NHS England

Network Contract DES

2026/27

Part A Guidance: Clinical and support services (Section 8)

9 November 2026



Publication reference: PC004_iii

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1. Introduction

1.1 The Network Contract Directed Enhanced Service (DES) was introduced during 2019. For 2026/27, the Network Contract DES Specification come into force on 1 April 2026 and, following participation in the DES, the requirements on practices and primary care networks (PCNs), as outlined in the DES specification, will apply from that date.

1.2 NHS England announced a number of changes to the DES from 2025/26 in order to support PCNs by streamlining requirements and increasing clinical autonomy over how to improve care.

1.3 This document forms part of a 'guidance' package designed to support commissioners, PCNs and their constituent practices to implement the DES. It does not take precedence over the DES specification. It includes:

- descriptions of best practice in support of the delivery of the Section 8 'Service Requirements' in the DES;
- links to additional resources available to networks and practices;
- an annex of SNOMED codes which should be used for recording of relevant activities

1.4 The part B guidance contains information on non-clinical service delivery matters for example, in relation to contract management and participation in the DES. This separate accompanying guidance can be found here.

2. Service requirements

2.1 The DES specifies that a PCN must deliver four key functions. Two of those functions relate to how the PCN organises and operates effectively:

- *"co-ordinate, organise and deploy shared resources to support and improve resilience and care delivery at both PCN and practice level.*

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- *improve health outcomes for its patients through effective population health management and reducing health inequalities.*
- *target resource and efforts in the most effective way to meet patient need, which includes delivering proactive care; and*
- *collaborate with non-GP providers to provide better joined up care, as part of an integrated neighbourhood team."*

2.2 The rest of this section provides information in support of best practice delivery of the last two bullets. It also provides guidance on delivery of the enhanced access service specification.

2.1 Improving health outcomes and reducing health inequalities

Population health management

2.1.1 The DES specification states that "*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."*

2.1.2 To achieve this PCNs should consider applying a population health management approach to service delivery. It can be visualised as improvement cycle as shown on the futures.nhs.uk web page.

2.1.3 PCNs are expected to engage proactively with wider delivery partners including secondary, community, and mental health services partners and agree formal data sharing arrangements with ICBs to support local integration of data in line with the What Good Looks Like Framework.

2.1.4 To use the data, a range of techniques can be used to understand and assess the needs of different population groups (segmentation, risk prediction, opportunity analysis, gaps in care). These are explained in the NHS England Analytics Playbook and Imperial College Health Partners How and Why to get started with Population Segmentation Analysis. PCNs can expect to be supported by ICB intelligence functions in their approach and in using the data. E-learning modules on the principles of Population Health Management can be accessed at the E-Learning for Health Hub.

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2.1.5 Additional resources include:

- The National Association of Primary Care (NAPC) describes a range of methods, including the population cube. This can provide ways to visualise how PCNs might take a life-course approach to understanding the needs of different population groups.
- Guidance on Logic Models which may aid PCNs with planning how best to impact on their populations.
- Additional tools resources and case studies can be found at Population Health Academy - Integrated Care (future.nhs.uk).

Health inequalities

2.1.6 The DES specification states that a PCN should "*actively seek to reduce health inequalities across its Core Network Practices in line with guidance and the CORE20PLUS5 approach*."

2.1.7 To achieve this a PCN should work in partnership within local communities to address health inequalities that are amenable to primary care interventions. The CORE20PLUS5 approach provides a helpful focal point for galvanising action and guiding targeting and outreach regarding conditions which disproportionately affect people from areas of greater deprivation. There is also a CORE20PLUS5 approach for the issues affecting children and young people.

2.1.8 Two of the five clinical areas set out in the of CORE20PLUS5 approach for adults focus on improving cardiovascular disease (CVD) prevention and diagnosis, and early cancer diagnosis. These are covered in more detail in the following section.

CVD prevention and diagnosis

2.1.9 The DES specification states that a PCN's approach must include: "*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.*"

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2.1.10 To achieve this, there are practical actions and steps that PCNs can take:

Outcome	**A PCN should:**
Improve detection and management of CVD risk factors	• review outputs from CVD intelligence tools (including CVDPREVENT) and local population health datasets and share key learning amongst PCN staff; • support the development of system pathways for people at risk of CVD through liaison with wider system partners; • collaborate with commissioners to improve levels of diagnostic capacity for **A**trial fibrillation, **B**lood Pressure and **C**holesterol (known as the 'ABC' of CVD risk) testing, including availability of ambulatory blood pressure monitors (ABPMs) and electrocardiogram (ECG) monitors; • ensure processes are in place to support the exchange of information with community pharmacies, including a process for accepting and documenting referrals between community pharmacies and GP practices for the Community Pharmacy Blood Pressure Check Service.

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Outcome	A PCN should:

Improve the detection of hypertension	• offer appropriate follow-ups, including following NICE guidance NG136 to ensure high blood pressure is followed up, and also proactively review historical records to identify patients who are not on the hypertension register, but whose last recorded BP was equal or higher than 140/90mmHg. In these scenarios, patients are expected to be offered a new blood pressure test plus diagnostic procedure (if needed) to confirm or exclude diagnosis of hypertension.
	• undertake activity to improve the coverage of blood pressure checks including:
	  • increasing opportunistic blood pressure testing where patients do not have a recently recorded BP reading;
	  • undertake blood pressure testing at suitable outreach venues, agreeing the approach with local partners and informed by local data on health inequalities;
	  • work pro-actively with community pharmacies to improve access to blood pressure checks.

Improve the detection of atrial fibrillation	• follow NICE guideline NG196, to improve the identification of those at risk of atrial fibrillation through opportunistic pulse checks alongside blood pressure checks undertaken in a clinical setting, and ensuring the results are recorded and communicated to the GP practice alongside the BP reading.

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Outcome	A PCN should:
Identify and manage raised lipids	**Cholesterol – primary and secondary prevention** • In line with NICE NG238, where clinically appropriate and using a shared decision making approach, offer statin treatment and/or other lipid lowering therapies in line with National Lipid Management Guidance, e.g.: - in primary prevention patients with a QRISK2or3 score ≥ 10%; - in all secondary prevention patients, aiming to achieve LDL-C</=2.0 mmol/l or non-HDL-C </= 2.6mmol/l. • Statin intolerance is expected to be addressed in line with the Statin Intolerance Pathway • work with the local authority to ensure uptake and delivery of the NHS Health Check is optimised for their population. Clinicians may identify patients using a range of validated tools, such as the UCL Partners Proactive Care Framework or CVDACTION

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Outcome	A PCN should:
	Familial Hypercholesterolaemia (FH) • use NICE guidance CG71 to guide the identification of people at risk of familial hypercholesterolaemia; • systematically search primary care records for those at highest risk, including people: - younger than 30 years, with a total cholesterol concentration greater than 7.5 mmol/l; and - 30 years or older, with a total cholesterol concentration greater than 9.0 mmol/l; It is recommended that FH risk be assessed using Simon-Broome or Dutch Lipid Clinic Criteria; and where probable or possible FH is suspected, patients should be referred for further specialist assessment (where available) to include DNA testing in line with local pathways, which may be accessed via genomics hubs in some areas.
Earlier identification of heart failure	• promote and facilitate the use of NT-proBNP amongst primary care clinicians, for people with symptoms or signs of heart failure, in line with GPDA guidance; • ensure that patients with suspected heart failure (symptoms and signs) and NT-proBNP>*400ng/l* are referred urgently for rapid heart failure diagnostic clinic assessment, in line with NICE guideline NG106; and • ensure coding is used as outlined in the appendix. Those who have confirmed heart failure should be coded according to accepted classification (following the results of an echocardiogram).

Early cancer diagnosis

2.1.11 The DES specification at section 8.3.1 also states that a PCN's approach must include the following:

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a) in collaboration with partners, reviewing the quality of cancer referral practice against the recommendations of NICE Guideline 12, 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;

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

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

d) 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.

2.1.12 To achieve this a PCN should take actions to improve in line with the guidance below.

Improving referral practice

2.1.13 A PCN should work with Cancer Alliances to increase early diagnosis rates and improve referral practice. Alliances have been allocated funding to support this work. Together, PCNs and Cancer Alliances should develop a clear set of actions and milestones to improve referral practice by:

- reviewing the recommendations of, and ensure local referral practice reflects, NICE Guideline NG12;
- reviewing safety netting practices and updating these as required, including through the use of structured electronic safety netting tools such as those available in EMIS Web and Ardens;
- considering auditing referrals for people who have received a diagnosis of cancer, including a focus on learnings to reduce diagnoses following emergency

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presentations. The following templates could be used to do this: NCDA Patient Proforma and NCDA Data collection template, and,

- making use of available resources to support GP Practices to make these improvements, for example Office for Health Improvement and Disparities (OHID) Fingertips, which provides data on cancer services at GP practice and PCN level, to inform improvement actions, and GatewayC, the free primary care cancer education resource.

2.1.14 PCNs and Cancer Alliances should also work to promote the use of pathways which support and streamline diagnosis and referral practice in primary care, including:

- Non-Specific Symptom (NSS) pathways for patients with symptoms that could indicate cancer but who do not fit clearly into a single Urgent Suspected Cancer referral pathway;
- teledermatology to support faster skin cancer referrals, with reference to NHS England guidance and the Best Practice Timed Pathway, and;
- maximising the use of alternative pathways where an urgent suspected cancer referral is not clinically required, and promoting the use of best practice pathways, including:
    - direct access tests where GPs consider an urgent investigation is required but do not think an urgent suspected cancer referral, as per NICE NG12 guidance, is appropriate, or where CT chest may be indicated, as outlined in NHS England GP Direct Access guidance;
    - Faecal Immunochemical Testing (FIT) for patients with signs and symptoms of colorectal cancer to identify those requiring a Lower GI Urgent Suspected Cancer referral, in accordance with NICE Diagnostics Guidance 56, utilising Advice and Guidance for patients with a FIT < 10, and;
    - referring on to unscheduled bleeding on HRT pathways in line with British Menopausal Society Guidance, and managing breast pain only patients in primary care with appropriate safety netting.

Screening uptake

2.1.15 Actions to improve screening uptake should include:

- using data on OHID Fingertips to understand any variance in screening programme uptake and take corrective action;

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- auditing non responders to the cancer screening programme/s, including breast, cervical and bowel, to analyse why uptake may be low and work with the NHS England regional public health commissioning teams, Cancer Alliances and ICBs to identify and action improvement priorities;
- adopting an 'Every Contact Counts' approach ensuring screening history is checked at every appointment;
- making use of resources available to identify initiatives, including:
    - CRUK Primary Care Good Practice Guide: Cervical Screening;
    - Macmillan Cancer Screening Quality Improvement Toolkit.
    - Healthcare professionals | Breast Cancer Now Resources for health professionals and patients;
    - Help Us Help You cancer screening campaigns;
    - Screening Saves Lives which can be delivered locally.

Lung Cancer Screening

2.1.16 Actions to support the uptake of the lung cancer screening programme should include:

- Taking opportunities to check and update smoking history in the target population (55 to 74 year olds)
- Working with Cancer Alliances, Lung Cancer Screening Providers and local hospital Trusts to agree pathways for the management of incidental findings to agree what is best managed in secondary care.
- Working with Cancer Alliances and Lung Cancer Screening Providers to develop common agreements for data sharing and data processing.

2.2 Targeting resource and efforts

Proactive care (for frailty)

2.2.1 The DES specification states that PCNs "*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. 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*."

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2.2.2 To achieve this, a PCN should refer to the proactive care guidance to identify and code the target cohort, develop a personalised care and support plan, deliver co-ordinated multi-professional interventions and provide a clear plan for continuity of care. Depending on local capacity to implement proactive care, further prioritisation may be needed based on risk of deterioration.

2.2.3 A PCN should utilise analysis of local data sets (as developed by ICS analytical teams where applicable), evidence-based risk prediction tools such as the electronic frailty index, the EFI2 (when published), clinical validation tools and local knowledge, and practitioners should use the SNOMED codes outlined in the appendix.

Proactive care needs assessments and care plans for winter 2026/27

2.2.4 The purpose of this service is to support Primary Care Networks (PCNs) to identify and proactively manage people at greatest risk of avoidable hospital admission during the winter period. As part of this approach, for 0.5% of the PCNs patients which are identified as at greatest risk of an avoidable hospital admission, a Proactive Care Plan should be developed for each eligible patient to ensure that the assessment process results in a documented, personalised plan of support rather than a one-off intervention. This requirement is intended to support earlier intervention, improve co-ordination of care and promote a more preventative approach for people at highest risk. There is no minimum number of patients that a PCN must support; however PCNs will receive funding for each eligible patient supported, up to the limit of their Proactive Care Entitlement, which is based on 0.5% of their adjusted population as at 1 July 2026. For each Proactive Care Plan developed, the PCN is entitled to payment up to the amount allocated to the PCN for this activity (see section 10.7 of the Network Contract DES 26/27 specification).

2.2.5 The Proactive Care Plan must be developed following a proactive, holistic assessment of need and should be informed by the PCN's identification of patients at highest risk of avoidable admission. This may include, but is not limited to, people living with moderate or severe frailty, COPD or other severe respiratory diseases or heart failure. The assessment and care planning process must involve engagement with the patient and/or their registered carer, where

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appropriate, and should reflect their individual needs, circumstances and preferences.

2.2.6 The proactive, holistic assessment of needs should cover:

- personal and social circumstances, including socio-cultural factors
- past medical history and current health and wellbeing needs
- mental capacity assessment, particularly around care planning and interventions where appropriate
- consideration of assessment under the Care Act 2014 and eligibility for NHS Continuing Healthcare
- consideration of carer assessment and a carer support plan.

2.2.7 PCNs are not required to use a specific assessment tool, risk stratification methodology or data source. Local clinical judgement should be used to determine the most appropriate approach for identifying eligible patients and agreeing suitable interventions - including working with other providers or local partners as appropriate. There is no requirement for Proactive Care Plans to be developed with, approved by, or agreed with commissioners. PCNs may involve other providers or local partners (e.g. community services, social care, specialist services and voluntary and community organisations) where this supports delivery of the patient's agreed Proactive Care Plan.

2.2.8 There is no nationally prescribed template or mandatory set of headings for the Proactive Care Plan. PCNs may use existing local care planning arrangements or care plan templates available within practice IT systems. The key requirement is that a documented, personalised care plan is agreed and in place following the proactive care needs assessment and discussion with the patient.

2.2.9 The Proactive Care Plan should reflect the following:

- A way of capturing and recording conversations, decisions, agreed outcomes or goals, and the interventions and actions to be undertaken, in a way that makes sense to the patient.
- Should be proportionate, flexible, coordinated and adaptable to a person's health condition, situation and care and support needs.

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- Should include a description of the person, what matters to them and all the necessary elements that would make the Proactive Care Plan achievable and effective.

2.2.10 A Proactive Care Plan must meet the 5 criteria below and the PCN must ensure that, if evidence of meeting these criteria is not contained within the Proactive Care Plan itself, there is a record of the actions taken to meet them:

1. Patients are central in developing and agreeing their Proactive Care Plan including deciding who is involved in the process.
2. Patients have proactive, personalised conversations which focus on what matters to them, paying attention to their needs and wider health and wellbeing.
3. Patients agree the health and wellbeing outcomes they want to achieve, in partnership with the relevant professionals.
4. Each patient has a sharable, Proactive Care Plan which records what matters to them, their outcomes, the interventions and actions to be undertaken, and how they will be achieved.
5. Patients are able to formally and informally review their Proactive Care Plan.

2.2.11 The expectation is that the Proactive Care Plan reflects the patient's assessed needs and documents the proactive interventions that have been agreed and put in place. Depending on individual circumstances, interventions may include, but are not limited to:

- Clinical assessment and management
- Medication optimisation
- Care co-ordination
- Falls prevention
- Comprehensive Geriatric Assessment
- ReSPECT protocol
- Supported self-management
- Planned review and follow up
- Escalation plans
- Anticipatory care planning
- Social prescribing
- Mental health and wellbeing support

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- Community service referrals
- Carer support
- Other actions tailored to the patient's identified needs, circumstances and preferences

2.2.12 PCNs must ensure that qualifying activity, including completion of a Proactive Care Plan, is appropriately recorded in the patient record using the coding requirements specified within the Network Contract DES 26/27 specification (section 10.7.4 of the specification).

Structured medication reviews (SMRs) and medicines optimisation

2.2.13 The DES specification states that PCNs must "*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*".

2.2.14 To achieve this a PCN can undertake three priority actions as described below:

Identify patients suitable for an SMR

2.2.15 PCNs should use appropriate tools to identify and prioritise patients who they deem high risk from their population, and would benefit from a SMR, which is expected to include those people where there is evidence of benefit including, but not restricted to, those:

- in care homes;
- with learning disabilities;
- with complex and problematic polypharmacy, specifically those on 10 or more medications;
- on medicines commonly associated with medication errors and risk of harm;
- with severe frailty who are particularly isolated or housebound or who have had recent hospital admissions and/or falls;
- using one or more medicines associated with dependence or withdrawal symptoms, from the following groups: antidepressants; opioids; gabapentinoids; benzodiazepines; and Z-drugs.

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2.2.16 PCNs should also be alert to the needs of communities and individuals at particular risk of health inequalities (e.g. CORE-20PLUS5 population, BAME, those with learning disabilities), including by considering how complex prescribing regimens may be rationalised to improve their safety.

2.2.17 PCNs should consider NICE guidelines NG5 and the Royal Pharmaceutical Society's polypharmacy guidance, as well as the findings of the National Overprescribing Review, in identifying patients and determining their approach.

2.2.18 Once patients have been identified, PCNs should create a process for developing SMR caseloads so that those patients in greatest need of a SMR are seen in a timely manner.

2.2.19 The patient's invitation to the SMR – whether oral or written – should explain what the SMR will involve, and that they will be coming in for a shared decision making conversation to review all their medications and make sure they are working well for them.

Conducting an SMR

2.2.20 Clinicians should conduct SMRs in line with the principles of shared decision making and personalisation: ensure the patient understands the purpose of the SMR appointment, consider the health literacy and holistic needs of the patient, provide advice and signpost, and make onward referrals where appropriate, including to community pharmacies who all deliver healthy living pharmacy services to advise on evidence-based alternatives to medicines if appropriate. Community pharmacies can also support people newly started on medicines through the NHS New Medicines Service.

2.2.21 When undertaking an SMR, in addition to the principles of shared decision making and personalisation, clinicians should consider:

- **Safety** – the balance of benefit and risk. Is the patient experiencing any side effects? Are these excessive when weighed against the benefits of the medicines? Is there any other risk of harm due to co-morbidities (high risk medicines, drug interactions, contraindications)?
- **Effectiveness** What is each medicine for, and is that recorded in the patient's record? Is it appropriate? Is it still indicated? Is it working? Does the patient still take or want it (patient opinion, objective evidence; see shared decision making

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above)? Are long-term condition(s) well controlled? Should anything be added to treatment?

- **Alternatives to medicine** – has the patient been given sufficient information about the available alternatives, which (where appropriate) may not be a medicine, including for example social prescribing?

2.2.22 Appropriate follow-up SMR appointments should be arranged to ensure the safety and effectiveness of any interventions. The clinician undertaking the SMR will determine the number of follow-ups needed in partnership with the patient; this will depend on complexity. It may be that other professionals could follow up the patient. These should be coded as outlined in the appendix.

Collaboration on wider medicines optimisation

2.2.23 The national medicines optimisation opportunities dashboard on ePACT2 provides data to determine where to focus efforts for the local population. PCNs should be aware of the opportunities that the ICB has prioritised for delivery. PCNs should take into account the National Medicines Optimisation Opportunities as part of their medicines optimisation stewardship plans. Due consideration should be given to national and local guidance on items which should not be routinely prescribed in primary care.

2.2.24 PCNs should also support the integration of national-level programmes, such as the, Net Zero report and STOMP (stopping over medication of people with a learning disability, autism or both with psychotropic medicines; specific resources for PCNs) set out in the Long Term Plan. Open data, e.g. Model Health System, OpenPrescribing,ePACT2 and other tools can further support this work.

2.2.25 The NHS BSA Polypharmacy prescribing comparators, the NHS BSA Opioid comparators and the NHS BSA Antimicrobial Stewardship comparators are freely available to all GP practices and ICBs, at GP practice, PCN, ICB and regional level. Developed by the NHS BSA and Health Innovation West of England, they have been shown to help PCNs understand their polypharmacy prescribing in comparison to other PCN and national averages, help identify areas of polypharmacy to prioritise and monitor the impact of any local interventions. Developed with GPs and pharmacists, they have been designed to

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identify manageable numbers of patients to prioritise for a structured medication review.

2.2.26 Through the increased collaboration across the system and working with ICBs, there is a significant opportunity to support the meeting of global commitments on antimicrobial prescribing to reduce antimicrobial resistance and the AMR action plan.

Social prescribing

2.2.27 The DES specification states that it is a key requirement of a PCN to "*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*"

2.2.28 To achieve this, a PCN is expected to:

- either directly employ link workers or subcontract provision of the service to another provider;
- make social prescribing service accessible to the whole patient population and able to take referrals from GPs, PCNs and other agencies, such as pharmacies, hospital discharge teams, fire service, job centres, social care services, housing associations, and voluntary, community and social enterprise (VCSE) organisations, as well as self-referrals;
- use targeted and outreach approaches to ensure social prescribing services reach people who need them most, such as people in Core20PLUS5 populations;
- co-produce with partners (especially Voluntary, Community and Social Enterprises - VCSE) and with people with lived experience;
- ensure social prescribing link workers are fully integrated in multidisciplinary teams alongside Health and Wellbeing Coaches and Care Co-ordinators as described in Annex B of the DES specification;
- consider developing specialist social prescribing link worker roles to meet local needs, focused on specific cohorts, for example children and young people with mental health needs; people with learning disabilities and/or autism; and people from inclusion health groups
- give due regard to the Social Prescribing Information Standard. This will enable PCNs to evaluate the performance of the social prescribing service;

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- work with partners in the ICS (such as Local Authorities and VCSE) to establish joined up approaches to developing social prescribing and community-based support; and
- ensure all link workers to have access to the GP information system used within the PCN and code their work as outlined in the appendix.

Cohort selection

2.2.29 A PCN can identify cohorts who would most benefit from social prescribing by working with local partners, using PHM data, health inequalities data (such as the Health Inequalities Improvement Dashboard) and community insights, to identify how best to target social prescribing services.

2.2.30 Social prescribing can be particularly beneficial to people who:

- have complex social needs (this should include people in Core20PLUS communities);
- experience loneliness or isolation;
- have multiple long-term conditions;
- experience low level mental health issues; and
- are high frequency users of primary, community or urgent and emergency care services..

2.2.31 A further range of tools, resources and case studies can be found on the NHS England social prescribing webpage and PCN reference guide.

Enhanced health in care homes (EHCH)

2.2.32 The DES specification states that it is a key requirement of a PCN to "*deliver an Enhanced Health in Care Homes service in accordance with the framework and guidance, including:*

- *agreement with the commissioner for which care homes the PCN is responsible;*
- *identifying a lead GP (or other senior clinician) with responsibility for the implementation of the EHCH framework for the agreed care homes, and to provide continuity of medical care;*
- *co-ordinating an MDT meeting and associated actions, including the lead GP or clinician and care home staff;*
- *delivering a weekly care home round; and*

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- *ensuring accurate coding of care*."

2.2.33 To achieve this PCNs should follow the Enhanced Health in Care Homes (EHCH) Framework which describes the implementation model in detail, describing the inputs and responsibilities across the system, to ensure person-centred integrated care is delivered at the care home level, with an emphasis on multi-disciplinary support and shared care planning. A PCN must also review each resident's overall vaccination status as part of personalised care planning, and where a resident is eligible for a routine vaccination, the PCN must work with the patient's registered practice to ensure they are offered vaccination at the earliest opportunity.

2.2.34 Additionally, a PCN is expected to:

- support people entering, or already resident in the PCN's Aligned Care Home, to register with a practice in the aligned PCN if this is not already the case; and ensure a lead GP (or GPs) is agreed for each of the PCN's Aligned Care Homes. By exception, the clinical lead may be a non-GP clinician with appropriate experience of working with care homes, provided this is agreed by the practices in the PCN, the commissioner and the relevant community provider;
- work with community service providers (whose contracts will describe their responsibility in this respect) and other relevant partners to establish and coordinate a multidisciplinary team ("MDT"); and have established arrangements for the MDT to enable the development of personalised care and support plans, in line with the guidance in the EHCH framework;
- identify and engage in locally organised shared learning opportunities as appropriate and as capacity allows; and support with a patient's discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 2756;
- ensure the coding of care home residence is accurately recorded using the relevant SNOMED codes as published in the supporting Business Rules.

3. Enhanced access

3.0.1 Section 8.6 of the DES specification sets out the requirements for delivery of enhanced access.

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3.0.2 For enhanced access the Network Standard Hours cover 6.30pm-8pm during the week and between 9am and 5pm on Saturdays. Where a Core Network Practice is required under a General Medical Services (GMS) contract to provide core services at its premises after 6.30pm, the patients of that practice must also have access to enhanced access appointments, and the enhanced access appointments must be in addition to the appointments offered as part of that practice's core hours service offer.

3.0.3 Core Network Practices within a PCN are collectively responsible for the delivery of enhanced access. In the event the commissioner is not satisfied that a PCN is delivering the requirements in accordance with the DES specification, then the commissioner may take action as set out in section 9 of the DES specification. If a commissioner determines to withhold payment, the amount withheld will be an appropriate proportion of the enhanced access payment and the Core PCN funding payment.

3.0.4 PCNs have the flexibility to sub-contract enhanced access services to other providers in accordance with any sub-contracting provisions of the GP practices' primary medical services contracts.

3.0.5 In relation to enhanced access, the DES specification sets out the minimum universal requirements for PCNs to deliver. It is expected that, where areas had additional patient services in place locally prior to the introduction of enhanced access in October 2022, commissioners will have made arrangements for these to continue (and any changes would be subject to local engagement). Where levels of capacity or funding as provided under the CCG Extended Access Service at 30 September 2022 exceed the minimum requirements for enhanced access set out in the DES specification, commissioners are expected to ensure these capacity and funding levels under the CCG Extended Access Service are maintained going forward.

Delivery of enhanced access

3.0.6 Enhanced Access should be delivered in accordance with the previously developed Enhanced Access Plan that was agreed with the commissioner.

3.0.7 It is up to the PCN to determine the delivery model for enhanced access as part of the Network Agreement, but PCNs will need to ensure this service is offered to the

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entire PCN population. The exact model of delivery in each PCN may vary and could include:

a. All practices in the PCN offering enhanced access to their own registered list.

b. One practice undertaking the majority of the enhanced access provision for the PCN's population, with other practices participating less frequently (but those practices' registered patients still having access to enhanced access at other sites).

c. One practice offering enhanced access to its own registered list and the other practices sub-contracting delivery for their respective patients.

d. The PCN subcontracting delivery as a whole or elements of the service to another provider for its collective population. A PCN may decide to sub-contract delivery of enhanced access and if doing so this must have due regard to the requirements set out in the statutory regulations or directions that underpin each Core Network Practice's primary medical services contracts in relation to sub-contracting, as set out in section 5.6 of the DES specification.

3.0.8 Irrespective of the delivery model, the PCN should ensure all network patients have access to a comparable enhanced access service offer. PCNs should ensure any sub-contracting arrangements are in accordance with any sub-contracting provisions of the Core Network Practices' primary medical services contracts.

Funding for enhanced access in the Network Contract DES

3.0.9 Enhanced access payments under the DES will be made using PCN Adjusted Populations, which are based on ICB Primary Medical Care allocations weighted populations.

3.0.10 PCNs can view their enhanced access funding here or in the GP contract ready reckoner.

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4. Appendix

Coding requirements – SNOMED codes

Heart failure To use following diagnosis. Knowing these classifications are important precursors to defining the appropriate evidence-based treatment.	• HF with reduced ejection fraction– code as HFREF: 70327200 • HF with mildly reduced ejection fraction – code as HFREF:788950000; and • HF with preserved ejection fraction – code as HFPEF: 446221000
Social Prescribing To use following social prescribing offer	• 871731000000106 – Referral to social prescribing service (procedure). • 871711000000103 – Social prescribing declined (situation);
Proactive Care To use in relation to commencement or ending of Proactive Care – supports the measurement of percentage of registered patients under the provision of Proactive Care [PR001]; and Percentage of registered patients discharged from Proactive Care service [PC003] using the count related clinical codes:	• 934231000000106 Provision of proactive care (regime/therapy)"; and • 934691000000105. Proactive care ended (situation)"
SMRs To use in the administration of an SMR, or a follow up.	• 1239511000000100 Structured Medication Review (procedure)

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