named GP, where appropriate).

8.4.2. Other key requirements of a PCN are to:

a) detail the measures a PCN will take to improve medicines optimisation and implement those measures, including ensuring medicines management and use of Structured Medication Reviews for high-risk cohorts, as specified in the Guidance. This should include medicines optimisation strategies for reducing polypharmacy, minimising risk of prescribing harm, reducing over-prescribing and managing the risk of dependency on prescription drugs;

b) provide access to a social prescribing service to those who may benefit, so as to help meet the practical, social and emotional needs that can otherwise affect health and wellbeing; and

c) deliver an Enhanced Health in Care Homes ("EHCH") service in accordance with the framework[49] and guidance[50], including:

i. agreement with the commissioner for which care homes the PCN is responsible;

ii. identifying a lead GP (or other senior clinician) with responsibility for implementation of the EHCH framework for the agreed care homes, and to provide continuity of medical care;

iii. co-ordinating an MDT meeting and associated actions, including the lead GP or clinician and care home staff;

iv. delivering a weekly care home round; and

v. ensuring accurate coding of care.

[48] Proactive care: providing care and support for people living at home with moderate or severe frailty

[49] NHS England » Providing proactive care for people living in care homes – Enhanced health in care homes framework

[50] https://www.england.nhs.uk/gp/investment/gp-contract/network-contract-directed-enhanced-service-des/

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d) use appropriate tools to identify PCN patients at greatest risk of avoidable hospital admission, informed by the PCN's risk stratification processes. This may include people living with moderate or severe frailty, COPD, other severe respiratory diseases, heart failure, or other patients identified by the PCN as being at high risk of avoidable admission. For 0.5% of the PCNs Patients which are identified as at greatest risk of avoidable hospital admission, the PCN should carry out a proactive, holistic assessment of need and, following engagement with the patient, develop and implement a personalised care plan (the "Proactive Care Plan"), including agreed interventions to address identified needs and risks. The Proactive Care Plan must reflect the patient's individual needs, circumstances and preferences, and set out the interventions and proactive care to be delivered or arranged by the PCN to support earlier intervention, improve co-ordination of care and reduce the risk of an avoidable hospital admission. The Proactive Care Plan should include the elements set out in the Guidance[51]. For each Proactive Care Plan developed, the PCN is entitled to payment up to the amount allocated to the PCN (see section 10.7). A PCN may claim this funding in respect of a PCN patient who is also receiving proactive care funded through another arrangement, provided that the interventions delivered in accordance with this section 8.4.2(d) are additional to those funded through that other arrangement. The determination of whether interventions are additional shall be made by the commissioner. The PCN must provide on reasonable request, evidence of the action they have taken for the patient in respect of their Proactive Care Plan.

8.4.3. Where one or more of the PCN's Core Network Practices offer adult influenza vaccination or adult influenza and COVID-19 vaccination under the General Practice COVID-19 and Adult Influenza Vaccination Enhanced Service 2026/27 (the "ES"), then as part of its EHCH service, the PCN must ensure all residents of the PCN's Aligned Care Homes, are offered the adult influenza vaccination or adult influenza and COVID-19 vaccination, as appropriate, in accordance with the published timescales and categories of Care Homes announced and authorised by NHS England[52].

8.4.4. In offering vaccinations in accordance with the ES and this Network Contract DES, the PCN must ensure that a joined up service is offered to all its Aligned Care homes. In particular it must:

8.4.4.1 amend its Network Agreement to set out arrangements, including payment arrangements, for offer and provision of adult influenza or adult

[51] NHS England » Network contract directed enhanced service – guidance for 2026/27 in England – part A: clinical and support services (section 8)
[52] National flu immunisation programme 2026 to 2027 letter - GOV.UK

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influenza and COVID-19 vaccination to all residents of its Aligned Care Homes and, where necessary to prevent the unlawful sharing and/or supply of vaccines, the Core Network Practices must adopt appropriate collaborative arrangements[53] and ensure these are documented in the Network Agreement or, if the arrangements involve an organisation that is not party to the Network Agreement, an alternative agreement; and

8.4.4.2 if any patient has not previously been offered vaccination during a campaign at that time for adult influenza or COVID-19, ensure that an offer is made in accordance with the terms of the ES.

8.4.5. Where the PCN's Core Member Practices offer adult influenza vaccination or adult influenza vaccination and COVID-19 vaccination under the ES, but in exceptional circumstances the PCN's Core Member Practices are unable to offer all residents in the PCN's Aligned Care Homes the adult influenza and/or COVID-19 vaccination and are unable to find an alternative provider, the PCN may seek support from the Commissioner to ensure appropriate coverage. Where this applies, the PCN must outline to the Commissioner the extent of the offer it can make to residents and an indication of why it cannot make the full offer. The PCN must also indicate clearly to whom it has not offered the relevant vaccination. The Commissioner will consider the request and where it is satisfied exceptional circumstances exist t will take on the responsibility to ensure appropriate coverage. The PCN must cooperate with the Commissioner in facilitating the appropriate coverage by an alternative provider.

If none of its Core Member Practices participate in the ES, the PCN must cooperate with NHS England to facilitate an offer of one or both vaccinations as required, by another provider nominated by NHS England.

8.4.6. Core Network Practices are reminded that the PCN Grouping concept that enabled sharing of vaccines between members will no longer be applicable from April 2026. Core Network Practices must therefore ensure there is no sharing of these vaccines between each other in a way that would contravene the provisions of the Human Medicines Regulations 2012. The collaborative arrangements referred to in section 8.4.4.1 may include subcontracting or agency arrangements that enable a Core Network Practice not participating in the ES to vaccinate on behalf of, or as agent of, a Core Network Practice that is participating in the ES.

8.4.7. Payments for adult influenza and COVID-19 vaccinations will be made in accordance with the terms of the ES. Where appropriate, the Core Network

[53] This could be a subcontract or agency arrangements between the Core Network Practices where needed

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Practices must ensure the Network Agreement sets out how payments will be managed between them.

8.4.8. As part of its EHCH service the PCN must:

8.4.4.3 review the vaccination status of all residents of its Aligned Care Homes in the categories of Care Home announced and authorised by NHS England and compare their vaccination status against their eligibility for routine and other vaccination programmes as set out in Part 5 of the SFE (Vaccines and Immunisations); and

8.4.4.4 where it identifies gaps in a resident's routine vaccination status, ensure that the practice at which the resident is registered is made aware of those gaps and work with the practice to ensure an offer is made, where appropriate.

8.5 Collaboration with non-GP providers to provide better care

8.5.1. 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 other clinical leaders and commissioners to successfully manage the health and care needs of the populations they serve.

8.6 Enhanced Access

8.6.1. A PCN must provide enhanced access between the hours of 6.30pm and 8pm Mondays to Fridays and between 9am and 5pm on Saturdays (which are referred to in this Network Contract DES Specification as “Network Standard Hours”), in accordance with this Network Contract DES Specification and with the plan it previously agreed with the commissioner to deliver Enhanced Access (“the Enhanced Access Plan”).

8.6.2. Commissioner approval is required for any significant change to the Enhanced Access Plan. Changes that will be considered significant include but are not limited to:

a) the PCN site(s) from which physical services will be delivered;

b) sub-contracting arrangements;

c) the staffing mix which will be available during the Network Standard Hours which significantly reduces the availability of a type of clinician, for example GPs, or other members of the team; and

d) timings and distribution for when the minimum 60 minutes of appointments per 1000 PCN adjusted patients per week is delivered.

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8.6.3. PCNs are required to deliver or sub-contract Enhanced Access in full in accordance with the requirements of this Network Contract DES Specification and the sub-contracting requirements set out in their Core Network Practices' primary medical care services contracts. Where a commissioner is not satisfied that a PCN is delivering Enhanced Access in accordance with the requirements of this Network Contract DES specification and the Enhanced Access Plan then the commissioner may take action as set out in section 9. If a commissioner determines to withhold payment[54], the amount withheld will be an appropriate proportion of the enhanced access payment and the Core PCN funding payment.

8.6.4. A PCN must provide bookable clinical appointments during the Network Standard Hours that satisfy all of the requirements set out below:

a) are available to all PCN Patients - this does not preclude practices from booking appropriate patients into appointments within Network Standard Hours which are delivered at the patient's registered practice;

b) are for any general practice services and services pursuant to the Network Contract DES that are provided to patients;

c) are for bookable appointments, that may be made in advance or on the same day, by the PCN's Core Network Practices, regardless of the access route via which patients contact their practice, and the PCN must:

i. make the appointments available a minimum of two weeks in advance, with the PCN's Core Network Practices utilising appropriate triage and/or navigation as required to book and/or offer patients available appointments;

ii. make the Network Standard Hours appointment book accessible to the Core Network Practices to enable efficient patient bookings into slots following patient contact;

iii. make same day online booking for available routine appointments where no triage is required up until as close to the slot time as possible;

iv. operate a system of enhanced access appointment reminders;

v. provide patients with a simple way of cancelling enhanced access appointments at all times;

vi. make available to NHS111 any unused on the day slots during the Network Standard Hours from 6.30pm on weekday evenings and between 9am-5pm on Saturdays, unless it is agreed with the commissioner that the

[54] Payment withheld in this context would be an appropriate proportion of the payments in relation to both extended hours access and Core PCN funding payments.

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timing for when these unused slots are made available is outside of these hours; and

vii. have in place appropriate data sharing and, where required data processing arrangements to support the delivery of Enhanced Access between the PCN's Core Network Practices and where applicable a sub-contractor.

d) are delivered by a multi-disciplinary team of healthcare professionals employed or engaged by the PCN's Core Network Practices, including GPs, nurses and Additional Roles and other persons employed or engaged by the PCN to assist the healthcare professional in the provision of health services;

e) are within Network Standard Hours:

i. a mixture of in person face to face and remote (telephone, video or online) appointments, provided that the PCN ensures a reasonable number of appointments are available for in person face-to-face consultations to meet the needs of their patient population, ensuring that the mixture of appointments seeks to minimises inequalities in access across the patient population;

ii. in locations that are convenient for the PCN's patients to access in person face-to-face services;

iii. ensuring that the premises from which Enhanced Access is delivered is as a minimum equivalent to the number of sites within the PCN's geographical area from which the CCG Extended Access Service was delivered;

f) are providing a minimum of 60 minutes of appointments per 1,000 PCN adjusted patients per week during the Network Standard Hours, calculated using the following formula:

additional minutes* = (the PCN adjusted population** ÷ 1,000) x 60

*convert to hours and minutes and round, either up or down, to the nearest quarter hour

**PCN adjusted population is based on the Primary Medical Care weighted population as at 1 January 2026.

g) not restrict access to Enhanced Access for any patients of the PCN's Core Network Practices whose primary medical services contracts[55] require

[55] For practices with PMS and APMS arrangements, the additional clinical appointments provided in accordance with this Enhanced Access requirement do not apply to any hours covered by core hours set out in the practice's primary medical services contracts. A PCN will be required to take consideration of this when

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appointments to be provided during the Network Standard Hours. For the avoidance of doubt, if a Core Network Practice was required under its primary medical services contract to provide core services at its premises until 8pm, then:

i. their registered patients must also have access to Enhanced Access appointments; and

ii. the Enhanced Access appointments must be in addition to appointments offered as part of their core hours service offer.

8.6.5. Unless otherwise agreed with the commissioner, a PCN must deliver the minimum 60 minutes per 1000 PCN adjusted patients per week within the Network Standard Hours. For the avoidance of doubt, a commissioner may agree to a proportion of the 60 minutes per 1000 PCN adjusted patients per week being provided outside of the Network Standard Hours where it is evidenced by the PCN that such appointments would better meet the needs of the PCN's patients. For example, through the provision of a morning clinic between 7am to 8am. Where this is agreed locally, the minutes must be provided in continuous periods of at least 30 minutes. By exception, the commissioner may also agree that a proportion of the minutes may be provided during core hours, where it can be demonstrated that such additional appointments would better meet the needs of the PCN's patients.

8.6.6. A PCN must ensure GP cover during the Network Standard Hours providing in person face-to-face consultations, remote consultations, leadership, clinical oversight and supervision of the MDT.

8.6.7. A PCN's Core Network Practices must actively communicate availability of these enhanced access appointments to their patients, including informing patients how they can be accessed, what and when specific services are available (for example vaccinations and immunisations, provision of personally administered items, screening, health checks, PCN services etc) and what and when different members of the MDT are available, through promotion and publication through multiple routes. This may include the NHS website (nhs.uk), the practice leaflet, the practice website, on a waiting room poster, by writing to patients and active offers by staff booking appointments.

8.6.8. Where a PCN cancels any Enhanced Access appointments or where appointments cannot be offered (for example, but not limited to, a bank holiday) the PCN must make up the cancelled time by offering additional appointments within a two-week period, unless an alternative time period is agreed with the commissioner. For the avoidance of doubt, any rescheduled appointments offered in a subsequent week

agreeing the Enhanced Access offer to the PCN Contractor Registered Population. For practices with GMS arrangements, core hours are from 08:00 to 18:30.

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or agreed timeframe are in addition to the minimum minutes that must be offered for that week as set out in section 8.2.1. The PCN must ensure that all patients within the PCN are notified of the cancelled and rescheduled appointments.

8.6.9. Core Network Practices of a PCN must inform patients with reasonable notice of any changes to Enhanced Access, including where or how to access the appointments and any changes in the services being offered.

8.6.10. A PCN must ensure, when available, appropriate telephony and IT interoperability will operate between the Core Network Practices within the PCN, any non-participating practices the PCN is providing enhanced access cover for and other relevant providers as necessary. This must include the ability, once consistently available to view, book into, and cancel appointments, make referrals and request tests, to view and update patients' records, and for all relevant staff to have the ability to access medical records within the PCN, and to cover other points in the core digital offer provided by member practices as part of their primary medical services contract.[56] Further guidance on IT interoperability will be made available.

8.6.11. Following from the above, when available a PCN's Core Network Practices will utilise core digital capabilities consistently across the PCN in accordance with the requirements of the PCN's Core Network Practices' primary medical care services contracts to:

a) enable practice and PCN staff to book appointments in Standard Network Hours; and

b) enable patients to book appointments online where appropriate, including up until as close to the slot time as possible;

8.6.12. A PCN must set out how enhanced access will be delivered in the Network Agreement.

8.6.13. A PCN must ensure that all practices in the PCN actively engage in planning of the provision of the enhanced access requirements and acknowledges that nothing in this Network Contract DES Specification require an individual clinician or practice within the PCN to deliver a particular share of the appointments.

8.6.14. A PCN should utilise population health management and capacity or demand tools and engage with their registered population to ensure the range of services offered

[56] For practices with PMS and APMS arrangements, the additional clinical appointments provided in accordance with this Enhanced Access requirement do not apply to any hours covered by core hours set out in the practice's primary medical services contracts. A PCN will be required to take consideration of this when agreeing the Enhanced Access offer to the PCN Contractor Registered Population. For practices with GMS arrangements, core hours are from 08:00 to 18:30.

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in the Network Standard Hours take into account patient preferences, to meet the requirements set out in section 8.2.1.

8.6.15. If any Core Network Practice of a PCN is providing out of hours services to its own list of patients, the PCN must, as part of Enhanced Access provision offer Network Standard Hours appointments to these patients in addition to the out of hours service.

8.6.16. A PCN must ensure that:

a) no Core Network Practice of the PCN will be closed for half a day on a weekly basis; and

b) the PCN's Patients are able to access core services, which meet the reasonable needs of patients during core hours, from their own practice or from any sub-contractor.

8.6.17. For the avoidance of doubt, unless a practice has prior written approval from the commissioner, all PCN Core Network Practices will not close for half a day on a weekly basis.

8.6.18. The term "prior written approval" in section 8.6.17 means an explicit agreement between the practice and the commissioner that specifically includes written approval to close for half a day on a weekly basis for the purposes of the Network Contract DES Specification. The agreement must expressly state that:

a) it is pursuant to the Network Contract DES Specification; and

b) it will expire no later than 31 March 2027.

8.6.19. Where a Core Network Practice does not have prior written approval to close for half a day on a weekly basis, a Core Network Practice that previously closed for half a day on a weekly basis will need to either:

a) be open for that half a day in the same way that it is open on other days of the week, or

b) have in place appropriate sub-contracting arrangements for the time the practice is closed - having due regard to the requirements set out in the statutory regulations or directions that underpin each Core Network Practices' primary medical services contracts in relation to sub-contracting as set out in section 5.6 as applicable - so that patients continue to have access to essential services which meet their reasonable[57] needs during core hours.

[57] NHS England's guidance is that it includes for example: the ability to book and cancel appointments, collect prescriptions, access urgent appointments/advice as clinically necessary, the ability to attend a pre-bookable appointment.

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8.6.20. PCNs will ensure that their appointment system used for Enhanced Access can be identified so that appointment data for that PCN can be incorporated into the General Practice Appointment Data ("**GPAD**") set. Where a commissioner requests further information regarding the PCN's Enhanced Access service appointment data, the PCN will provide such requested information as soon as reasonably practicable and in any event within 30 days of the date the request was made.

9. Contract management

9.1 General

9.1.1. Section 3 of this Network Contract DES Specification states that each Core Network Practice of a PCN is responsible for ensuring that a requirement or obligation of a PCN as set out in this Network Contract DES Specification is carried out on behalf of that PCN.

9.1.2. A PCN acknowledges that, where a requirement or obligation of a PCN is not carried out, each Core Network Practice will be in breach of this Network Contract DES Specification.

9.1.3. A PCN further acknowledges that as the provisions of this Network Contract DES Specification are part of a Core Network Practice's primary medical services contract, the commissioner is able to take any action set out in the relevant primary medical services contracts in relation to a breach of this Network Contract DES Specification.

9.1.4. Where a breach of this Network Contract DES Specification occurs, a commissioner may require a PCN to work with the commissioner to compile and agree a collaborative action plan setting out actions to address non-delivery and timescales for those actions. The commissioner and the PCN will make all reasonable efforts to agree the action plan.

9.1.5. It is not expected that commissioners will need to resort to contract management processes such as issuing of breach or remedial notices due to the support options available across the system and the action plan development process as described in section 9.1.4.

9.1.6. The commissioner acknowledges that the action plan is intended to be a first step towards remedying the breach. If:

a) the commissioner, acting reasonably, determines that an action plan is not appropriate;

b) an action plan cannot be agreed within a reasonable timescale; or

c) a breach is not remedied by an action plan,

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the commissioner may take any appropriate action set out in the Core Network Practice's primary medical services contracts in relation to the breach. This may include issue of a breach or remedial notice, withholding of payments or termination.

9.1.7. A PCN (and each Core Network Practice in the PCN) acknowledges that:

a) the legislation underpinning GMS and PMS arrangements include references to "**Contract Sanctions**" and "**Agreement Sanctions**" respectively which enable the commissioner, in certain circumstances, to terminate certain obligations under the primary medical services contracts; and

b) in the unlikely event that a breach cannot be resolved by the application of the provisions of this Network Contract DES Specification and the contract management provisions of the primary medical services contract, the commissioner is able to rely on the Contract Sanctions or Agreement Sanctions, as relevant, to terminate a Core Network Practice's participation in the Network Contract DES while the rest of the obligations in the primary medical services contract are not terminated;

c) if the commissioner is minded to terminate Core Network Practices' participation in the Network Contract DES, it must act in accordance with section 6.6 as if references to the Core Network Practice's primary medical services contract terminating are references to the Core Network Practice's participation in the Network Contract DES terminating; and

d) where a PCN's members include a Core Network Practice which holds an APMS contract, the commissioner must consider if there are corresponding rights in the APMS contract for the commissioner to partially terminate the APMS contract to terminate only the provisions relating to the Network Contract DES. The commissioner acknowledges that if such rights are not included, the need to deal with all PCN Core Network Practices in a similar way may mean that the commissioner is not able to terminate the PCN's Core Network Practices' participation in the Network Contract DES.

10. Network financial entitlements

10.1 General

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.

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10.1.2. A PCN acknowledges that where confirmation of participation in the Network Contract DES is required from the commissioner pursuant to section 4, such confirmation may not occur until after 30 April 2026 but that this Network Contract DES Specification sets out certain elements of the Network financial entitlements that will, provided any required criteria or conditions are satisfied, be backdated to April 2026. Any such backdating is set out in the relevant sections of this section 10.

10.1.3. Where information relating to a new proposed PCN is submitted to the commissioner between 1 April 2026 and 31 March 2027, the commissioner will, where a PCN is approved, indicate to the PCN the relevant service delivery commencement date and when payments of the financial entitlements will be made.

10.1.4. Where a new proposed PCN is approved after 1 April 2026, the Core Network Practices of that PCN acknowledge that payments due under the Network Contract DES will be calculated as set out in sections 10.3 and 10.4, and split into 12 monthly instalments. The Core Network Practices will only be entitled to receive the monthly instalments for the months they deliver the service requirements of the Network Contract DES.

10.1.5. Where the financial entitlement refers to a payment being based on practice list size or PCN list size, the relevant figure in most cases will be taken from the registration system approved by NHS England as at 1 January 2026 or a later date if the commissioner, in its absolute discretion, considers that a PCN has satisfactorily evidenced that there has been a large fluctuation in its Core Network Practices' lists of patients such that the figure derived from the later date is more appropriate.

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. For the avoidance of doubt, the Network Participation Payment is not a payment due to a PCN as it is payable directly to a Core Network Practice. 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.

10.1.7. If there is a change to the Nominated Payee that takes effect in accordance with section 6.3 prior to a payment being made, the commissioner will make the payment to the new Nominated Payee. A PCN acknowledges that, where there is any change to the membership of the PCN after 31 March 2027 and before the receipt of a payment that relates to this Network Contract DES, the commissioner will make the payment to the Nominated Payee that relates to the PCN as at the date of the payment and it is for the PCN to manage any distribution of the payment. A PCN acknowledges that, if there is no applicable Nominated Payee, either because the PCN no longer exists or otherwise, the commissioner will make

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the payment to the bank account of the previously notified Nominated Payee and it is for the controller of that bank account to manage any distribution of the payment.

10.1.8. A PCN and its commissioner acknowledge that:

a) payments made in accordance with this Network Contract DES Specification are not payments for specific services (except for those payments referred to in section 10.7) and instead are made in consideration of the PCN delivering the requirements of this Network Contract DES Specification; and

b) the calculation of the payments in accordance with this Network Contract DES Specification are split into separate elements which are listed in more detail in sections 10.3 to 10.7.

10.1.9. Where an ODS Change Instruction Notice needs to be submitted prior to a payment being made, the payment will be made by the end of the month in which the notice was submitted provided the notice was submitted before the end of the last working day on or before the 14th day of that month. If submitted after the end of the last working day on or after the 14th day of the month, payment will be made at the end of the following month. The exact date of payment is subject to local payment arrangements.

10.1.10. If a practice is allocated to a PCN in accordance with section 4.6, an adjustment will be made to reflect that practice's patient list in the calculation of a payment due to the PCN. The adjustment will only apply to payments that are made once the ODS Change Instruction Notice has been submitted in accordance with the timescales in section 10.1.9, which, for the avoidance of doubt, will only occur after the commissioner has confirmed the practice's participation in the Network Contract DES in accordance with section 4.6.5.

10.1.11. The adjustment referred to in section 10.1.10 which is to be made to reflect the practice's patient list in the calculation of a payment due to the PCN is as follows:

a) The relevant payment will be recalculated with the relevant measure of the practice's patient list included;

b) The amount recalculated will be divided into 12 equal monthly instalments;

c) Each monthly payment to the PCN, made after the ODS Change Instruction Notice has been submitted in accordance with the timescales in section 10.1.9, will be an amount equal to the recalculated monthly instalment; and

d) For the avoidance of doubt, there will be no adjustment to the previous monthly payments that have already been paid to the PCN.

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10.2 Administrative provisions relating to payment

10.2.1. Payments under the Network Contract DES are to be treated for accounting and superannuation purposes as gross income of the PCN's Core Network Practices, in the financial year. Where payments are made to the Nominated Payee, how the income is apportioned for accounting and superannuation purposes will depend on the arrangements for the distribution of payments between the Core Network Practices, as set out in the Network Agreement. Core Network Practices are responsible for ensuring that their arrangements are appropriate.

10.2.2. Payments made in accordance with this Network Contract DES Specification may be changed when there is any change to a PCN, including, but not limited to, where there is a change to the Core Network Practices members.

10.2.3. A PCN (and its Core Network Practices) is required to adhere to current financial probity standards that are in place across the NHS, ensuring that the deployment of resources would stand up to wider scrutiny as an efficient and effective use of NHS funding.

10.2.4. The commissioner will be responsible for post payment verification. This may include auditing claims of the PCN (and a Core Network Practice in relation to the Network Participation Payment) to ensure that they meet the requirements of the Network Contract DES. Where required, PCNs and/or a Core Network Practice as relevant will provide to the commissioner in a timely manner all relevant information and assistance to support assessment of compliance with the requirements of this service and expenditure against the Network Contract DES.

10.2.5. Payments pursuant to the Network Contract DES, or any part thereof, are only payable if a PCN or a Core Network Practice if relevant satisfies the following conditions:

a) the PCN or Core Network Practice as relevant makes available to the commissioner any information under the Network Contract DES, which the commissioner requests and the PCN or Core Network Practice as relevant either has or could be reasonably expected to obtain;

b) the PCN or Core Network Practice as relevant makes any returns required of it (whether computerised or otherwise) to the payment system or CQRS and does so promptly and fully; and

c) all information supplied pursuant to or in accordance with this section 10 must be accurate.

10.2.6. If a commissioner makes a payment under the Network Contract DES and:

a) the recipient was not entitled to receive all or part thereof, whether because it did not meet the conditions for the payment or because the payment was

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calculated incorrectly (including where a payment on account overestimates the amount that is to fall due); or

b) the commissioner was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money has already been paid,

then the commissioner is entitled to repayment of all or part of the money paid. The commissioner may, in this circumstance, recover the money paid by deducting an equivalent amount from any payment payable to the PCN (or if the payment relates to payments of the Network Participation, from any payment to the relevant Core Network Practice), and where no such deduction can be made, it is a condition of the payments made under the Network Contract DES that the PCN[58] or relevant Core Network Practice must pay to the commissioner that equivalent amount.

10.2.7. Where the commissioner is entitled under the Network Contract DES to withhold all or part of a payment because of a breach of a payment condition and the commissioner does so or recovers the money by deducting an equivalent amount from another payment in accordance with this section 10, it may, where it sees fit to do so, reimburse the PCN or relevant Core Network Practice as relevant the amount withheld or recovered, if the breach is cured.

10.3 Network Participation Payment

10.3.1. Each practice that:

a) is eligible to participate in this Network Contract DES;

b) has submitted information for confirmation of participation in accordance with section 4;

c) has been confirmed as participating in the Network Contract DES as a Core Network Practice of a PCN; and

d) commits to being active members of their PCN as it evolves over the coming years,

will be eligible for a Network Participation Payment ("**NPP**") with effect from 1 April 2026 to support practice engagement.

10.3.2. For the avoidance of doubt:

a) the NPP payment is only made in respect of a PCN of which the practice is a Core Network Practice; and

[58] The PCN must agree how it would deal with such a circumstance so as not to disadvantage the Nominated Payee. Where required, the commissioner may consider withholding the SFE payment in accordance with the provisions of the SFE.

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b) the NPP payment is paid directly to a Core Network Practice and not the PCN's Nominated Payee.

10.3.3. For practices to whom the SFE applies, the NPP will be paid in accordance with the SFE and is not a financial entitlement pursuant to this Network Contract DES Specification.

10.3.4. For practices to whom the SFE does not apply, it is a requirement of this Network Contract DES that the commissioner ensures that a payment is made in respect of those practices that equates to the NPP that would have been made to the practice if the SFE applied to that practice.

10.3.5. The NPP for the period 1 April 2026 to 31 March 2027 is calculated as £1.761 multiplied by the practice's **"Contractor Weighted Population"** as at 1 January 2026.

10.3.6. Subject to sections 10.1.4 and 10.3.7, the amount calculated as the NPP is payable in 12 equal monthly instalments and the commissioner must arrange for the relevant payment to be made to a Core Network Practice no later than the last day of the month following the month in which the payment applied and taking into account local payment arrangements.

10.3.7. Subject to section 10.1.9, section 10.3 and local payment arrangements, for a Core Network Practice of a Previously Approved PCN with membership changes the NPP will be made no later than the end of the month following the month in which the participation of all Core Network Practices of that PCN has been confirmed. Where the first payment is paid after May 2026, the first payment will include payment of instalments backdated to 1 April 2026.

10.3.8. A Core Network Practice will no longer be eligible to receive the NPP if under exceptional circumstances it leaves the PCN after 30 April 2026. The change will take effect from the month following the month in which the Core Network Practice leaves the PCN.

10.4 Core PCN Funding, Care Home Premium, Enhanced Access Payment

10.4.1. Subject to sections 10.1.4, the amount calculated for each of the payments in this section 10.4 are payable in 12 equal monthly instalments payments and will be automatically calculated by PCSE Online.

10.4.2. Subject to section 10.1.9 and local payment arrangements, for a Previously Approved PCN with membership changes, each of the payments in this section 10.4 will be made no later than the end of the month in which the participation of all Core Network Practices of that PCN has been confirmed. Where the first payment is paid after April 2026, the first payment will include instalments backdated to 1 April 2026.

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10.4.3. Table 1 sets out the relevant payment calculations for each of the payments which the PCN is entitled to as set out in this section (i.e. 10.4).

Table 1: PCN payments for 2026/27 - 1 April 2026 to 31 March 2027

Financial Entitlement	Payment provisions and calculation
Core PCN Funding	The Core PCN Funding for the period 1 April 2026 to 31 March 2027 is calculated as £3.059 per patient, with £2.311 being multiplied by the PCN registered list size as at 1 January 2026 and £0.748 multiplied by PCN adjusted population as at 1 January 2026. This combines the funding that was previously labelled as Core PCN Funding, Clinical Director Payment and PCN Leadership and Management Payment.
Enhanced Access payment	The Enhanced Access payment for the period 1 April 2026 to 31 March 2027 is calculated as £8.903 multiplied by the PCN's Adjusted Population at 1 January 2026.
Care Home Premium	The payment is calculated on the basis of £133.158 per bed for the period 1 April 2026 to 31 March 2027. The number of beds will be based on Care Quality Commission ("**CQC**") data on beds within services that are registered as care home services with nursing ("**CHN**") and care home services without nursing ("**CHS**") in England[59]. PCSE will make monthly payments based on care home bed numbers provided by commissioners. Payments are made at a rate of £11.0965

[59] See https://www.cqc.org.uk/guidance-providers/regulations-enforcement/service-types for further information on the definition of care home services for this purpose.

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	per bed per month for the period 1 April 2026 to 31 March 2027, based on the number of relevant beds in the PCN's Aligned Care Homes. The commissioner must ensure that the number of beds on which payment is based is updated on a monthly basis in line with the CQC Care Directory[60]. Payment will only be made where the commissioner is satisfied that the PCN or its Core Network Practices have comprehensively coded care home residents using appropriate clinical codes as follows: **160734000 – Lives in a nursing home;** **394923006 – Lives in a residential home; and** **248171000000108 – Lives in care home (finding).**

10.5 Workforce

10.5.1. Subject to sections 10.5.6 to 0, a PCN is entitled to claim 100 per cent reimbursement of the aggregate WTE actual[61] salary (including employer on-costs for NI and pension[62]) up to the maximum amount per role as outlined in Table 2 and within that PCN's overall Additional Roles Reimbursement Sum, for the delivery of health services.

10.5.2. Subject to sections 10.5.6 to 0, a PCN is entitled to claim reimbursement of the aggregate WTE actual[63] salary (including employer on-costs for NI and pension[64]) for adult MHPs (or CYP MHPs if agreed locally), up to the maximum amount per role as outlined in Table 3a or 3b and within that PCN's overall Additional Roles Reimbursement Sum, for the delivery of health services.

a) Subject to sections 10.5.6 to 0, a PCN is entitled to claim reimbursement of the aggregate WTE actual[65] salary (including employer on-costs for NI and pension[66]) for General Medical Practitioners, up to the maximum amount per role as outlined

[60] See https://www.cqc.org.uk/guidance-providers/regulations-enforcement/service-types for further information on the definition of care home services for this purpose.
[61] If relevant the percentage will be appropriately apportioned to PCN related activity.
[62] This does not include the additional 9.4% per cent employer contributions.
[63] If relevant the percentage will be appropriately apportioned to PCN related activity.
[64] This does not include the additional 9.4% per cent employer contributions.
[65] If relevant the percentage will be appropriately apportioned to PCN related activity.
[66] This does not include the additional 9.4% per cent employer contributions.

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in Table 3c and within that PCN's overall Additional Roles Reimbursement Sum, for the delivery of health services.

b) Subject to sections 10.5.6 to 0, a PCN within the London Region (as defined in clauses 28, 29, and 30 of the Model terms and conditions of service for a salaried general practitioner employed by a GMS practice[67]), is entitled to claim the London reimbursement rate for General Medical Practitioners up to a maximum reimbursable amount per role as outlined in Table 3c for actual salary (including employer on-costs for NI and pension).

10.5.3. Subject to sections 10.5.6 to 0, a PCN within the London Region is entitled to claim the inner or outer London maximum reimbursement rate for its engaged Additional Roles (other than General Medical Practitioners):

a. up to the relevant maximum reimbursable amount per role as outlined in Tables 2 and Tables 3a and 3b for actual salary plus employer (NI and pension) on costs;

b. within the PCN's overall Additional Roles Reimbursement Sum; and

c. eligibility for either an inner or outer London maximum reimbursement rate will be determined by the commissioner based on the geographical location of the PCN's Core Network Practices and the definition of the areas as outlined in Annex 8 of Agenda for Change. Where a PCN has Core Network Practices in both the inner and outer areas, or Core Network Practices in both the outer area and within the inner area, the commissioner will have discretion to determine which of the London maximum reimbursable rates (or, in the case of the latter, whether either of the London maximum reimbursable rates) applies. The commissioner must ensure this discretion is consistently applied across the PCNs within its area.

10.5.4. A PCN's Additional Roles Reimbursement Sum equates to £27.668 multiplied by the PCN Contractor Weighted Population as at 1 January 2026. Further details of the method for determining Additional Roles Reimbursement Sum are set out in the Network Contract DES Guidance.

10.5.5. A PCN must use the mandatory electronic online portal to submit the monthly workforce claim (ARRS PCN claims portal - PCNs and Practices Support Hub - Futures). The PCN acknowledges that any relevant maximum amount per role figure used for the purpose of a claim pursuant to this section 10.5 will be divided by twelve for the purpose of the monthly workforce claim. The PCN must ensure that any claim for workforce include on the online portal a person's registration

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

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number where that person is subject to professional regulation and the relevant regulatory body has issued such a number.

10.5.6. The following conditions apply to any claim made pursuant to sections 10.5.1, 10.5.2,10.5.2.a), 10.5.2.b) and 10.5.3:

a. The commissioner will arrange for payment to be made on a monthly basis in arrears following the start of employment of the relevant Additional Role or the commencement of service provision where a PCN engages a third party organisation to provide a service related to the relevant Additional Role. The commissioner will only make payments following the start of the employment or commencement of service provision.

b. The PCN must, in accordance with local payment arrangements, submit a claim for the reimbursement of the cost relating to the previous month.

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

d. The claim must relate to reimbursement of costs referred to in sections 10.5.1, 10.5.2, 10.5.2.a), 10.5.2.b) and 10.5.3 from the roles covered by the Additional Roles Reimbursement Scheme in accordance with section 7.

e. A PCN must demonstrate that claims being made are for additional staff roles beyond the baseline (including in future years, replacement as a result of staff turnover) as set out in this Network Contract DES Specification. The commissioner will be required to ensure the claims meet the ‘additionality rules’ set out in section 7.

f. A PCN (and Core Network Practices) not adhering to the additionality rules and principles will not be eligible for workforce reimbursement under this Network Contract DES Specification and could be subject to the recovery of funds and referral for investigation of fraud.

g. The commissioner will carry out audit appropriately and a PCN must co-operate fully in providing the relevant information. Failure by a PCN to provide the requested information will enable the commissioner to withhold or reclaim reimbursements.

h. A PCN must ensure that clinical pharmacists, reimbursed under the national *Clinical Pharmacists in General Practice Scheme,* and any pharmacists reimbursed under the *MOCH Scheme*, that have been

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transferred[68] between 1 April 2021 and 30 September 2021 to receive funding under the Network Contract DES, meet the terms set out in this Network Contract DES Specification. The PCN must ensure that the clinical pharmacists and pharmacists work across the PCN and carry out the relevant duties pursuant to section 7 in the delivery of health services.

i. The commissioner will make any payments due under this section 10.5 to the Nominated Payee.

j. Table 2, and Tables 3a and 3b set out the figures for the maximum annual equivalent reimbursement rate for each role that applies to all workforce claims made pursuant to this section 10.5 that relate to any month from 1 April 2026 to 31 March 2027.

10.5.7. For the purposes of this section, "**WTE**" is defined as 37.5 hours in line with AfC terms, but this may vary for non-AfC posts. Where AfC does not apply, a PCN 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.

10.5.8. If the person delivering the health services is employed by a non-PCN body, the contribution will be the aggregate WTE equivalent actual salary and employer on-costs (NI and pension only) up to the maximum reimbursable amount for the role as outlined in Table 2 or 3a or 3b or 3c, that have been appropriately apportioned to PCN-related activity.

10.5.9. In addition to the reimbursement of 100 per cent of actual WTE equivalent salary and employer on costs (pension and national insurance contributions), where a PCN does not employ a Social Prescriber Link Worker and sub-contracts the delivery of the social prescribing service, a PCN may claim a contribution towards additional costs charged by the sub-contracted provider for the provision of the social prescribing service. A PCN may claim a contribution of up to £200 per month (£2,400 per year) for each whole WTE that the sub-contracted provider has appropriately apportioned to PCN-related activity provided that:

a. a claim for the contribution towards additional costs charged by the sub-contracted provider must not exceed £200 in respect of any month; and

b. the total annual amount claimed by the PCN in respect of the social prescribing element in respect of each WTE does not exceed the maximum reimbursable amount set out in Table 2. For the avoidance of doubt, the contribution towards additional costs charged by the sub-

[68] Information regarding the transition arrangements is available in the Network Contract DES guidance.

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contracted provider is included when considering whether the total annual amount is within the maximum reimbursable amount.

Table 2: Maximum reimbursement amounts per role for 2026/27

	Indicative band	Annual equivalent maximum reimbursable amount per role	Annual equivalent maximum reimbursable amount per role plus inner HCAS	Annual maximum reimbursable amount per role plus outer HCAS
		National	Inner London	Outer London
Clinical pharmacists	7-8a	£71,725	£83,040	£79,665
Pharmacy technicians	5	£46,447	£55,887	£53,527
Social prescribing link workers	Up to 5	£46,447	£55,887	£53,527
Health and wellbeing coaches	Up to 5	£46,447	£55,887	£53,527
Care co-ordinators	4	£38,739	£46,637	£45,039
Physician Assistants (also known as Physician Associates)	7	£69,515	£80,830	£77,455
First contact physiotherapists	7-8a	£71,725	£83,040	£79,665
Dieticians	7	£69,515	£80,830	£77,455
Podiatrists	7	£69,515	£80,830	£77,455
Occupational therapists	7	£69,515	£80,830	£77,455

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	Indicative band	Annual equivalent maximum reimbursable amount per role	Annual equivalent maximum reimbursable amount per role plus inner HCAS	Annual maximum reimbursable amount per role plus outer HCAS
Student Nursing Associates (previously trainee nursing associates)	3	£34,469	£41,962	£40,769
Nursing Associates	4	£38,739	£46,637	£45,039
Community Paramedics	7	£69,515	£80,830	£77,455
Advanced Practitioners	8a	£78,534	£89,848	£86,474
General Practice Assistants	4	£38,739	£46,637	£45,039
Digital and Transformation Leads	8a	£78,534	£89,848	£86,474
Apprentice Physician Assistants	5	£46,447	£55,887	£53,527
Enhanced Practice Nurses	7	£69,515	£80,830	£77,455
Healthcare Support Workers	3	£34,469	£41,962	£40,769
New to General Practice Nurses	5	£46,447	£55,887	£53,527
Experienced General Practice Nurses	6	£57,114	£68,429	£65,054
Consultant Nurses Primary Care	8c	£109,943	£121,258	£117,883

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	Indicative band	Annual equivalent maximum reimbursable amount per role	Annual equivalent maximum reimbursable amount per role plus inner HCAS	Annual maximum reimbursable amount per role plus outer HCAS
Other direct patient care roles, as per section 7.3.2	As agreed with commissioner and within the band maxima for the band recruited as set out above.			
Other non-direct patient care roles, as per section 7.3.2	As agreed with commissioner and within the band maxima for the band recruited as set out above.			

Table 3a: for initial (existing) MHPs funded 50:50 with Mental Health Provider

	AfC Band	Annual equivalent maximum reimbursable amount per role	Annual equivalent maximum reimbursable amount per role plus inner HCAS	Annual equivalent maximum reimbursable amount per role plus outer HCAS
Adult Mental Health Practitioner and CYP Mental Health Practitioner	4	£19,370	£23,319	£22,519
	5	£23,224	£27,943	£26,763
	6	£28,557	£34,214	£32,527
	7	£34,758	£40,415	£38,728
	8a	£39,267	£44,924	£43,237

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Table 3b: Additional MHPs, where funding arrangements are for agreement between PCN and mental health provider,

	AfC Band	Annual equivalent maximum reimbursable amount per role	Annual equivalent maximum reimbursable amount per role plus inner HCAS	Annual equivalent maximum reimbursable amount per role plus outer HCAS
Adult Mental Health Practitioner and CYP Mental Health Practitioner	4	£38,739	£46,637	£45,039
	5	£46,447	£55,887	£53,527
	6	£57,114	£68,429	£65,054
	7	£69,515	£80,830	£77,455
	8a	£78,534	£89,848	£86,474

N.B. the amounts provided in table 3b reflect the maximum reimbursement available to the PCN, and are based on the PCN funding 100% of the role. The actual amount claimed will depend on local funding agreements. For example, if the PCN and mental health provider agree to fund 70% and 30% of the role respectively, the PCN will only claim 70% of the amount quoted above.

Table 3c: Maximum reimbursement amounts per role for General Medical Practitioners for 2026/27

	Annual equivalent maximum reimbursable amount per role	Annual equivalent maximum reimbursable amount per role plus London weighting
General Medical Practitioners	£152,900	£155,698

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10.5.10. A PCN will only be eligible for payment where all of the following requirements have been met:

a. For workforce related claims, the PCN has met the requirements as set out in section 7 for the relevant roles against which payment is being claimed.

b. The employing organisation (whether this is a PCN member or a third-party organisation) continues to employ the individual(s) for whom payments are being claimed and the PCN continues to have access to those individual(s);

c. The PCN makes available to commissioners any information under the Network Contract DES, which the commissioner needs and the PCN either has or can be reasonably expected to obtain in order to establish that the PCN has fulfilled the requirements of the Network Contract DES Specification;

d. The PCN complies with the relevant local payment arrangements including submitting a workforce related claim in accordance with this Specification prior to the expiration of any deadline set by the local commissioner as part of the local payment arrangements;

e. The PCN makes any returns required of it and does so promptly and fully; and

f. All information supplied pursuant to or in accordance with this Network Contract DES Specification is complete and accurate.

10.6 Investment and Impact Fund

10.6.1. A PCN is entitled to additional funding by virtue of the Investment and Impact Fund ("**IIF**").

10.6.2. Subject to adherence to the provisions of this section 10.6, a PCN is entitled to an achievement payment (the "**Total Indicator Achievement Payment**") in relation to any IIF indicators listed in Annex D.

10.6.3. In relation to the Total Indicator Achievement Payment, a PCN acknowledges that:

a. it will achieve points based on its performance in relation to the IIF indicators (the "**Indicators**"), as listed in Annex D;

b. every Indicator has been allocated a certain number of points;

c. it will achieve a number of points for each Indicator between zero and the maximum number of points allocated to that Indicator;

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d. there are a total of 58 points across all Indicators; and

e. each point is worth £198.00.

10.6.4. In relation to the Indicators, a PCN acknowledges that these are classed as 'Standard Quantitative,' meaning that:

a. Performance and earnings depend on:

i. a numerator (N);

ii. a denominator (D);

iii. a prevalence numerator (E);

iv. a lower performance threshold (L);

v. an upper performance threshold (U); and

vi. a maximum number of points that can be achieved (A).

b. The Indicator value, also referred to as performance (X), equals the numerator divided by the denominator (X=N/D).

c. The maximum number of points that can be achieved (A) will have an integer value. The points achieved by each PCN in relation to each indicator will be calculated exactly, based on their performance.

d. The desired direction of performance for an individual Indicator may be upwards or downwards. The desired direction of performance for each Indicator is set out in the descriptions of the Indicators in Annex D.

e. If the desired direction of performance is upwards, a higher value of performance means better performance, while a lower value of performance means worse performance.

f. If the desired direction of performance is downwards, a lower value of performance means better performance, while a higher value of performance means worse performance.

10.6.5. The commissioner will calculate a PCN's Total Indicator Achievement Payment in accordance with the five steps listed below, each of which is set out in more detail in Annex C:

a. Step 1: For each Indicator, a numerator and denominator will be calculated for the PCN by adding up the corresponding practice-level numerators and denominators for the Core Network Practices of the PCN.

b. Step 2: For each Indicator, the performance of the PCN will be calculated.

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c. Step 3: For each Indicator, the number of points (“Achievement Points”) achieved by the PCN will be calculated.

d. Step 4: For each Indicator, the level of payment (“Achievement Payment”) will be calculated.

e. Step 5: The Total Indicator Achievement Payment for the PCN (the sum of Achievement Payments across all Indicators) will be calculated.

10.6.6. The commissioner will calculate the Total Indicator Achievement Payment in respect of a PCN after 31 March 2027.

10.6.7. The commissioner will, in a timely manner after 31 March 2027, make available to a PCN a summary of the data and calculations (including Achievement Points and Achievement Payments) in relation to it.

10.6.8. To be eligible to receive the Total Indicator Achievement Payment, a PCN must review and declare the data and calculations provided under section 10.6.7 and extracted from GP systems or otherwise subject to declaration, during the ‘declaration window’.

a. The ‘declaration window’ will last from whenever declaration is made available until:

i. 30 April 2027, if declaration is made available before 16 April 2027.

ii. 14 calendar days after declaration is made available if declaration is made available on or after 16 April 2027.

b. Declaration means that the PCN confirms that:

i. The data extracted from GP systems or manually submitted is an accurate summary of its performance in relation to the Indicators.

ii. Any calculations performed in relation to data extracted from GP systems or manually submitted are also accurate.

c. If a PCN believes that the data and calculations provided under section 10.6.7 and extracted from GP systems or manually submitted are inaccurate for any reason, the PCN may decline to declare its achievement when given the opportunity to do so, and may enter into correspondence with the commissioner. If, after reviewing any evidence submitted, the commissioner agrees that there is an inaccuracy, the commissioner may at its sole discretion resubmit accurate data on behalf of the PCN, before final performance and achievement is calculated. For avoidance of doubt, irrespective of the circumstances or any other facts, failure to declare achievement within the declaration window means that any deadlines pertaining to end of year Achievement Payments do not apply.

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10.6.9. A PCN must nominate two persons to act as the Nominated Persons on behalf of the PCN's Core Network Practices prior to the release of the data. The commissioner must approve these nominations and make the necessary arrangements for the Nominated Persons to have access to CQRS. The data extracted from GP systems or manually submitted and provided under section 10.6.7 must be declared on a PCN's behalf by either of the Nominated Persons. Where the commissioner receives the declaration from either of the Nominated Persons, it will consider that the PCN has declared the data in accordance with this section 10.6. If the PCN needs to change the identity of one or both Nominated Persons at any time after nomination, the PCN must provide the identity and contact details of the new Nominated Person(s) prior to the date the commissioner makes available the summary of data as set out in section 10.6.7. Where a PCN nominates the Nominated Persons to the commissioner, each Core Network Practice of the PCN warrants that:

a. it has agreed the nomination of the Nominated Persons;

b. in respect of the data about which this section 10.6 requires declaration, it consents to that data being disclosed to the Nominated Persons; and

c. it has ensured that the Nominated Persons have the necessary authority and authorisation to review and declare the relevant data to the commissioner on its behalf.

10.6.10. Where a Total Indicator Achievement Payment in respect of IIF is due to a PCN, the commissioner will make that payment by 31 August 2027. The commissioner will make any payment due to the Nominated Payee of the PCN. If there is a change to the Nominated Payee or PCN prior to the payment being made, the commissioner will comply with section 10.1.7.

10.6.11. To be eligible to receive the Total Indicator Achievement Payment, a PCN must:

a. commit in writing to the commissioner to reinvest any IIF Achievement Payment into additional workforce, additional primary medical services, and/or other areas of investment in a Core Network Practice (e.g. equipment, premises);

b. undertake the clinical coding required of it to calculate performance and achievement in relation to Indicators, including the recording of any Personalised Care Adjustments ("**PCAs**", defined in Annex C). Further details of the codes used to calculate performance and achievement, and to record PCAs, are provided in the Network Contract DES Guidance and Network Contract DES Service Business Rules[69]. In the

[69] Network Contract DES Service Business rules are available in the relevant business rules under the relevant years 'Enhanced Services, Vaccinations and Immunisations and Core Contract components' page.

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event of any discrepancy, the Network Contract DES Service Business Rules are the definitive statement of the codes that will be used to calculate performance and achievement in relation to the IIF;

c. consent to extraction of data required to calculate performance and achievement and to the use of extracted data for the purpose of calculating performance and achievement;

d. make any manual return required of it to enable calculation of performance and achievement and consent to the use of the returned data for this purpose;

e. ensure that all the information made available (whether by an automated extract or otherwise) for the purpose of calculating performance and achievement is accurate and reliable;

f. declare any data extracted from GP systems or manually submitted requiring declaration that is made available to it concerning its performance in relation to the Indicators;

g. ensure that it is able to provide to the commissioner any information that may reasonably be requested to demonstrate that it is entitled to each Achievement Point to which it says it is entitled and make that information available to the commissioner on request. In verifying that information has been correctly recorded, the commissioner may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator;

h. co-operate fully with any reasonable inspection or review that the commissioner or another relevant statutory authority wishes to undertake in respect of the Achievement Points to which it says it is entitled; and

i. ensure that all information supplied pursuant to or in accordance with this paragraph is accurate.

10.6.12. If the conditions set out in section 10.6.11 are not met, the commissioner may withhold payment of all or part of the Total Indicator Achievement Payment that is otherwise payable.

10.7 Proactive Care Plans

10.7.1. A PCN is entitled to additional payments for complying with requirements set out in section 8.4.2(d) relating to developing and implementing Proactive Care Plans, subject to the provisions of this section 10.7.

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10.7.2. A PCN is only entitled to payment in respect of Proactive Care Plans up to the amount allocated to the PCN in relation to Proactive Care Plans (the "Proactive Care Allocation"). The funding allocation will be calculated as 0.5% of the PCN Adjusted Population figure as of 1 July 2026.

10.7.3. Subject to section 10.7.2, a PCN will be entitled to £126 per relevant PCN Patient in respect of whom a Proactive Care Plan is developed and implemented in accordance with section 8.4.2(d).

10.7.4. A PCN must make a manual claim to their commissioner for payment via CQRS National. Claims must be on the basis of the number of unique PCN patients with a qualifying Proactive Care Plan coded on the basis of the SNOMED codes below:

1. 1239461000000102 Proactive care needs assessment (procedure), and
2. 802321000000106 Care plan agreed (finding) within two working days of the Proactive care needs assessment

10.7.5. Only one claim for payment per PCN Patient may be made and only activity which takes place between 1 October 2026 and 31 March 2027 would be eligible for claiming under the terms of this Section 10.7.

10.7.6. Claims for payment should be made monthly, within 12 days of the end of the month in which the activity was delivered.

10.7.7. The commissioner will, subject to being satisfied as set out in section 10.7.2 to 10.7.6, make the relevant payment on a monthly basis. The relevant payment for a month is, subject to the aggregate amount paid to the PCN not exceeding the Proactive Care Allocation, the number of eligible patients multiplied by the amount per patient referred to in section 10.7.3.

10.7.8. The commissioner will make any payments due to the Nominated Payee of the PCN. If there is a change to the Nominated Payee or PCN prior to the payment being made, the commissioner will comply with section 10.1.7.

10.7.9. The commissioner must ensure that approved claims do not exceed the PCN's Proactive Care Allocation. To be satisfied that the patient is eligible and the PCN has complied with section 8.4.2(d):

- The patient must satisfy the eligibility criteria set out in section 8.4.2(d);

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- The patient must not receive interventions in accordance with section 8.4.2(d) which are funded through another proactive care arrangement, unless the interventions delivered in accordance with section 8.4.2(d) are additional to those funded through that other arrangement. Whether the interventions are additional shall be determined by the commissioner;

- The patient must have the relevant evidence of the Proactive Care Plan within their patient record, in accordance with 10.7.4. The commissioner is responsible for post-payment verification and may require the PCN to promptly make available to the commissioner, in an appropriate form, the Proactive Care Plans (or a sample of them), evidence that the interventions identified within those plans have been undertaken, or any other information reasonably required to support verification. In verifying that information provided is accurate, the commissioner may choose to inspect the output from a computer search that has been used to provide information on the relevant PCN patients;

- The PCN must co-operate fully with any reasonable inspection or review that the commissioner or another relevant statutory authority wishes to undertake in respect of the Proactive Care Plans in respect of which the PCN is claiming payment; and

- The PCN must ensure that all information supplied pursuant to, or in accordance with, this section 10.7 is accurate.

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Annex A – Network Contract DES Participation and Notification of Change Form

The Network Contract DES Participation and Notification of Change Form is available at https://www.england.nhs.uk/publication/network-contract-des-participation-and-notification-form-2022-23/ .

Annex B – Additional Roles Reimbursement Scheme – Minimum Role Requirements

B.1 Clinical Pharmacist

B1.1. Where a PCN employs or engages a Clinical Pharmacist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Clinical Pharmacist is enrolled in, or has qualified from, an approved 18-month training pathway or equivalent that equips the Clinical Pharmacist to:

a. be able to practice and prescribe safely and effectively in a primary care setting (for example, the CPPE Clinical Pharmacist training pathways[70,71]); and

b. deliver the key responsibilities outlined in section B.1.3

B1.2. Where a PCN employs or engages a Clinical Pharmacist under the Additional Roles Reimbursement Scheme, the PCN must ensure this is a minimum 0.5 WTE 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 while working across multiple providers within the PCN.

B1.3. Where a PCN employs or engages one or more Clinical Pharmacists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Clinical Pharmacist has the following key responsibilities in relation to delivering health services:

a. work as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas;

[70] https://www.cppe.ac.uk/career/clinical-pharmacists-in-general-practice-education#navTop

[71] https://www.cppe.ac.uk/wizard/files/general-practice/clinical-pharmacists-in-general-practice-education-brochure.pdf

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b. be a prescriber, or completing training to become prescribers, and work with and alongside the general practice team;

c. be responsible for the care management of patients with chronic diseases and undertake clinical medication reviews to proactively manage people with complex polypharmacy, especially older people, people in care homes, those with multiple co-morbidities (in particular frailty, COPD and asthma) and people with learning disabilities or autism (through STOMP – Stop Over Medication Programme);

d. provide specialist expertise in the use of medicines whilst helping to address both the public health and social care needs of patients at the PCN's practice(s) and to help in tackling inequalities;

e. provide leadership on person-centred medicines optimisation (including ensuring prescribers in the practice conserve antibiotics in line with local antimicrobial stewardship guidance) and quality improvement, whilst contributing to the quality and outcomes framework and enhanced services;

f. through structured medication reviews, support patients to take their medications to get the best from them, reduce waste and promote self-care;

g. have a leadership role in supporting further integration of general practice with the wider healthcare teams (including community and hospital pharmacy) to help improve patient outcomes, ensure better access to healthcare and help manage general practice workload;

h. develop relationships and work closely with other pharmacy professionals across PCNs and the wider health and social care system;

i. take a central role in the clinical aspects of shared care protocols, clinical research with medicines, liaison with specialist pharmacists (including mental health and reduction of inappropriate antipsychotic use in people with learning disabilities), liaison with community pharmacists and anticoagulation; and

j. be part of a professional clinical network and have access to appropriate clinical supervision. Appropriate clinical supervision means:

    i. each clinical pharmacist must receive a minimum of one supervision session per month by a senior clinical / advanced practice pharmacist[72];

[72] This does not need to be a senior clinical / advanced practice pharmacist within the PCN but could be part of a wider local network, including from secondary care or another PCN.

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ii. the senior clinical / advanced practice pharmacist must receive a minimum of one supervision session every three months by a GP clinical supervisor;

iii. each clinical pharmacist/senior clinical pharmacist/advanced practice pharmacist will have access to an assigned GP clinical supervisor for support and development; and

iv. a ratio of one senior clinical / advanced practice pharmacist to no more than five junior clinical pharmacists, with appropriate peer support and supervision in place.

B.2 Pharmacy Technicians

B2.1. Where a PCN employs or engages a Pharmacy Technician under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Pharmacy Technician:

a. is registered with the General Pharmaceutical Council (GPhC);

b. meets the specific qualification and training requirements as specified by the GPhC criteria[73] to register as a Pharmacy Technician;

c. enrolled in, undertaking or qualified from, an approved training pathway. For example, the Primary Care Pharmacy Educational Pathway (PCPEP) or Medicines Optimisation in Care Homes (MOCH) or courses approved by the Association of Pharmacy Technicians UK (APTUK) as meeting the requirements of the UK-wide APTUK/PCPA National Competency Framework for Primary Care Pharmacy Technicians; and

d. is working under appropriate clinical supervision to ensure safe, effective and efficient use of medicines

in order to deliver the key responsibilities outlined in section B2.2.

B2.2. Where a PCN employs or engages one or more Pharmacy Technicians under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Pharmacy Technician has the following key clinical, and technical and administrative responsibilities, in delivering health services:

B2.2.1. Clinical responsibilities of the Pharmacy Technician:

[73] The training requirements for Pharmacy Technicians are currently in transition and further information is available on the General Pharmaceutical Council (GPhC) website. This information will provide the specific criteria to register as a pharmacy technician – see https://www.pharmacyregulation.org/i-am-pharmacy-technician

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a. undertake patient facing and patient supporting roles to ensure effective medicines use, through shared decision-making conversations with patients;

b. carry out medicines optimisation tasks including effective medicine administration (e.g. checking inhaler technique), supporting medication reviews, and medicines reconciliation. Where required, utilise consultation skills to work in partnership with patients to ensure they use their medicines effectively;

c. support, as determined by the PCN, medication reviews and medicines reconciliation for new care home patients and synchronising medicines for patient transfers between care settings and linking with local community pharmacists.

d. provide specialist expertise, where competent, to address both the public health and social care needs of patients, including lifestyle advice, service information, and help in tackling local health inequalities;

e. take a central role in the clinical aspects of shared care protocols and liaising with specialist pharmacists for more complex patients;

f. support initiatives for antimicrobial stewardship to reduce inappropriate antibiotic prescribing;

g. assist in the delivery of medicines optimisation and management incentive schemes and patient safety audits;

h. support the implementation of national prescribing policies and guidance within GP practices, care homes and other primary care settings. This will be achieved through undertaking clinical audits (e.g. use of antibiotics), supporting quality improvement measures and contributing to the Quality and Outcomes Framework and enhanced services;

B2.2.2. Technical and Administrative responsibilities of the Pharmacy Technician:

a. work with the PCN multi-disciplinary team to ensure efficient medicines optimisation, including implementing efficient ordering and return processes, and reducing wastage;

b. supervise practice reception teams in sorting and streaming general prescription requests, so as to allow GPs and clinical pharmacists to review the more clinically complex requests;

c. provide leadership for medicines optimisation systems across PCNs, supporting practices with a range of services to get the best value from

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medicines by encouraging and implementing Electronic Prescriptions, safe repeat prescribing systems, and timely monitoring and management of high-risk medicines;

d. provide training and support on the legal, safe and secure handling of medicines, including the implementation of the Electronic Prescription Service (EPS); and

e. develop relationships with other pharmacy technicians, pharmacists and members of the multi-disciplinary team to support integration of the pharmacy team across health and social care including primary care, community pharmacy, secondary care, and mental health.

B.3 Social Prescribing Link Workers

B3.1. A PCN must provide to the PCN's patients access to a social prescribing service. To comply with this, a PCN may:

a. directly employ Social Prescribing Link Worker(s); or

b. sub-contract provision of the service to another provider

in accordance with this Network Contract DES Specification.

B3.2. Where a PCN employs or engages a Social Prescribing Link Worker under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Social Prescribing Link Worker:

a. has completed the NHS England and online learning programme[74] accessed via the Personalised Care Institute website; and

b. attends the peer support networks delivered at place or system by the ICS in the region.

Additionally, where the Social Prescribing Link Worker **does not** already have any level 3 qualification (e.g. A level or other equivalent post-16 education), the PCN should ensure that they are enrolled in or, undertaking, appropriate training or an apprenticeship to obtain a level 3 occupational standard, with consideration given to the Workforce Development Framework for Social Prescribing Link Workers[75]. For those workers who already have a qualification at level 3, a level 3 social prescribing course is recommended but not mandatory.

In order to deliver the key responsibilities outlined in section B3.3a a PCN can claim reimbursement for the time Social Prescribing Link Workers spend out of

[74] https://www.e-lfh.org.uk/programmes/social-prescribing/
[75] https://www.england.nhs.uk/publication/workforce-development-framework-social-prescribing-link-workers/

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practice undertaking these three activities, noting the provisos for level 3 training, i.e. that reimbursement is for those who do not already hold and equivalent qualification.

B3.3. Where a PCN employs or engages one or more Social Prescribing Link Workers under the Additional Roles Reimbursement Scheme or sub-contracts provision of the social prescribing service to another provider, the PCN must ensure that each Social Prescribing Link Worker providing the service has the following key responsibilities in delivering the service to patients:

a. as members of the PCN's team of health professionals, take referrals from the PCN's Core Network Practices and from a wide range of agencies[76] to support the health and wellbeing of patients;

b. assess how far a patient's health and wellbeing needs can be met by services and other opportunities available in the community;

c. co-produce a simple personalised care and support plan to address the patient's health and wellbeing needs by introducing or reconnecting people to community groups and statutory services, and signposting where appropriate and as it matters to the person;

d. evaluate how far the actions in the care and support plan are meeting the patient's health and wellbeing needs[77];

e. provide personalised support to patients, their families and carers to take control of their health and wellbeing, live independently, improve their health outcomes and maintain a healthy lifestyle (including, where appropriate, by referral to weight management services);

f. develop trusting relationships by giving people time and focus on 'what matters to them';

g. take a holistic approach, based on the patient's priorities and the wider determinants of health, including supporting people to take up employment, training and welfare support;

h. explore and support access to a personal health budget where appropriate;

[76] These agencies include but are not limited to: the PCN's members, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations.

[77] Including considering if the persons needs are met (for example, reasonable adjustments, interpreter etc).

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i. manage and prioritise their own caseload, in accordance with the health and wellbeing needs of their population; and

j. where required and as appropriate, refer patients back to other health professionals within the PCN.

B3.4. A PCN's Core Network Practices must identify a first point of contact for general advice and support and (if different) a member of staff with relevant competencies, as described in the Workforce Development Framework to provide supervision for the Social Prescribing Link Worker(s). This could be provided by one or more named individuals within the PCN. A PCN's Core Network Practices must provide monthly access to clinical supervision with a relevant health professional.

B3.5. A PCN will ensure the Social Prescribing Link Worker(s) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.

B3.6. A PCN must ensure referrals to the Social Prescribing Link Worker(s) are recorded within GP clinical systems using the new national SNOMED codes (see section 7.4.1 and 5.4.7).

B3.7. Where a PCN employs or engages one or more Social Prescribing Link Workers under the Additional Roles Reimbursement Scheme or sub-contracts provision of the social prescribing service to another provider, the PCN must ensure that each Social Prescribing Link Worker has the following key wider responsibilities:

a. draw on and increase the strength and capacity of local communities, enabling local Voluntary, Community and Social Enterprise (VCSE) organisations and community groups to receive social prescribing referrals from the Social Prescribing Link Worker;

b. work collaboratively with all local partners to contribute towards supporting the local VCSE organisations and community groups to become sustainable and that community assets are nurtured, through sharing intelligence regarding any gaps or problems identified in local provision with commissioners, local authorities and (where appropriate) VCSE infrastructure organisations;

c. have a role in educating non-clinical and clinical staff within the PCN through verbal or written advice or guidance on what other services are available within the community and how and when patients can access them;

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B3.8. A PCN must be satisfied that organisations and groups to whom the Social Prescribing Link Workers(s) directs patients:

a. have basic safeguarding processes in place for vulnerable individuals; and

b. provide opportunities for the patient to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence.

B3.9. A PCN must ensure that all staff working in practices that are members of the PCN are aware of the identity of the Social Prescribing Link Worker(s) and the process for referrals.

B3.10. A PCN must work in partnership with commissioners, social prescribing schemes, Local Authorities and voluntary sector leaders to create a shared plan for social prescribing which must include how the organisations will build on existing schemes and work collaboratively to recruit additional social prescribing link workers to embed one in every PCN and direct referrals to the voluntary sector.

B.4 Health and Wellbeing Coach

B4.1. Where a PCN employs or engages a Health and Wellbeing Coach under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Health and Wellbeing Coach:

a. is enrolled in, undertaking or qualified from Personalised Care Institute accredited health coaching training as set out in the NHS England Workforce Development Framework[78], including training, or apprenticeships to obtain a level three occupational standard, with the training delivered by a training organisation listed by the Personalised Care Institute[79];

b. adheres to scope of practice and professional standards set out in the workforce Development Framework for Health and Wellbeing Coaches;

c. has formal individual and group coaching supervision which must come from a suitably qualified or experienced individual; and

d. working closely in partnership with the Social Prescribing Link Worker(s) or social prescribing service provider to identify and work alongside people who may need additional support, but are not yet ready to benefit fully from social prescribing

[78] https://www.england.nhs.uk/publication/workforce-development-framework-health-and-wellbeing-coaches/

[79] https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

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in order to deliver the key responsibilities outlined in section B4.2. a PCN can claim reimbursement for the time Health and Wellbeing Coaches spend out of practice undertaking these activities.

B4.2. Where a PCN employs or engages one or more Health and Wellbeing Coaches under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Health and Wellbeing Coach has the following key responsibilities, in delivering health services:

a. manage and prioritise a caseload, in accordance with the health and wellbeing needs of their population through taking an approach that is non-judgemental, based on strong communication and negotiation skills, while considering the whole person when addressing existing issues. Where required and as appropriate, the Health and Wellbeing Coach will refer people back to other health professionals within the PCN;

b. utilise existing IT and MDT channels to screen patients, with an aim to identify those that would benefit most from health coaching;

c. provide personalised support to individuals, their families, and carers to support them to be active participants in their own healthcare; empowering them to manage their own health and wellbeing and live independently through:

i. coaching and motivating patients through multiple sessions to identify their needs, set goals, and supporting patients to achieve their personalised health and care plan objectives;

ii. providing interventions such as self-management education and peer support;

iii. supporting patients to establish and attain goals that are important to the patient;

iv. supporting personal choice and positive risk taking while ensuring that patients understand the accountability of their own actions and decisions, thus encouraging the proactive prevention of further illnesses;

v. working in partnership with the social prescribing service to connect patients to community-based activities which support them to take increased control of their health and wellbeing; and

vi. increasing patient motivation to self-manage and adopt healthy behaviours;

d. work in partnership with patients to support them to develop their level of knowledge, skills and confidence enabling them to engage with their

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health and well-being and subsequently supporting them in shared decision-making conversations;

e. utilise health coaching skills to support to develop the knowledge, skills, and confidence to manage their health and wellbeing, whilst increasing their ability to access and utilise community support offers; and

f. explore and support patient access to a personal health budget, where appropriate, for their care and support.

B4.3. The following sets out the key wider responsibilities of Health and Wellbeing Coaches:

a. develop collaborative relationships and work in partnership with health, social care, and community and voluntary sector providers and multi-disciplinary teams to holistically support patients' wider health and well-being, public health, and contributing to the reduction of health inequalities;

b. provide education and specialist expertise to PCN staff, supporting them to improve their skills and understanding of personalised care, behavioural approaches and ensuring consistency in the follow up of people's goals with MDT input; and

c. raise awareness within the PCN of shared decision-making and decision support tools.

B4.4. A PCN must be satisfied that organisations and groups to whom its Health and Wellbeing Coach(es) directs patients:

a. have basic safeguarding processes in place for vulnerable individuals; and

b. provide opportunities for the patient to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence.

B4.5. A PCN's Core Network Practices must identify a first point of contact for general advice and support and (if different) a member of staff with relevant competencies, as described in the Workforce Development Framework to provide supervision. This could be provided by one or more named individuals within the PCN. The Health and Wellbeing Coach must have access to regular formal and individual group coaching supervision from a suitably qualified or experienced health coaching supervisor.

B4.6. A PCN will ensure the PCN's Health and Wellbeing Coach(es) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.

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B4.7. A PCN must ensure that all staff working in practices that are members of the PCN are aware of the identity of the PCN's Health and Wellbeing Coach(es).

B.5 Care Coordinator

B5.1. Where a PCN employs or engages a Care Coordinator under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Care Coordinator:

a. is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute as set out in the Workforce Development Framework for Care Co-ordinators[80], including training, or apprenticeships to obtain a level three standard[81]; and

b. works closely and in partnership with the Social Prescribing Link Worker(s) or social prescribing service provider and Health and Wellbeing Coach(es),

in order to deliver the key responsibilities outlined in section B5.2. A PCN can claim reimbursement for the time Care Co-ordinators spend out of practice undertaking these activities.

B5.2. Where a PCN employs or engages one or more Care Coordinators under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Care Coordinator has the following key responsibilities, in delivering health services:

a. utilise population health intelligence to proactively identify and work with a cohort of patients to deliver personalised care;

b. support patients to utilise decision aids in preparation for a shared decision-making conversation;

c. holistically bring together all of a person's identified care and support needs, and explore options to meet these within a single personalised care and support plan (PCSP), in line with PCSP best practice, based on what matters to the person;

d. help people to manage their needs through answering queries, making and managing appointments, and ensuring that people have good quality written or verbal information to help them make choices about their care, using tools to understand peoples level of knowledge, confidence in skills in managing their own health;

[80] https://www.england.nhs.uk/publication/workforce-development-framework-for-care-co-ordinators/
[81] https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

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e. support people to take up training and employment, and to access appropriate benefits where eligible for example, through referral to social prescribing link workers;

f. assist people to access self-management education courses, peer support or interventions that support them to take more control of their health and wellbeing;

g. explore and assist people to access personal health budgets where appropriate;

h. provide coordination and navigation for people and their carers across health and care services, working closely with social prescribing link workers, health and wellbeing coaches, and other primary care professionals; and

i. support the coordination and delivery of MDTs within the PCN.

B5.3. The following sets out the key wider responsibilities of Care Coordinators:

a. work with the GPs and other primary care professionals within the PCN to identify and manage a caseload of patients, and where required and as appropriate, refer people back to other health professionals within the PCN;

b. raise awareness within the PCN of shared decision-making and decision support tools; and

c. raise awareness of how to identify patients who may benefit from shared decision making and support PCN staff and patients to be more prepared to have shared decision-making conversations.

B5.1. A PCN must be satisfied that organisations and groups to whom its Care Coordinator directs patients:

a. have basic safeguarding processes in place for vulnerable individuals; and

b. provide opportunities for the patient to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence.

B5.4. A PCN's Core Network Practices must identify a first point of contact for general advice and support and (if different) a member of staff with relevant competencies, as described in the Workforce Development Framework to provide supervision. This could be provided by one or more named individuals within the PCN.

B5.5. A PCN will ensure the PCN's Care Coordinator(s) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.

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B5.6. A PCN must ensure that all staff working in practices that are members of the PCN are aware of the identity of the PCN's Care Coordinator(s).

B.6 Physician Assistant (also known as Physician Associate)

B6.1. Where a PCN employs or engages a Physician Assistant under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Physician Assistant:

a. has completed a post-graduate physician assistant course (either PG Diploma or MSc) or integrated undergraduate masters degree and passed both parts of the Physician Associate National Exam (PANE), Physician Associate Registration Assessment;

b. is registered with or in the process of joining the General Medical Council register ahead of registration becoming a legal requirement from December 2026;

c. demonstrates ongoing fitness to practice through supervision and appraisal processes and successfully completes all applicable re-certification and re-accreditation requirements (including, from December 2026, any reaccreditation requirements defined by the General Medical Council);

d. participates in continuing professional development opportunities by keeping up to date with evidence-based knowledge and competence in all aspects of their role, meeting clinical governance guidelines for continuing professional development (CPD),

e. completes all mandatory training within required timescales: and

f. is working under supervision of a named qualified GP or doctor on the GMC GP register as part of the multidisciplinary team,

in order to deliver the key responsibilities outlined in section B6.2.

B6.2. Where a PCN employs or engages one or more Physician Assistants[82] under the Additional Roles Reimbursement Scheme, the PCN must ensure that the

[82] The Government accepted all 18 recommendations of The Leng Review, published in July 2025. This includes a recommendation that newly qualified physician assistants should gain at least 2 years' experience in secondary care prior to taking a role in primary care or a mental health trust. This applies to all newly qualified PAs after July 2025.

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key responsibilities for each Physicians Assistant in delivering health services and determined by their named GP supervisor, having regard to:

a. applicable guidance and clinical protocols, including GMC's Good Medical Practice, guidance published by NHS England and appropriate Royal Colleges; and

b. the Physician Assistant's knowledge, skills and experience gained through their training and development.

B6.3. A PCN's Core Network practices must identify a suitable named GP supervisor for each physician assistant, to ensure they always work under appropriate clinical supervision, which must include appropriate debriefing.

B.6A Apprentice Physician Assistant

B.6A.1 Where a PCN employs an apprentice Physician Assistant under the Additional Roles Reimbursement Scheme, they must ensure that the apprentice Physician Assistant:

a. is enrolled on a postgraduate degree apprenticeship from the approved national framework of providers[83]; and

b. gradually builds experience against the tasks outlined in the Physician Assistant job description through on-job training, in line with the apprenticeship standard[84].

B.6A.2 During the initial phase of the apprenticeship, all apprentice Physician Assistant work activities should be under direct guidance and supervision of a named registered medical practitioner. As the apprenticeship progresses, following discussion and agreement with mentors and supervisors, supervision and guidance may be both direct and indirect. Supervision and guidance may be provided by both the GP and other members of the practice team.

B.7 First Contact Physiotherapists

B7.1. Where a PCN employs or engages a First Contact Physiotherapist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the First Contact Physiotherapist:

[83] https://haso.skillsforhealth.org.uk/physician-associate-pa-apprenticeship-faq/

[84] To note the PA Apprenticeship Standard is in revision to align with the GMC's professional standards Physician associate / Skills England

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a. has completed an undergraduate degree in physiotherapy;

b. is a registered Physiotherapist with the Health and Care Professional Council;

c. holds the relevant public liability insurance;

d. has a Masters Level qualification or the equivalent specialist knowledge, skills and experience;

e. can demonstrate working at Level 7 capability in MSK related areas of practice or equivalent (such as advanced assessment diagnosis and treatment);

f. can demonstrate ability to operate at an advanced level of practice,

in order to deliver the key responsibilities outlined in section B7.2.

B7.2. Where a PCN employs or engages one or more First Contact Physiotherapists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each First Contact Physiotherapist has the following key responsibilities, in delivering health services:

a. work independently, without day to day supervision, to assess, diagnose, triage, and manage patients, within agreed scope of practice taking responsibility for prioritising and managing a caseload of the PCN's Registered Patients;

b. receive patients who self-refer (where systems permit) or from a clinical professional within the PCN, and where required refer to other health professionals within the PCN;

c. work as part of a multi-disciplinary team in a patient facing role, using their expert knowledge of movement and function issues, to create stronger links for wider services through clinical leadership, teaching and evaluation;

d. develop integrated and tailored care programmes in partnership with patients, providing a range of first line treatment options including self-management, referral to rehabilitation focussed services and social prescribing;

e. make use of their full scope of practice, developing skills relating to independent prescribing, injection therapy and investigation to make professional judgements and decisions in unpredictable situations, including when provided with incomplete or contradictory information. They will take responsibility for making and justifying these decisions;

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f. manage complex interactions, including working with patients with psychosocial and mental health needs, referring onwards as required and including social prescribing when appropriate;

g. communicate effectively with patients, and their carers where applicable, complex and sensitive information regarding diagnoses, pathology, prognosis and treatment choices supporting personalised care;

h. implement all aspects of effective clinical governance for own practice, including undertaking regular audit and evaluation, supervision and training;

i. develop integrated and tailored care programmes in partnership with patients through:

   i. effective shared decision-making with a range of first line management options (appropriate for a patient's level of activation);

   ii. assessing levels of patient activation to support a patient's own level of knowledge, skills and confidence to self-manage their conditions, ensuring they are able to evaluate and improve the effectiveness of self-management interventions, particularly for those at low levels of activation;

   iii. agreeing with patient's appropriate support for self-management through referral to rehabilitation focussed services and wider social prescribing as appropriate; and

   iv. designing and implementing plans that facilitate behavioural change, optimise patient's physical activity and mobility, support fulfilment of personal goals and independence, and reduce the need for pharmacological interventions;

j. request and progress investigations (such as x-rays and blood tests) and referrals to facilitate the diagnosis and choice of treatment regime including, considering the limitations of these investigations, interpret and act on results and feedback to aid patients' diagnoses and management plans; and

k. be accountable for decisions and actions via Health and Care Professions Council (HCPC) registration, supported by a professional culture of peer networking/review and engagement in evidence-based practice.

B7.3. The following sets out the key wider responsibilities of First Contact Physiotherapists:

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a. work across the multi-disciplinary team to create and evaluate effective and streamlined clinical pathways and services;

b. provide leadership and support on MSK clinical and service development across the PCN, alongside learning opportunities for the whole multi-disciplinary team within primary care;

c. develop relationships and a collaborative working approach across the PCN, supporting the integration of pathways in primary care;

d. encourage collaborative working across the wider health economy and be a key contributor to supporting the development of physiotherapy clinical services across the PCN;

e. liaising with secondary and community care services, and secondary and community MSK services where required, using local social and community interventions as required to support the management of patients within the PCN; and

f. support regional and national research and audit programmes to evaluate and improve the effectiveness of the First Contact Practitioner (FCP) programme. This will include communicating outcomes and integrating findings into own and wider service practice and pathway development.

B.8 Dietitians

B8.1. Where a PCN employs or engages a Dietitian under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Dietitian:

a. has a BSc or pre-reg MSc in Dietetics under a training programme approved by the British Dietetic Association (BDA);

b. is a registered Dietitian with the Health and Care Professionals Council (HCPC);

c. is able to operate at an advanced level of practice; and

d. has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis,

in order to deliver the key responsibilities outlined in section B8.2.

B8.2. Where a PCN employs or engages one or more Dietitians under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Dietitian has the following key responsibilities, in delivering health services:

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a. provide specialist nutrition and diet advice to patients, their carers, and healthcare professionals through treatment, education plans, and prescriptions;

b. educate patients with diet-related disorders on how they can improve their health and prevent disease by adopting healthier eating and drinking habits;

c. provide dietary support to patients of all ages (from early-life to end-of-life care) in a variety of settings including nurseries, patient homes and care homes;

d. work as part of a multi-disciplinary team to gain patient's cooperation and understanding in following recommended dietary treatments;

e. develop, implement and evaluate a seamless nutrition support service across the PCN, working with community and secondary care where appropriate, and aimed at continuously improving standards of patient care and wider multi-disciplinary team working;

f. work with clinicians, multi-disciplinary team colleagues and external agencies to ensure the smooth transition of patients discharged from hospital back into primary care, so that they can continue their diet plan;

g. make recommendations to PCN staff regarding changes to medications for the nutritional management of patients, based on interpretation of biochemical, physiological, and dietary requirements; and

h. implement all aspects of effective clinical governance for own practice, including undertaking regular audit and evaluation, supervision and training.

B8.3. The following sets out the key wider responsibilities of Dietitians:

a. undertake a range of administrative tasks such as ensuring stock levels are maintained and securely stored, and equipment is kept in good working order; and

b. ensure delivery of best practice in clinical practice, caseload management, education, research, and audit, to achieve corporate PCN and local population objectives.

B.9 Podiatrists

B9.1. Where a PCN employs or engages a Podiatrist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Podiatrist:

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a. has a BSc or pre-reg MSc in Podiatry under a training programme approved by the College of Podiatry;

b. is a registered Podiatrist with the Health and Care Professionals Council ("**HCPC**");

c. is able to operate at an advanced level of practice; and

d. has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis,

in order to deliver the key responsibilities outlined in section B9.2.

B9.2. Where a PCN employs or engages one or more Podiatrists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Podiatrist has the following key responsibilities, in delivering health services:

a. work as part of a PCN's multi-disciplinary team to clinically assess, treat, and manage a caseload of patients of all ages with lower limb conditions and foot pathologies, using their expert knowledge of podiatry for specific conditions and topics;

b. utilise and provide guidance to patients on equipment such as surgical instruments, dressings, treatment tables and orthotics;

c. prescribe, produce, and fit orthotics and other aids and appliances;

d. provide specialist treatment and support for high-risk patient groups such as older people and those with increased risk of amputation;

e. support patients through the use of therapeutic and surgical techniques to treat foot and lower leg issues (e.g. carrying out nail and soft tissue surgery using local anaesthetic);

f. deliver foot health education to patients;

g. implement all aspects of effective clinical governance for their own practice, including undertaking regular audit and evaluation, supervision, and training;

h. liaise with PCN multi-disciplinary team, community and secondary care staff, and named clinicians to arrange further investigations and onward referrals;

i. communicate outcomes and integrate findings into their own and wider service practice and pathway development; and

j. develop, implement and evaluate a seamless podiatry support service across the PCN, working with community and secondary care where

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appropriate, and aimed at continuously improving standards of patient care and wider multi-disciplinary team working.

B9.3. The following sets out the key wider responsibilities of Podiatrists:

a. undertake continued professional development to understand the mechanics of the body in order to preserve, restore, and develop movement for patients;

b. provide leadership and support on podiatry clinical service development across the PCN, alongside learning opportunities for the whole multi-disciplinary team within primary care;

c. provide education and specialist expertise to PCN staff, raising awareness of good practice in good foot health;

d. ensure delivery of best practice in clinical practice, caseload management, education, research, and audit, to achieve corporate PCN and local population objectives; and

e. undertake a range of administrative tasks such as ensuring stock levels are maintained and securely stored, and equipment is kept in good working order.

B.10 Occupational Therapists

B10.1. Where a PCN employs or engages an Occupational Therapist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Occupational Therapist:

a. has a BSc in or pre-reg MSc in Occupational Therapy under a training programme approved by the Royal College of Occupational Therapists;

b. is a registered Occupational Therapist with the Health and Care Professionals Council (HCPC);

c. is able to operate at an advanced level of practice; and

d. has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis,

in order to deliver the key responsibilities outlined in section B10.2.

B10.2. Where a PCN employs or engages one or more Occupational Therapists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Occupational Therapist has the following key responsibilities, in delivering health services:

a. assess, plan, implement, and evaluate treatment plans, with an aim to increase patients' productivity and self-care;

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b. work with patients through a shared-decision making approach to plan realistic, outcomes-focused goals;

c. undertake both verbal and non-verbal communication methods to address the needs of patients that have communication difficulties;

d. work in partnership with multi-disciplinary team colleagues, physiotherapists and social workers, alongside the patients' families, teachers, carers, and employers in treatment planning to aid rehabilitation;

e. where appropriate, support the development of discharge and contingency plans with relevant professionals to arrange on-going care in residential, care home, hospital, and community settings;

f. periodically review, evaluate and change rehabilitation programmes to rebuild lost skills and restore confidence;

g. as required, advise on home, school, and workplace environmental alterations, such as adjustments for wheelchair access, technological needs, and ergonomic support;

h. advise patients, and their families or carers, on specialist equipment and organisations that can help with daily activities;

i. help patients to adapt to and manage their physical and mental health long-term conditions, through the teaching of coping strategies; and

j. develop, implement and evaluate a seamless occupational therapy support service across the PCN, working with community and secondary care where appropriate, and aimed at continuously improving standards of patient care and wider multi-disciplinary team working.

B10.3. The following sets out the key wider responsibilities of Occupational Therapists:

a. provide education and specialist expertise to PCN staff, raising awareness of good practice occupational therapy techniques; and

b. ensure delivery of best practice in clinical practice, caseload management, education, research, and audit, to achieve corporate PCN and local population objectives.

B.11 Nursing Associate

B11.1. Where a PCN employs or engages a Nursing Associate under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Nursing Associate:

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a. meets the specific qualification and training requirements as specified in the Nursing Midwifery Standards of proficiency by having undertaken and completed the two-year Foundation Degree delivered by a Nursing and Midwifery Council (NMC) - approved provider; and

b. is registered with the NMC and revalidation is undertaken in line with NMC requirements.

B11.2. Where a PCN employs or engages one or more Nursing Associates under the Additional Roles Reimbursement Scheme, the PCN must ensure that each nursing associate has the following key responsibilities in relation to delivering health services:

a. work as part of the PCN's MDT to provide and monitor care, under direct or indirect supervision[85];

b. improve safety and quality of care at every opportunity;

c. contribute to the delivery of integrated care;

d. work with the PCN MDT to ensure delivery of nursing associate duties complement existing workforce;

e. provide support and supervision to training nursing associates, healthcare assistants, apprentices, and those on learning assignments/placements as required;

f. support registered nurses to enable them to be able to focus on the more complex clinical care;

g. develop relationships across the MDT to support integration of the role across health and social care including primary care, secondary care, and mental health;

h. perform and record clinical observations such as blood pressure, temperature, respirations, and pulse;

i. after undertaking additional training, provide flu vaccinations, ECGs, and venepuncture, and other relevant clinical tasks as required by the PCN, in line with the competencies of the role;

j. promote health and well-being to all patients, for example undertaking the NHS health check;

k. care for individuals with dementia, mental health conditions, and learning disabilities;

[85] For example, as set out in the NMC Standards for Nursing Associates

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l. advise patients on general healthcare and promote self-management where appropriate, including signposting patients to personalised care colleagues and local community and voluntary sector services;

m. communicate proactively and effectively with all MDT colleagues across the PCN, attending and contributing to meetings as required;

n. maintain accurate and contemporaneous patient health records; and

o. enhance own performance through continuous professional development, imparting own knowledge and behaviours to meet the needs of the service.

B11.3. A PCN must ensure that the postholder has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis.

B11.4. PCNs are now able to claim reimbursement for Registered Nursing Associates for the time they spend training to become a Registered Nurse.

B11.5. Nursing Associates can undertake an eighteen month 'top up' programme, utilising recognised prior learning (RPL), to qualify as a Registered Nurse while continuing to deliver their Nursing Associate role within the PCN.

B11.6. Alongside their existing responsibilities, Nursing Associates undertaking the top up programme may also:

a. work with a supervisor to take responsibility for developing their own clinical competence, leadership, and reflective practice skills within the workplace, while on placements and through attending the GPN Training Programme; and

b. develop by the end of the training programme the ability to assess patient needs, evaluate plan and coordinate their care and lead and manage nursing teams.

B.12 Student Nursing Associate (SNA) (previously Trainee Nursing Associate (TNA))

B12.1. Where a PCN employs or engages a student nursing associate (SNA) under the Additional Roles Reimbursement Scheme, the PCN must ensure that the TNA:

a. has a minimum of GCSE Maths and English at grade 9 to 4 (A to C) or Functional Skills Level 2 in Maths and English;

b. is working towards completion of the Nursing Associate Apprenticeship programme; and

c. is enrolled on a foundation degree awarded by a Nursing and Midwifery Council (NMC) - approved provider over a 2-year period.

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B12.2. Where a PCN employs or engages one or more SNAs under the Additional Roles Reimbursement Scheme, the PCN must ensure that each SNA has the following key responsibilities in relation to delivering health services:

a. delivery of high quality, compassionate care whilst undertaking specific clinical and care tasks under the direction of a registered nurse (or other registered care professional dependent on PCN), with a focus on promoting good health and independence;

b. work as part of a PCN's multidisciplinary team (MDT), delivering a high standard of care that focuses on the direct needs of the patient;

c. work with a supervisor to take responsibility for developing own clinical competence, leadership, and reflective practice skills within the workplace, while on placements and through attending the Student Nursing Associate Training Programme; and

d. develop by the end of the Student Nursing Associate Training Programme the ability to work without direct supervision, at times delivering care independently in line with the individual's defined plan of care, within the parameters of the nursing associate role, accessing clinical and care advice when needed.

B12.3. Over the course of the 2-year SNA programme, develop the skills and knowledge to provide direct care to patients and families which may include:

a. after undertaking additional training, provide flu vaccinations, ECGs, venepuncture, and other relevant clinical tasks as required by the PCN, in line with the competencies of the role;

b. supporting individuals and their families and carers when faced with unwelcome news and life-changing diagnoses, for example by providing relevant information on the diagnosis, signposting patients to further information, or referral to social prescribing link workers etc;

c. performing and recording clinical observations such as blood pressure, temperature, respirations, and pulse;

d. discussing and sharing information with registered nurses on patients' health conditions, activities, and responses; and

e. developing an understanding of caring and supporting people with dementia, mental health conditions, and learning disabilities.

B12.4. A PCN must ensure that the postholder has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis.

B.13 Paramedics

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B13.1. Where a PCN employs or engages a Paramedic under the Additional Roles Reimbursement Scheme, the PCN must ensure that the paramedic:

a. is educated to degree/diploma level in Paramedicine or equivalent experience;

b. is a registered Paramedic with the HCPC;

c. has completed their two-year 'Consolidation of Learning' period as a "newly qualified paramedic";

d. has a further three years' experience as a band 6 (or equivalent) paramedic; and

e. is working towards developing masters level or equivalent capability in paramedic areas of practice and, within six months of the commencement of reimbursement for that individual (or a longer time period as agreed with the commissioner), has completed and been signed off formally within the clinical pillar competencies of the paramedic FCP/AP roadmap to practice.

B13.2. Where a PCN employs or engages a Paramedic to work in primary care under the Additional Roles Reimbursement Scheme, if the Paramedic cannot demonstrate working at masters level or equivalent capability in paramedic areas of practice or equivalent (such as advanced assessment diagnosis and treatment) the PCN must ensure that each Paramedic is working as part of a rotational model, in which they have access to regular supervision and support from clinicians signed off at clinical practice masters level or equivalent.

B13.3. Where a PCN employs or engages one or more Paramedics under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Paramedic has the following key responsibilities, in delivering health services:

a. work as part of a MDT within the PCN;

b. assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team;

c. advise patients on general healthcare and promote self-management where appropriate, including signposting patients to the PCN's social prescribing service, and where appropriate, other community or voluntary services;

d. be able to:

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i. perform specialist health checks and reviews within their agreed scope of practice and in line with local and national guidance;

ii. perform and interpret ECGs;

iii. perform investigatory procedures as required; and

iv. undertake the collection of pathological specimens including intravenous blood samples, swabs, and other samples within their scope of practice, and within line of local and national guidance;

e. support the delivery of 'anticipatory care plans' and lead certain community services (e.g. monitoring blood pressure and diabetes risk of patients living in sheltered housing);

f. provide an alternative model to urgent and same day GP home visit for the network and clinical audits;

g. communicate at all levels across organisations ensuring that an effective, person-centred service is delivered;

h. communicate proactively and effectively with all colleagues across the multi-disciplinary team, attending and contributing to meetings as required;

i. maintain accurate and contemporaneous health records appropriate to the consultation, ensuring accurate completion of all necessary documentation associated with patient health care and registration with the practice; and

j. communicate effectively with patients, and where appropriate family members and their carers, where applicable, complex and sensitive information regarding their physical health needs, results, findings, and treatment choices.

B.14 Mental Health Practitioners

B14.1. The mental health practitioner role may be undertaken by any practitioner (registered or non-registered) operating at Agenda for Change Band 4 up to 8a including, but not limited to, a Community Psychiatric Nurse, Clinical Psychologist, Mental Health Occupational Therapist, Peer Support Worker, Mental Health Community Connector or other role, as agreed between the PCN and community mental health service provider, to support adults and older adults with complex mental health needs that are not suitable for NHS Talking Therapies provision.

B14.2. Where a PCN engages one or more Mental Health Practitioners under the Additional Roles Reimbursement Scheme, the PCN must ensure that each

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Mental Health Practitioner provides the following functions depending on local context, supervision and appropriate clinical governance:

a. mental health advice, support, consultation, and liaison across the wider local health and social care system, including acting as a first point of contact in primary care for patients whose care needs are not suitable for Talking Therapies services;

b. facilitation of onward access to mental and physical health, well-being, and biopsychosocial interventions;

c. provision of brief psychological interventions, where qualified to do so and where appropriate;

d. work closely with other PCN-based roles to help address the potential range of biopsychosocial needs of patients with mental health problems. This will include the PCN's MDT, including, for example, PCN clinical pharmacists for medication reviews, and social prescribing link workers for access to community-based support; and

e. may operate without the need for formal referral from GPs, including accepting some direct bookings where appropriate, subject to agreement on volumes and the mechanism of booking between the PCN and the provider.

B14.3. A PCN must ensure that the postholder is supported through the local community mental health services provider (or by the employer of the postholder, where the local community mental health services provider has subcontracted the service to another organisation) by robust clinical governance structures to maintain quality and safety, including supervision where appropriate.

B.15 Advanced Practitioners

B15.1. Advanced Practitioners are designated to the Network Contract DES roles for Clinical Pharmacists, First Contact Physiotherapists, Dietitians, Podiatrists, Occupational Therapists, Paramedics and Advanced Practitioner Nurses.

B15.2. Where a PCN employs or engages an Advanced Practitioner as outlined in B15.1 under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Advanced Practitioner meets the following requirements:

a. has a master's degree level in the relevant area of expertise;

b. is working at a master's level or equivalent encompassing the four pillars of clinical practice, leadership and management, education and

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research, with demonstration of core capabilities and area specific clinical competencies[86];

c. for advanced practice pharmacists only, has qualified from an approved 18-month training pathway or equivalent and is qualified as an independent prescriber; and

d. for Advanced Practitioner Nurses only that consideration is given to best practice guidance recommending advanced practitioners are able to show recognised preparation for advanced practice in line with NHS England's standards, this usually includes:

1. graduating from a Centre for Advancing Practice accredited MSc advanced practice programme or having completed the Centre's ePortfolio (Supported) Route; both pathways enable eligibility for an 'Advanced' digital badge issued by the Centre for Advancing Practice, demonstrating recognised educational and experiential preparation in advanced practice; or

2. enrolled as a trainee on a Centre for Advancing Practice accredited MSc advanced practice programme linked with subsequent progression onto a reimbursable Advanced Practitioner Nurse role on completion of training; or

3. enrolled on and progressed past the initial Learning Needs Analysis (LNA) stage of the Centre for Advancing Practice ePortfolio (supported) Route, linked with subsequent progression onto a reimbursable Advanced Practitioner Nurse role on completion of the ePortfolio process.

in order to deliver the key responsibilities outlined in section B15.

B15.3. Where a PCN employs or engages an Advanced Practitioner under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Advanced Practitioner has the following additional key responsibilities to those outlined in the relevant section of this Annex B, in delivering health services:

a. assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team;

b. manage undifferentiated undiagnosed condition and identify red flags and underlying serious pathology and take appropriate action;

[86] https://advanced-practice.hee.nhs.uk/mpf2025/introduction/

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c. use complex decision making to inform the diagnosis, investigation, complete management of episodes of care within a broad scope of practice;

d. actively take a personalised care approach and population centred care approach to enable shared decision making with the presenting person; and

e. complete the relevant training in order to provide multi-professional clinical practice and CPD supervision to other roles within primary care, for example first contact practitioners and the personalised care roles.

B15.4. A PCN is able to claim reimbursement for the time any Allied Health Professional First Contact Practitioners, reimbursed through the scheme, spend training to become an Advanced Practitioner.

B.16 General Practice Assistants

B16.1. General Practice Assistants ("**GPA**"s), support the smooth running of clinics by performing more routine administration and clinical tasks on behalf of the GP, freeing up their time to focus on the patient.

B16.2. The role is subject to a maximum reimbursement equivalent of an Agenda for Change band 4 level. Staff can be trained in-practice, with on-job training and development led by GPs, in line with the role outline and national competency framework. Trainee GPAs may also complete HEE's accreditation programme, aligned to the competency framework, equipping them with formal certification of their learning. These staff are supported by a structured development programme (managed by HEE) and gain formal certification after around nine months.

B16.3. While in post, GPAs are expected to deliver a combination of the following requirements based on their level of skills and experience. PCNs may claim reimbursement for the time GPAs spend delivering these activities, or undertaking training to deliver them:

a. arranging appointments, referrals, tests and follow up appointments of patients;

b. completing simple clinical observations /investigations as directed locally, such as dipstick urine, taking blood pressure, ECG, phlebotomy;

c. supporting the GP with immunisations/wound care;

d. preparing patients prior to going in to see the GP, taking a brief history and basic readings in readiness for the GP appointment;

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e. completing basic (non-opinion) forms and core elements of some forms for the GP to approve and sign such as insurance forms, mortgage, benefits agency forms etc;

f. explaining treatment procedures to patients;

g. helping the GP liaise with outside agencies e.g. getting an on call doctor on the phone to ask advice or arrange admission while the GP can continue with their consultation(s);

h. sorting clinical post and prioritising for the GP. Signposting some post to other members of staff; and

i. extracting information from clinical letters that needs coding; adding this to patient notes. Supporting with QOF reviews.

B16.4. GPAs should also:

a. Participate in an annual individual performance review.

b. Track and record evidence of their experience against the national competency framework.

c. Inform the lead GP of any concerns regarding their role and request professional development as needed.

d. Be aware of their own professional boundaries and what to do when they are reached.

B.17 Digital and Transformation Lead

B17.1. Digital and Transformation Leads support increased access to care for patients, by

a. supporting the adoption of new technology and other initiatives to improve the care offer, and

b. enabling PCN staff to work more effectively to support the sustainability of general practice services.

B17.2. They are expected to deliver a combination of the following responsibilities:

a. improve adoption of new technology to enhance patient access and experience and increase PCN productivity;

b. build relationships and facilitate collaboration between practices to support the delivery of care to each other's patients (for example to delivery of enhanced access or other hub type working arrangements);

c. review and improve the PCN's digital maturity;

d. use data, and improve data quality, to:

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i. Understand demand, capacity and activity and drive improvements in:
   a. Patient experience of access
   b. Operational efficiency
   c. Staff experience at work
ii. Support population health management, improvements in care quality and PCN operational efficiency;
iii. understand the type and intensity of support needs of their PCN and coordinate this support, including through OD programmes;
iv. support the effective adoption of national and local initiatives, including integrated working at neighbourhood and place level to improve access to services for patients; and
v. ensure that digital and operational PCN transformation is embedded in, and aligned with, ICS and national strategies.

B.18 Enhanced Practice Nurse

B18.1. Where a PCN employs or engages an enhanced practice nurse under the Additional Roles Reimbursement Roles Scheme, the PCN must ensure that the enhanced practice nurse:

a. is registered with the NMC and maintains revalidation in line with NMC requirements;
b. has a post graduate qualification at level 7 or above relevant to their area of enhanced practice, for example in wound care, diabetes plus respiratory and CVD, dementia, women's health and public health and population health management, or other area of enhanced practice;
c. is working at an enhanced level of practice as described in the Primary Care and General Practice Nursing Career and Core Capabilities Framework[87]; and
d. works across the PCN, in services that enhance the core general practice offer.

in order to deliver the key responsibilities outlined in section B18.1

B18.2. Where a PCN employs or engages one or more Enhanced Practice Nurses under the Additional Roles Reimbursement Scheme, the PCN must ensure that each enhanced practice nurse has the following key responsibilities in relation to delivering health services:

[87] Primary Care and General Practice Nursing Career and Core Capabilities Framework

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a. works as part of a MDT within the PCN;

b. consults with patients, their family, and the multi-professional team to undertake assessments of patient need and devise and evaluate complex care plans;

c. evaluates and analyses clinical problems using their clinical knowledge, seeking out and applying relevant evidence, enhanced techniques, interventions, and equipment to make clinical decisions;

d. delivers enhanced clinical care in the context of continual change, challenging environments, different models of care delivery, innovation and rapidly evolving technologies using analysis and their underpinning knowledge to manage complex interventions;

e. teaches and advises patients and their families on how to manage their condition or support the multi-disciplinary team to do so;

f. participates in clinical audits and research projects and implements changes as required, including the development, and updating of practice protocols / guidelines and procedures locally;

g. works within national and local protocols where these exist;

h. recognises boundaries of their practice and know when and to whom patients should be referred;

i. using the principles of delegation, delegates work to other members of the MDT and take responsibility for the delegated activity as appropriate;

j. demonstrates initiative and are creative in finding solutions to problems;

k. holds responsibility for team performance and service delivery; and

l. provides supervision to trainee nurse associate, nurse associates and general practice nurses.

B18.3. Where a PCN employs or engages one or more Enhanced Practice Nurses under the Additional Roles Reimbursement Scheme or sub-contracts provision of this service to another provider, the PCN must ensure that each enhanced practice nurse has the following key wider responsibilities:

1. Facilitate and support the development and delivery of innovative training and education to staff, to improve competence and confidence, in line with best practice and guidance related to area of expertise.
2. Participate in and/or lead formal training events promoting best practice in area of expertise.
3. Provide professional and clinical leadership and mentorship, acting as a clinical role model on the delivery of evidence-based practice.

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4. Advise and support on the development and delivery of work streams relating to area of expertise as part of the PCN's strategy, where appropriate.
5. Work proactively with key local and national stakeholders to develop more integrated care pathways and holistic models of care, through dissemination of specialist skills and knowledge.
6. Contribute to the delivery of local policy, procedures, and protocols for the PCN to improve identification, assessment, ongoing support for patients and their family carers.

B.19 General Medical Practitioner

B19.1. Where a PCN employs or engages a General Medical Practitioner under the Additional Role Reimbursement Scheme, the PCN must ensure that the General Medical Practitioner is not:

a. Prohibited from performing any such service by regulation 24 of the National Health Service (Performers Lists) (England) Regulations 2013;

b. Suspended from the list of medical practitioners maintained and published by NHS England in accordance with section 91 of the NHS Act 2006 or from the registers kept under section 2 of the Medical Act 1983; and/or

c. Subject to interim suspension under 41A of the Medical Act 1983.

B19.2. Where a PCN employs or engages a General Medical Practitioner under the Additional Role Reimbursement Scheme, the PCN must ensure that the General Medical Practitioner is:

a. Included in the list of medical practitioners maintained and published by NHS England in accordance with section 91 of the NHS Act 2006; and

b. a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council under section 2 of the Medical Act 1983.

B19.3. Where a PCN employs or engages a General Medical Practitioner under the Additional Role Reimbursement Scheme, the PCN must ensure that the General Medical Practitioner is employed or engaged 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"[88]

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

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B.20 Healthcare Support Worker

B20.1. Where a PCN employs or engages a Healthcare Support Worker under the Additional Roles Reimbursement Scheme, the PCN must ensure that the worker:

B20.2. has completed the Care Certificate or equivalent qualification;

a. has relevant experience in health promotion, prevention, and supporting long-term condition management;

b. works under the supervision of a registered clinician while developing competencies in community-based care; and

c. is working at Support Worker Level Practice as described in the Primary Care and General Practice Nursing Career and Core Capabilities Framework[89].

B20.3. Where a PCN employs or engages one or more Healthcare Support Workers under the Additional Roles Reimbursement Scheme, the PCN must ensure that each worker has the following key responsibilities:

a. supports health promotion and prevention activities across the PCN, including smoking cessation, weight management, and lifestyle interventions;

b. plays a key role in vaccination and immunisation programmes within the PCN;

c. works within a Multi-Disciplinary Team to support patients with long-term conditions and health inequalities;

d. provides clinical support to registered nurses and other healthcare professionals within the PCN; and

e. delivers basic clinical care interventions under supervision, supporting continuity of care and patient safety initiatives.

B.21 New to General Practice Nurse

B21.1. Where a PCN employs or engages a New to General Practice General Practice Nurse under the Additional Roles Reimbursement Scheme, the PCN must ensure that the nurse:

a. is registered with the NMC and maintains revalidation in line with NMC requirements; and

[89] General practice nursing capabilities framework | Skills for Health

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b. is working at Registered Nurse Level Practice as described in the Primary Care and General Practice Nursing Career and Core Capabilities Framework.

B21.2. Where a PCN employs or engages one or more New to General Practice General Practice Nurses under the Additional Roles Reimbursement Scheme, the PCN must ensure that each nurse has the following key responsibilities:

a. Provides fundamental nurse-led care to communities across the PCN;

b. Undertakes early detection, prevention, and management of cardiovascular disease and other long-term conditions;

c. Takes a lead role in managing one specific long-term condition ("LTC") following structured mentorship and preceptorship;

d. Participates in quality improvement initiatives to enhance patient outcomes and reduce health inequalities; and

e. Works within a multi-disciplinary team, supporting integrated care and personalised approaches to patient management.

B.22 Experienced General Practice Nurse

B22.1. Where a PCN employs or engages an Experienced General Practice Nurse under the Additional Roles Reimbursement Scheme, the PCN must ensure that the nurse:

a. holds more than one academic Level 6 diploma or postgraduate certification in long-term conditions care and/or public health initiatives;

b. has demonstrable experience in leading long-term conditions management and quality improvement within a PCN;

c. is registered with the NMC and maintains revalidation in line with NMC requirements; and

d. is working at Registered Nurse Level Practice as described in the Primary Care and General Practice Nursing Career and Core Capabilities Framework.

B22.2. Where a PCN employs or engages one or more Experienced General Practice Nurses under the Additional Roles Reimbursement Scheme, the PCN must ensure that each GPN has the following key responsibilities:

a. leads long-term condition management across the PCN, supporting quality improvement and assurance initiatives:

b. supports public health and screening programmes, including immunisations, vaccinations, and cervical screening;

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c. embeds population health management approaches within general practice, targeting health inequalities and improving access;

d. supports, mentors, and supervises new-to-practice nurses and other healthcare professionals within the PCN; and

e. works collaboratively across the PCN to enhance integration with community, secondary, and social care services.

B.23 Registered Nurse: Consultant Level Practice

B23.1. Where a PCN employs or engages a Consultant Nurse under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Consultant Nurse:

a. holds a Master's degree and is working towards a PhD, Educational Doctorate, or equivalent research qualification;

b. has extensive experience in advanced clinical leadership, service development, workforce planning, and system-wide innovation; and

c. is registered with the NMC and maintains revalidation in line with NMC requirements.

B23.2. Where a PCN employs or engages one or more Consultant Nurses under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Consultant Nurse has the following key responsibilities:

a. provides strategic leadership and innovation in PCN-led service development;

b. leads on workforce planning and the professional development of nurses across the PCN;

c. drives improvements in population health outcomes, reducing health inequalities and improving access for underrepresented communities;

d. leads research, evaluation, and implementation of best practice to transform service delivery;

e. operates independently at an expert level, leading complex care management and service improvement initiatives; and

f. works across traditional boundaries to integrate care with secondary, community, and social care partners.

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Annex C - Investment and Impact Fund Calculation of Achievement[90]

C1. Step 1: For each Indicator, aggregate practice-level numerators and denominators to PCN level

C1.1 For each Indicator set out in Annex D, a denominator will be collected for each Core Network Practice in the PCN which is equal to the size of the target cohort for that Core Network Practice and Indicator.

a. For all Indicators, the 'size of the target cohort' will be a count of eligible patients or interventions (e.g. medications) delivered to a set of eligible patients.

b. For Indicators eligible for Personalised Care Adjustments (defined in Annex C, section C6 below), the size of the target cohort for each Core Network Practice will be calculated by omitting any patient eligible for a Personalised Care Adjustment unless the intervention in question has been delivered, in which case the patient shall remain included.

C1.2 For each Indicator, a PCN-level denominator (D) will be calculated by adding up all the denominators for the Core Network Practices of the PCN.

C1.3 For each Indicator, a numerator will be collected for each Core Network Practice in the PCN.

a. For Indicators with a desired direction of upwards, the numerator will capture the extent to which a desired intervention or event has occurred.

b. For Indicators with a desired direction of downwards, the numerator will capture the extent to which an undesired intervention or event has occurred.

C1.4 For each Indicator, a PCN-level numerator (N) will be calculated by adding up all the numerators for the Core Network Practices of the PCN.

C2. Step 2: For each Indicator, calculate performance for the PCN

C2.1 For each Indicator, the performance of the PCN (X) will be calculated by dividing the PCN-level numerator (N) by the PCN-level denominator (D): X=N/D.

C3. Step 3: For each Indicator, calculate Achievement Points for the PCN

[90] Throughout Annex C, for the purpose of any calculation, all percentages (including, where relevant, performance, the lower performance threshold, and the upper performance threshold) will take the form of the fraction corresponding to the percentage. For instance, performance of 77 per cent would be entered into any calculation as 0.77, not as 77.

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C3.1 For all Indicators, points achieved by the PCN (Q) will be calculated on a linear sliding scale between the lower performance threshold (L) and upper performance threshold (U);

a. If the PCN's performance is worse than or equal to the lower performance threshold (X<L or X=L), the PCN will achieve zero points for the indicator: Q=0.

b. If the PCN's performance is strictly between the lower and upper performance thresholds (L<X<U), points achieved by the PCN will be calculated as follows:

i. Subtract the lower performance threshold from performance, and call this number V: V=X-L.

ii. Subtract the lower performance threshold from the upper performance threshold, and call this number W: W=U-L.

iii. The points achieved by the PCN will then be equal to the number of points available (A), multiplied by V, divided by W: Q=A*V/W.

a. If the PCN's performance is better than or equal to the upper performance threshold (X>U or X=U), the PCN will achieve the maximum points available for the indicator: Q=A.

C4. Step 4: For each Indicator, calculate Achievement Payments for the PCN

C4.1 For each Indicator, payments earned by the PCN will incorporate a List Size Adjustment and a Prevalence Adjustment. All references to practice list size, PCN list size and List Size Adjustment in relation to the IIF refer to registered unweighted list size. The IIF calculations do not make any use of weighted list size.

C4.2 For each PCN, 'prevalence' (C) for an indicator is defined as being equal to a 'prevalence numerator' (E) divided by registered unweighted PCN list size (S): C=E/S. This prevalence numerator (E) will often, though not always, be defined as being equal to the Indicator denominator (D): E=D. The prevalence numerator for each Indicator is defined in Annex D.

C4.3 For each Indicator, national prevalence (K) is defined as the sum of prevalence numerators (E) divided by the sum of all registered unweighted PCN list sizes (S).

C4.4 For each Indicator, the Prevalence Adjustment for a PCN will be equal to PCN-level prevalence (C) divided by national prevalence (K).

C4.5 National average registered unweighted PCN list size (T) is equal to the sum of all registered unweighted PCN list sizes (S) divided by the number of PCNs.

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C4.6 The List Size Adjustment for a PCN will be the same for all Indicators and will be equal to registered unweighted PCN list size (S) divided by national average registered unweighted PCN list size (T).

C4.7 For each Indicator, payments earned by the PCN (M) will be calculated by multiplying points earnt (Q), by the value of an IIF point (P), by the Prevalence Adjustment (C/K), by the List Size Adjustment (S/T): M=Q*P*(C/K)*(S/T).

C5. Step 5: For the PCN, calculate Total Indicator Achievement Payment

C5.1 For the PCN the Total Indicator Achievement Payment is equal to the sum of Achievement Payments for each Indicator.

C6. Personalised Care Adjustments

C6.1 A **PCA** may be applied for the Indicators and reasons set out in this paragraph. The effect of applying a PCA to a patient for a given Indicator will be to remove that patient, and any services or interventions they receive, from the denominator for that Indicator – *unless* the patient (or any services or interventions they receive) meet the success criteria outlined in the numerator for that indicator, in which case they shall be retained in the denominator and counted as success in the numerator. The Indicators and reasons to which a PCA may be applied are (see Annex D for details of each indicator, further details will be available in the 2026/27 Part B guidance):

a. HI03: Patient refused the offer of a learning disability health check or a health action plan

b. CAN04: Patients with anal ulceration or with anal or rectal masses, Provision of faecal immunochemical test kit declined.

C7. Timing conventions and payment calculation period

C7.1 Unless otherwise stated or unless any of the provisions of section C8 apply, the following timing conventions will be employed for the purpose of calculating performance, Achievement Points and Achievement Payments for Indicators. If any of the provisions of section C8 apply, the following timing conventions will apply to the extent they are compatible with the provisions of section C8:

a. Unless explicitly noted in the indicator wording, calculations in respect of the Indicators will be made in relation to the period 1 April 2026 to 31 March 2027. The time periods to which calculations are applied shall be employed regardless of when the participation of a PCN's Core Network Practices was confirmed.

b. PCN membership will be defined using ODS PCN membership as of 31 March 2027.

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C7.2 A PCN may propose to vary this principle if there is a compelling case for doing so, but agreement to any such proposal shall be at the sole discretion of the commissioner. Where the commissioner agrees to such a variation, if the indicator is subject to declaration the PCN may decline to declare its achievement and the commissioner may manually vary the baseline numerators and denominators in accordance with whatever is agreed between the PCN and commissioner. If the indicator is not subject to declaration, any such variation must be implemented via a manual adjustment outside of the main process of calculating IIF achievement.

C7.3 The following uses of practice list size or PCN list size in the calculations set out here will be based on the registered unweighted practice list size or registered unweighted PCN list size as of 1 January 2026:

a. The Prevalence Adjustment.

b. The List Size Adjustment.

C7.4 For all indicators (defined in Annex D), data on achievement will be manually submitted via the Calculating Quality Reporting System (CQRS).

C7.5 For all indicators (defined in Annex D):

a. The denominators will be measured on 31 March 2027 (or where unavailable, the latest available date prior to 31 March 2027).

b. The numerators will be defined with respect to the denominator defined on 31 March 2027 and, except where explicitly noted in the indicator definition, will count all activity undertaken between 1 April 2026 and 31 March 2027.

C8. Impact of PCN changes on calculation of Total Indicator Achievement Payment

C8.1 Where a Core Network Practice of a PCN ceases (for whatever reason) to be a Core Network Practice of that PCN before 31 March 2027:

a. That Core Network Practice's performance in relation to IIF Indicators will not enter in any way into the calculation of that PCN's performance.

b. That Core Network Practice's practice list size will not enter into the calculation of PCN list size.

c. That Core Network Practice's denominator and practice list size will not enter into the calculation of PCN prevalence.

C8.2 Where a practice (for whatever reason but provided it is not a New Practice) becomes a Core Network Practice of a PCN at any time after 1 April 2026, and remains a Core Network Practice of that PCN on 31 March 2027, then that Core Network Practice's performance in relation to the Indicators for the entire period from 1 April 2026 to 31 March 2027, where specified in Section

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C7) will enter into the calculation of that PCN's Achievement Points and Achievement Payments, including that portion of the period from 1 April 2026 to 31 March 2027 during which the practice was not a Core Network Practice of the PCN.

C8.3 Where a New Practice becomes a Core Network Practice of a PCN at any time after 30 April 2026, and remains a Core Network Practice of that PCN on 31 March 2027 then that practice's performance in relation to the Indicators from the period it became a New Practice to 31 March 2027 will enter into the calculation of that PCN's Achievement Points and Achievement Payments with no adjustment in that practice's performance to account for any portion of the period from 1 April 2026 to it becoming a New Practice.

C8.4 If a new PCN is approved (for whatever reason) in the period 1 April 2026 to 31 March 2027, and at least one Core Network Practice of the new PCN was previously a Core Network Practice of a different PCN, then the performance of the Core Network Practices in relation to the Indicators for the period from 1 April 2026 to 31 March 2027 will enter into the calculation of that PCN's Achievement Points and Achievement Payments, including that portion of the period from 1 April 2026 to 31 March 2027 during which the PCN did not exist.

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Annex D - Investment and Impact Fund Indicators

D1. Tackling Health Inequalities domain

D1.1 A PCN is able to achieve up to 36 points in the Tackling Health Inequalities domain. The following indicator definition applies for this domain.

ID	Description	Numerator (N)	Denominator (D)	Prevalence numerator (E)	Indicator Type; Desired Direction; Points; Thresholds; Data source
Tackling health inequalities (HI) area					
HI03	Percentage of patients on the Learning Disability register (as defined in the SFE) aged 14 years or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan in addition to a recording of ethnicity	Of the denominator, the number who received an annual Learning Disability Health Check and have a completed Health Action Plan in addition to a recording of ethnicity	Number of patients on the Learning Disability register (as defined in the SFE) aged 14 years or over	Indicator denominator	Standard Quantitative; Upwards; 36; 60% (LT) / 80% (UT); GPES

D2. Cancer domain

D2.1 A PCN is able to achieve up to 22 points in the Cancer domain. The following indicator definition applies for the indicator in this domain.

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ID	Description	Numerator (N)	Denominator (D)	Prevalence numerator (E)	Indicator Type; Points; Desired Direction; Thresholds; Data source
Cancer (CAN) area					
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.	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.	The number of patients who have had a lower gastrointestinal urgent suspected cancer referral in the reporting year.	Indicator denominator	Standard Quantitative; Upwards; 22; 65% (LT) / 80% (UT); GPES

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Annex E - Payments For Specific Purposes

E1. General

E1.1. For the purposes of this Annex E:

E1.1.1. "**AR GP**" means a General Medical Practitioner in respect of whom the PCN is claiming reimbursement under the Additional Role Reimbursement Scheme;

E1.1.2. "**Third Party Organisation**" means a legal entity, other than a Core Network Practice of a PCN, who is employing an AR GP. This includes but is not limited to a PCN that has incorporated, an incorporated federation of GP practices, an incorporated voluntary sector provider, a Local Authority, or an NHS Trust; and

E1.1.3. "**Separately Employed AR GP**" means an AR GP employed by a Third-party Organisation; and

E1.1.4. "**PCN GP**" means:

- a GP performer who is a party to a primary medical services contract with a Core Network Practice of the PCN; or
- a GP performer who is already employed or engaged by a Core Network Practice of the PCN,

or more than one such person.

E2. Payments for covering maternity, paternity, neonatal care, adoption leave and shared parental leave

E2.1. If a Separately Employed AR GP takes time off for maternity leave, paternity leave, adoption leave, parental leave, neonatal care leave, or shared parental leave, the Third-party Organisation may need to employ a locum or a salaried GP under a fixed term contract or use the services of a PCN GP to maintain the level of services that it provides to the PCN. Even if the commissioner is not

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directed in this Annex E to pay the PCN for such cover, it may do so as a matter of discretion. However, if:

E2.1.1. the performer is an AR GP; and

E2.1.2. the leave is ordinary or additional maternity, paternity leave or ordinary or additional adoption leave or shared parental leave or neonatal care leave,

the PCN may be entitled to payment of, or a contribution towards, the costs of cover as set out in this Annex E.

Entitlement to payments for covering ordinary or additional maternity leave, paternity leave, neonatal care leave, ordinary or additional adoption leave or shared parental leave

E2.2. In any case where a Third-party Organisation actually and necessarily engages a locum or a salaried GP under a fixed term contract or uses the services of a PCN GP to cover for the absence of a Separately Employed AR GP on ordinary or additional maternity leave, paternity leave, neonatal care leave or ordinary or additional adoption leave or shared parental leave and:

E2.2.1. the leave of absence is for more than one week;

E2.2.2. the Separately Employed AR GP on leave is entitled to that leave either under:

a. statute; or

b. a contract of employment, provided that the performer on leave is entitled under their contract of employment to be paid their full salary by the Third-party Organisation during their leave of absence;

E2.2.3. the PCN GP is not employed full time;

E2.2.4. the Third-party Organisation is not also claiming another payment for cover in respect of the Separately Employed AR GP on leave under this Network Contract DES Specification or the SFE or other arrangement; and

E2.2.5. the Separately Employed AR GP on leave was providing services to the PCN,

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then, subject to the following provisions of this paragraph E2 the commissioner must provide financial assistance to the PCN who must ensure this is provided to the Third-party Organisation in respect of the cost of engaging that cover (which may or may not be the maximum amount payable, as set out in paragraph E2.4 of this Annex E).

E2.3. The commissioner must consider whether or not it is necessary for the Third-party Organisation to engage, or continue to engage, a locum or a salaried GP on a fixed term contract or to use, or continue to use, the services of a PCN GP to cover for the absence of the Separately Employed AR GP under this paragraph E2 having regard to the following principles:

E2.3.1. it should not normally be considered necessary for a Third-party Organisation to employ a locum or a salaried GP on a fixed term contract, or to use the services of a PCN GP, if the Separately Employed AR GP on leave had a right to return but that right has been extinguished; and

E2.3.2. it should not normally be considered necessary for a Third-party Organisation to employ a locum or a salaried GP on a fixed term contract, or to use the services of a PCN GP performer, if the Third-party Organisation has engaged a new employee or partner to perform the duties of the Separately Employed AR GP on leave and it is not carrying a vacancy in respect of another position which the Separately Employed AR GP on leave will fill on their return.

Amounts payable

E2.4. The maximum amount payable under this paragraph E2 by the commissioner in respect of cover for a Separately Employed AR GP is to be the same as set out in Part 4, Section 9 of the SFE.

E2.5. Any amounts payable by way of reimbursement under this paragraph E2:

E2.5.1. are not to be paid on a pro-rata basis having regard to the absent Separately Employed AR GP's working pattern; and

E2.5.2. are to be whichever is the lower of the invoiced costs or the maximum amount payable in respect of any week under paragraph E2.4.

Payment arrangements

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E2.6. The PCN is to submit claims for costs actually incurred after they have been incurred, at a frequency to be agreed between the PCN and the commissioner, or if agreement cannot be reached, within 14 days of the end of the month during which the costs were incurred. Any amount payable falls due 14 days after the claim is submitted.

Conditions attached to the amounts payable

E2.7. Payments or any part of a payment under this paragraph E2 are only payable if the Third-party Organisation satisfies the following conditions:

E2.7.1. if the leave of absence is maternity leave, the Third-party Organisation must supply the PCN with a certificate of expected confinement as used for the purposes of obtaining statutory maternity pay, or a private certificate providing comparable information, who must then provide it to the commissioner;

E2.7.2. if the leave of absence is for paternity leave, the Third-party Organisation must supply the PCN with a letter written by the Separately Employed AR GP confirming prospective fatherhood and giving the date of expected confinement, who must then provide it to the commissioner;

E2.7.3. if the leave of absence is for neonatal care leave, the Third-party Organisation must supply the PCN with a letter written by the Separately Employed AR GP confirming the date and duration which neonatal care leave will be taken, who must then provide it to the commissioner;

E2.7.4. if the leave of absence is for adoption leave, the Third-party Organisation must supply the PCN with a letter written by the Separately Employed AR GP confirming the date of the adoption and the name of the main care provider, countersigned by the appropriate adoption agency, who must then provide it to the commissioner;

E2.7.5. if the leave of absence is for shared parental leave, the Third-party Organisation must supply the PCN with a certificate as used for the purposes of confirming the Separately Employed AR GP'S eligibility for shared parental leave or a letter written by the Separately Employed AR GP providing comparable information and countersigned by the Third-Party Organisation, who must then provide it to the commissioner;

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E2.7.6. the Third-party Organisation and/or PCN must, on request, provide the PCN and/or commissioner, respectively, with written records demonstrating the actual cost to it of the cover, or the additional cost to it of the cover provided by another GP performer who is already employed or engaged by the PCN; and

E2.7.7. once the arrangements are in place, the Third-party Organisation must inform the PCN who must inform the commissioner:

a. if there is to be any change to the arrangements; or

b. if, for any other reason, there is to be a change to the Third-party Organisation's arrangements for performing the duties of the Separately Employed AR GP on leave,

at which point the commissioner is to determine whether it still considers the cover necessary.

E2.8. If the Third-party Organisation or the PCN breaches any of these conditions, the commissioner may, in appropriate circumstances, withhold payment of any sum otherwise payable under this paragraph E2.

E3. Payments for covering sickness leave

General

E3.1. If a Separately Employed AR GP takes any sickness leave, the Third-party Organisation may need to employ a locum, or a salaried GP on a fixed term contract or use the services of a PCN GP to maintain the level of services that it normally provides to the PCN. Even if the commissioner is not directed in this Network Contract DES Specification or in the SFE to pay for such cover, it may do so as a matter of discretion and it may also provide support in order for the Third-party Organisation to provide cover for performers who are returning from sickness leave or for those who are at risk of needing to go on sickness leave. It should in particular consider exercising its discretion:

E3.1.1. where there is an unusually high rate of sickness in the area where the Separately Employed AR GP performs services; or

E3.1.2. to support PCNs in rural areas where the distances involved in making home visits make it impracticable for a Separately Employed AR GP

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returning from sickness leave to assume responsibility for the same number of patients for which that Separately Employed AR GP previously had responsibility.

Entitlement to payments for covering sickness leave

E3.2. In any case where a Third-party Organisation actually and necessarily engages a locum or a salaried GP on a fixed term contract or use the services of a PCN GP to cover for the absence of a Separately Employed AR GP on sickness leave, and:

E3.2.1. the Third-party Organisation must:

a. be required to pay statutory sick pay to the Separately Employed AR GP; or

b. be required to pay the full salary of the Separately Employed AR GP on leave during absences on sick leave under the Separately Employed AR GP'S contract of employment;

E3.2.2. if the Separately Employed AR GP's absence is as a result of an accident, the contractor must be unable to claim any compensation from whoever caused the accident towards meeting the cost of engaging a locum or salaried GP on a fixed term contract to cover for the Separately Employed AR GP during their absence. But if such compensation is payable, the commissioner may loan the relevant PCN the cost of cover, who will then loan it onto the relevant Third-party Organisation, as necessary, on the condition that the loan is repaid when the compensation is paid unless:

a. no part of the compensation paid is referable to the cost of cover, in which case the loan is to be considered a reimbursement by the commissioner of the costs of the locum which is subject to the following provisions of this paragraph E3; or

b. only part of the compensation paid is referable to the cost of cover, in which case the liability to repay shall be proportionate to the extent to which the claim for full reimbursement of the costs of the locum was successful;

E3.2.3. the PCN GP is not employed full time;

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E3.2.4. the contractor is not already claiming another payment for cover in respect of the Separately Employed AR GP on leave under this Network Contract DES Specification or the SFE or other arrangement; and

E3.2.5. the Separately Employed AR GP on leave was providing services to the PCN,

then subject to the following provisions of this paragraph E3, the commissioner must provide financial assistance to the relevant PCN who must then ensure this is provided to any Third-party Organisation in respect of the cost of engaging that cover (which may or may not be the maximum amount payable, as set out in paragraph E3.4).

E3.3. It is for the commissioner to determine whether or not it was in fact necessary for the Third-party Organisation to engage cover, or to continue to engage cover, but it is to have regard to the following principles:

E3.3.1. it should not normally be considered necessary to employ cover if the Separately Employed AR GP on leave had a right to return but that right has been extinguished; and

E3.3.2. it should not normally be considered necessary to employ cover if the Third-party Organisation has engaged a new employee or partner to perform the duties of the Separately Employed AR GP on leave and it is not carrying a vacancy in respect of another position which the Separately Employed AR GP on leave will fill on return.

Ceilings on the amounts payable

E3.4. The maximum amount payable under this paragraph E3 by the commissioner in respect of cover for a Separately Employed AR GP is to be the same as set out in Part 4, Section 10 of the SFE.

E3.5. Any amounts payable by way of reimbursement under this paragraph E3:

E3.5.1. are not to be paid on a pro-rata basis having regard to the absent Separately Employed AR GP's working pattern; and

E3.5.2. are to be whichever is the lower of the invoiced costs or the maximum amount payable in respect of any week under paragraph E3.4.

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E3.6. No reimbursement under this paragraph E3 will be paid in respect of the first two weeks period of each period of leave of absence. After that, the maximum periods in respect of which payments under this paragraph E3 are payable in relation to a particular Separately Employed AR GP in respect of any such period are:

E3.6.1. 26 weeks for the full amount of the sum that the commissioner has determined is payable; and

E3.6.2. a further 26 weeks for half the full amount of the sum the commissioner initially determined was payable.

E3.7. In order to calculate these periods, a determination is to be made in respect of the first day of the Separately Employed AR GP's absence as to whether in the previous 52 weeks, any amounts have been payable in respect of that performer under this paragraph E3. If any amounts have been payable in those 52 weeks, the periods in respect of which they were payable are to be aggregated together. That aggregate period (whether or not it in fact relates to more than one period of absence):

E3.7.1. if it is 26 weeks or less, is then to be deducted from the period referred to in E3.6.1; or

E3.7.2. if it more than 26 weeks, then 26 weeks of it is to be deducted from the period referred to in E3.6.1 and the balance is to be deducted from the period referred to in E3.6.2.

E3.8. Accordingly, if payments have been made in respect of cover for the Separately Employed AR GP for 32 weeks out of the previous 52 weeks, the remaining entitlement in respect of that Separately Employed AR GP is for a maximum of 20 weeks, and at half the full amount that the commissioner initially determined was payable.

Payment arrangements

E3.9. The PCN is to submit to the commissioner claims for costs actually incurred during a month at the end of that month, and any amount payable is to fall due on the same day of the following month that the contractor’s Payable GSMP (as defined in the SFE) falls due.

Conditions attached to the amounts payable

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E3.10. Payments or any part of a payment under this paragraph E3 are only payable if the following conditions are satisfied:

E3.10.1. the Third-party Organisation must obtain the prior agreement of the relevant PCN and the commissioner to the engagement of the locum or salaried GP on a fixed term contract (but the request to do so must be determined as quickly as possible by the commissioner), including agreement as to the amount that is to be paid for the cover;

E3.10.2. the Third-party Organisation must, without delay, supply the PCN with medical certificates in respect of each period of absence for which a request for assistance with payment for cover is being made, who must then provide them to the commissioner;

E3.10.3. the Third-party Organisation and/or PCN must, on request, provide the PCN and/or commissioner, respectively, with written records demonstrating the actual cost to it of the cover, who must then provide them to the commissioner;

E3.10.4. once the arrangements for cover are in place, the Third-party Organisation must inform the PCN who will then inform the commissioner:

a. if there is to be any change to the arrangements for cover; or

b. if, for any other reason, there is to be a change to the Third-party Organisation's arrangements for performing the duties of the Separately Employed AR GP on leave,

at which point the commissioner is to determine whether it still considers the cover necessary;

E3.10.5. if the arrangements for cover are in respect of a Separately Employed AR GP on leave who is or was entitled to statutory sick pay, the Third-party Organisation must inform the PCN, who must inform the commissioner immediately if it stops paying statutory sick pay to that employee;

E3.10.6. the Separately Employed AR GP on leave must not engage in conduct that is prejudicial to their recovery; and

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E3.10.7. the Separately Employed AR GP on leave must not be performing clinical services for any other person, unless under medical direction and with the approval of the commissioner.

E3.11. If any of these conditions are breached, the commissioner, and/or the PCN, may, in appropriate circumstances, withhold payment of any sum otherwise payable under this paragraph E3.

E4. Payments to cover suspended doctors

Eligible cases

E4.1. In any case where a Third-party Organisation:

E4.1.1. either:

a. is paying a suspended Separately Employed AR GP who is an employee of the Third-party Organisation, at least 90% of that Separately Employed AR GP's normal salary (or a pro rata amount in the case of part months); or

b. paid a suspended Separately Employed AR GP the amount mentioned in paragraph E4.1.1a for at least six months of that Separately Employed AR GP's suspension, and the suspended Separately Employed AR GP is still an employee of the Third-party Organisation;

E4.1.2. actually and necessarily engages a locum (or more than one such person) to cover for the absence of the suspended Separately Employed AR GP;

E4.1.3. the locum is not a partner in a partnership or shareholder in a company limited by shares where that partnership or company is the Third-party Organisation, or already an employee of the Third-party Organisation, unless the absent Separately Employed AR GP is a job-sharer; and

E4.1.4. the Third-party Organisation is not also claiming any other payment for locum cover in respect of the absent Separately Employed AR GP under the SFE,

then subject to the provisions in this paragraph E4, the commissioner must provide financial assistance the relevant PCN who must then ensure this is provided to any Third-party Organisation, as necessary, in respect of the cost

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of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph E4.3).

E4.2. It is for the commissioner to determine whether or not it is or was in fact necessary to engage the locum, or to continue to engage the locum, but it is to have regard to the following principles:

E4.2.1. it should not normally be considered necessary to employ a locum if the Separately Employed AR GP on leave had a right to return but that right has been extinguished; and

E4.2.2. it should not normally be considered necessary to employ a locum if the Third-party Organisation has engaged a new employee or partner to perform the duties of the Separately Employed AR GP on leave and it is not carrying a vacancy in respect of another position which the Separately Employed AR GP on leave will fill on their return.

Ceilings on the amount payable

E4.3. The maximum amount payable under this paragraph E4 by the commissioner in respect of locum cover for a Separately Employed AR GP is to be the same as set out in Part 4, Section 11 of the SFE.

Payment arrangements

E4.4. The PCN is to submit claims for costs actually incurred after they have been incurred, at a frequency to be agreed between the PCN and the commissioner, or if agreement cannot be reached, within 14 days of the end of the month during which the costs were incurred. Any amount payable falls due 14 days after the date on which the claim is submitted.

Conditions attached to the amounts payable

E4.5. Payments or any part of a payment under this paragraph E4 are only payable if the Third-party Organisation satisfies the following conditions:

E4.5.1. the Third-party Organisation and/or PCN must, on request, provide the relevant PCN and/or commissioner, respectively, with written records demonstrating:

a. the actual cost to it of the locum cover; and

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b. that it is continuing to pay the suspended Separately Employed AR GP at least 90% of their normal income before the suspension (i.e. the normal monthly drawings from the partnership account, that Separately Employed AR GP's normal salary or a pro rata amount in the case of part months);

who must then provide them to the commissioner; and

E4.5.2. once the locum arrangements are in place, the Third-party Organisation must inform the relevant PCN:

a. if there is to be any change to the locum arrangements, or

b. if, for any other reason, there is to be a change to the Third-party Organisation's arrangements for performing the duties of the absent Separately Employed AR GP,

who must then inform the commissioner, at which point the commissioner is to determine whether it still considers the locum cover necessary.

E4.6. If the Third-party Organisation breaches any of these conditions, PCN and/or the commissioner may, in appropriate circumstances, withhold payment of any such sum otherwise payable under this paragraph E4.

E5. **Payments in respect of prolonged study leave**

Types of study in respect of which prolonged study leave may be taken

E5.1. Payments may only be made under this paragraph E5 in respect of Prolonged Study Leave taken by a Separately Employed AR GP where:

E5.1.1. the study leave is for at least 10 weeks but not more than 12 months;

E5.1.2. the educational aspects of the study leave have been approved by the commissioner or a committee or person recognised by the commissioner, having regard to any guidance on Prolonged Study Leave that has been agreed nationally; and

E5.1.3. the commissioner has determined that the payments for the Third-party Organisation under this paragraph E5 in respect of the Prolonged Study Leave are affordable, having regard to the budgetary targets it has set itself.

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Educational allowance payment

E5.2. Where the criteria set out in paragraph E5.1 are met, in respect of each week for which the Separately Employed AR GP is on Prolonged Study Leave, the commissioner must pay the PCN, who will pay the Third-party Organisation, the Educational Allowance Payment as set out in Part 4, Section 12 of the relevant SFE (which for the purpose of this paragraph E5 is referred to as the "Educational Allowance Payment"), subject to the condition that where the Third-party Organisation is aware of any change in circumstances that may affect its entitlement to the Educational Allowance Payment, it notifies the PCN who must notify the commissioner of that change in circumstances.

E5.3. If the Third-party Organisation breaches the condition set out in paragraph E5.2, the PCN, and/or the commissioner may, in appropriate circumstances, withhold payment of all or any part of any Educational Allowance Payment that is otherwise payable.

Locum cover in respect of doctors on prolonged study leave

E5.4. In any case where a Third-party Organisation actually and necessarily engages a locum (or more than one such person) to cover for the absence of a Separately Employed AR GP on Prolonged Study Leave, then subject to the following provisions of this paragraph E5, the commissioner must provide financial assistance to the PCN who must then ensure this is provided to the Third-party Organisation in respect of the cost of engaging that locum (which may or may not be the maximum amount payable, as set out in paragraph E5.6).

E5.5. It is for the commissioner to determine whether or not it was in fact necessary to engage the locum, or to continue to engage the locum, but it is to have regard to the following principles:

E5.5.1. it should not normally be considered necessary to employ a locum if the Separately Employed AR GP on leave had a right to return but that right has been extinguished; and

E5.5.2. it should not normally be considered necessary to employ a locum if the Third-party Organisation has engaged a new employee or partner to perform the duties of the Separately Employed AR GP on leave and it is not

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carrying a vacancy in respect of another position which the Separately Employed AR GP on leave will fill on their return.

E5.6. The maximum amount payable under this paragraph E5 by the commissioner in respect of locum cover for a Separately Employed AR GP is the same as set out in Part 4, Section 12 of the SFE.

Payment arrangements

E5.7. The PCN is to submit to the commissioner claims for costs actually incurred during a month at the end of that month, and any amount payable is to fall due on the same day of the following month that the contractor's Payable GSMP (as defined in the SFE) falls due.

Conditions attached to the amounts payable

E5.8. Payments or any part of a payment in respect of locum cover under this paragraph E5 are only payable if the following conditions are satisfied:

E5.8.1. the Third-party Organisation must obtain the prior agreement of the PCN and the commissioner to the engagement of the locum (but its request to do so must be determined as quickly as possible by the commissioner), including agreement as to the amount that is to be paid for the locum cover;

E5.8.2. the locum must not be a partner or shareholder in the Third-party Organisation, or already an employee of the Third-party Organisation, unless the Separately Employed AR GP on leave is a job-sharer;

E5.8.3. the Third-party Organisation and/or PCN must, on request, provide the PCN and/or commissioner, respectively, with written records demonstrating the actual cost to it of the locum cover, who must then provide it to the commissioner; and

E5.8.4. once the locum arrangements are in place, the Third-party Organisation must inform the PCN, who must inform the commissioner:

a. if there is to be any change to the locum arrangements; or

b. if, for any other reason, there is to be a change to the Third-party Organisation's arrangements for performing the duties of the Separately Employed AR GP on leave,

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at which point commissioner is to determine whether it still considers the locum cover necessary.

E5.9. If any of these conditions are breached, the PCN and/or commissioner may, in appropriate circumstances, withhold payment of any sum in respect of locum cover otherwise payable under this paragraph E5.

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