

**Cheshire Local Medical Committee Ltd**

**Investment and evolution:**

**A five-year framework for GP contract reform to implement *The NHS Long Term Plan***

**Questions asked about Primary Care Networks**

A resource for 2019/20

Version 2: April 2019

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**Introduction**

This document has been developed and issued by Cheshire LMC. **No part of the document or our interpretation supersedes the actual guidance or formal notes issued by NHS England.** It is our intention to update the guide on our web site as the detailed instruction on various sections is released.

In this second edition of our FAQ paper we have taken the chance to set out some of the next steps required to sign up to the Network DES and updates the FAQs.

As always we welcome your questions and will try to gain answers for you if the LMCs representatives do not have them readily to hand.

William Greenwood

Chief Executive

April 2019

**General Practice Network Contract DES: Overview**

**Description:**

The new DES is ‘voluntary’ but NHSE and the BMA expect 100% uptake. To quality for funding from July 2019, practices will need to join a network and appoint a Clinical Lead. Following that your network will have to work towards seven ‘service specifications’ based on the aims of the NHS Long Term Plan.

**How much?**

As a DES all practices are eligible to participate and so receive an annual weighted Network Participation Payment of £1.76 for doing so (see below). This is paid alongside the global sum from 1 July 2019.

The DES has several additional funding elements:

Network Financial Entitlements of:

* The Additional Roles Reimbursement Scheme
* Recurrent funding for the role of Clinical Director (sliding scale)
* £1.50 per head recurrent funding from CCG allocation
* £1.76 Network Participation Payment (see previous paragraph - this is paid directly to the practice and not the Network)

**Timeframe:**

Complete the initial registration form and submit by 15 May 2019. Practices must complete and return all schedules to the agreement by 30 June 2019.

**Establishing a PCN/ How to Apply**

It’s an entitlement for all practices and the biggest way to increase practice income.

The target is 100% coverage of the DES by 1 July. To be eligible for the Network Contract DES, a Primary Care Network needs to submit a completed initial registration form to its CCG by no later than 15 May 2019, and have all member practices signed-up to the DES. The form is attached at Annex C to the Contract Agreement. All schedules to the mandatory Network Agreement must be submitted to the CCG by 30 June 2019.

The registration process asks for six factual pieces of information:

(i) the names and the ODS codes of the member practices;

(ii) the Network list size, i.e. the sum of its member practices’ registered lists as of 1 January 2019;

(iii) a map clearly marking the agreed Network area;

(iv) the initial Network Agreement signed by all member practices;

(v) the single practice or provider that will receive funding on behalf of the PCN; and

(vi) the named accountable Clinical Director.

**In Plain English…**

You are being asked to lead change at local levels and work in Primary Care Networks to provide services to registered populations of 30-50,000. Working collaboratively, possibly sharing (some) community staff across the network you will start to lead integration of out of hospital services.

The aim is that you will look at things from new perspectives and develop the skills and confidence to be a leader of change. In time your network will engage a wider range of professionals – some health and some other sectors to meet the needs of your registered population. It is very likely the new Integrated Care Partnerships will look to support PCNs in terms of service delivery.

In subsequent years, seven 'service specifications' will be gradually implemented as part of the DES based on the clinical strategies set out in the NHS long-term plan, including increased screening and earlier detection of cancer.

**General Practice Network Contract DES: Applying to Join Network**

**Declaration of Intent to join a Network: Deadline 15 May 2019**

We suggest that you draft an initial expression of interest along these lines –

**On Practice headed notepaper**

“Declaration of Intent to Join the Primary Care Network

We, the undersigned partners at \_ \_ \_ \_ \_ \_ practice, confirm our intention to join the ­­­\_ \_ \_ \_ \_ \_ \_ \_ Primary Care Network.

Our list size as at 1st January 2019 is \_ \_ \_ \_ \_

We recognise that we will be core members of the Primary Care Network and as such will have certain rights and responsibilities as set out in the Mandatory Network Agreement. We will play our full part in Network decision making to ensure the success of our Primary Care Network.

|  |  |
| --- | --- |
| Partner | Signature |
|  |  |
|  |  |
|  |  |
|  |  |

We have agreed that our representative to take part in Network meetings and decision making and the principle point of communication between our practice and the Network shall be:

Partner

Signature

Contact details (Telephone and e-mail)

This person has full delegated authority to take part in PCN decision making processes on behalf of the practice. In the event that our representative feels unable to commit to a decision on behalf of our practice without further practice consideration this will be considered by the practice as soon as possible and fed back to the next PCN meeting.

In the event that our representative is unavailable the practice will nominate and inform the PCN of a designated deputy.”

We would suggest one practice coordinates the submission of expressions of interest by all core member practices to ensure 100% sign up.

**Network Agreement: 30 June 2019**

The Network Agreement is mandatory and all the clauses, 1 – 106 have to be used, apart from one or two specific instances where the clause can be amended to give more detail.

There are seven schedules that set out more information over and above the 106 clauses and these schedules need to be completed by the PCN. The initial core membership and configuration of the PCN needs to be submitted by 15th May, but there is more time, until 30th June, to complete the seven schedules setting out the detailed working arrangements of your PCN.

The BMA have produced some useful checklists which will help you in completing the above. Check out the BMA web site for full details.

Primary Care Networks are not being established in a vacuum and many localities, neighbourhood teams, integrated care communities or primary care networks already exist in some form, albeit without the full range of responsibilities now set out in the Network DES. These communities may wish to continue with their existing practice membership. Alternatively, they may wish to fine tune their membership in the light of the new requirements and responsibilities. Either is fine and the LMC can help you through this process.

It is interesting to note that there is no mention in the guidance of any requirement to give a name of the Primary Care Network. Most existing locality arrangements will already have a name and you may well wish to continue with this name. If not and your PCN wishes to establish itself with a new name, now is the time to act.

**Schedule 1**

This schedule sets out in more detail those matters initially specified in the initial registration process of 15th May. Items 1 – 6 have already been submitted and just need to be repeated. It is noted that although not specified it would be a good opportunity to reiterate the name of your Primary Care Network.

Items 7 onwards set out how decisions are to be made in the PCN. These need to be specified in sufficient detail to give assurance that good governance arrangements, without being overly bureaucratic, will support effective and inclusive decision making that can command the confidence of PCN practices and other stakeholders involved in the PCN.

We would suggest that these arrangements be kept as simple as possible in the first year. They can be refined in the light of experience as the PCN grows in experience and responsibilities. It may be worth including a clause that the schedules will be reviewed in March each year in readiness for the next planning year.

A particularly complex area will be in relation to the arrangements that were in place before the new GP Contract. Many areas had neighbourhood teams, locality clusters, integrated care communities or primary care networks. These would have meetings with a range of participants although the governance arrangements would be less formal that the new requirements of the DES. The PCN needs to decide how much of the previous arrangements stay the same and should discuss with the commissioner, what they think the best size for the Network should be, and the reasoning behind it prior to submitting their application documentation.

**Schedule 2 Additional Terms** to be covered in future updates

**Schedule 3 Activities** to be covered in future updates

**Schedule 4 Financial Arrangements** to be covered in future updates

**Schedule 5 Workforce** to be covered in future updates

**Schedule 6 Insolvency** to be covered in future updates

**Schedule 7 Arrangements with Organisations Outside the Network** to be covered in future updates

**FAQs**

**Network Structure and Size**

**We are a practice with a patient list of over 30k; can we be a network on our own?**

There will be some practices with patients’ lists in excess of the suggested 30k – 50k and which already operate across multiple sites within a geographic area. In such cases it is possible for the practice to operate as a Network itself, with an informal split of its constituent sites into ‘neighbourhoods’ of approximately 30k-50k patients. More detail on how this will operate will be available in later guidance.

**Can practices in different areas form a Network?**

Networks should form a single coherent area, without any gaps in coverage within the Networks outer boundaries.

**Can CCGs dictate Network configurations?**

No. The decision about how Networks will be configured rests almost entirely with the practices who can define their own structure subject to the rules around size and geographical contiguity. The exception to this rule is that CCGs have a responsibility to ensure that all practices can be a part of a Network and may need to intervene to ensure this. It is expected that CCGs will work with LMCs in these discussions, but outside of this caveat the power to define structure rests completely with the practices themselves.

**Will the geographical mapping be a problem for practices, with branch surgeries?**

It has been agreed that PCNs can overlap one another. The essential requirement is that all patients within a CCG area are covered but if there are no geographical gaps then there should be some flexibility. For example, currently if a branch surgery sits within a different CCG to the main practice then they would be counted under the main CCG patch. A similar arrangement would work for PCNs. Therefore, if this is an issue the LMC should be working with CCGs to try and work with PCNs within an area to agree sensible working arrangements.

**Can a PCN close/merge/split, and if so, what happens to the PCN's assets/liabilities?**

Yes it can. How this works in practice will be dependent on the Network Agreement.

**If a core member wishes to leave it needs to notify the commissioner of its decision and consent will not be "unreasonably withheld", but if this takes a PCN significantly below the population floor is this adequate reason for a CCG to refuse?**

This is the similar to forming PCNs. the CCG's role is to ensure there are no gaps or patients left out and that PCNs are of sufficient size to ensure viability. A practice won't be prevented from leaving a PCN and ending their role in this activity. But if that leads to the remaining PCN being outside the population ‘norms’ for PCNs it will lead to the CCG, working with the LMC, to consider the best way forward for the area.

**If a large ‘core member’ practice (e.g. a practice with say half the PCN population number) leaves but the patients ‘stay’, will the smaller members practices continue to have to deliver all the services across the whole PCN's patients (e.g. the extended access requirement)?**

Again this might lead to a wider discussion in the area between remaining PCNs, the CCG and LMC. One option may be for the smaller practices joining with a neighbouring PCN but it’s for the local area to consider the best options for patient services.

**Network Agreement**

**Is there a checklist to help us draft the Agreement?**

Cheshire LMC is drafting notes on this (see earlier section) but there is also a useful list to support those on the road to completing their Network Agreement at:-<https://www.bma.org.uk//media/files/word%20files/collective%20voice/committees/gpc/pcns/setting%20up%20a%20pcn%20checklist.docx?la=en>

**How important is the Network Agreement?**

The Network Agreement is the essential element containing the operational rules of each Network. You should seek appropriate professional advice as this document is crucial to the PCNs future development and success.

 The Network Agreement is also the formal basis for working with other community-based organisations going forward. A Primary Care Network cannot exist without its constituent practices, but it membership and purpose goes much wider. The NHS Long Term Plan sets out a clear ambition to deliver the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care.

The Primary Care Network is a foundation of all Integrated Care Systems and every Integrated Care System will have a critical role in ensuring that PCNs work in an integrated way with other community staff such as community nurses, community geriatricians, dementia workers, and podiatrists/chiropodists. Collaboration arrangements with other local organisations including community health providers will form a distinct part of every Network Agreement as they are developed.

**Network DES Services**

**What will the Network Services within the DES contain?**

The service requirements within the DES will be phased in gradually over the next 5 years, covering the 7 areas as below:

1. Medication review and optimisation

2. Enhanced health in care home service

3. Anticipatory care (with community services)

4. Personalised care

5. Supporting early cancer diagnosis

6. Cardiovascular disease prevention and diagnosis, through case finding

7. Action to tackle inequalities

These will be discussed and agreed with GPC England prior to each implementation, and full guidance will be issued as each service specification is introduced to the DES. Further information on what is broadly expected that each of these 7 services will cover will be available within the full DES guidance.

**Do all practices have to ensure that their patients are covered by the Extended Hours DES as part of the PCN arrangements?**

Yes. The DES will require 100% coverage for all patients. Practices and their Networks can agree how coverage is achieved. This could be through a hub model organised via the local GP Federation or some other locally agreed approach. It must be delivered within a network area from 1 July 2019.

**If a practice is delivering a service that the LMC doesn’t think is part of essential services, and to support this can point to another local CCG where it is commissioned as an LES, then what is the status, in terms of commissioning arrangements, of that service in the CCG where there is no clarified commissioning vehicle? Is it an NHS service covered by CNSGP? Is it a non-NHS service which practices are delivering for free, because they are not allowed to charge their NHS registered patients, and, if the latter, which is of course is what the LMC would argue, is it still covered by CNSGP or as part of the private cover practices are buying – even though no private income is generated from this work?**

The key point is whether the service meets the definition, in the scheme rules, of Primary Medical Services:

“Primary Medical Services” means the primary medical services that, in accordance with section 83 of the 2006 Act, NHS England is under a duty to secure and which are provided, or to be provided, under a contractual arrangement (including any such arrangement that is part of a set of arrangements for the provision of services, in addition to the primary medical services specified in that contractual arrangement):

a) made under section 83(2), 84(1) or 92(1) of the 2006 Act; or

b) made by a Part 4 Contractor with a Primary Medical Services Sub-contractor;

If it is not commissioned then it could be considered as private work, even though it accrues no income. We know that there are many services that are delivered by practices that are commissioned elsewhere by CCGs and would be regarded as routine general practice activity by many in the NHS. For instance spirometry is funded in some areas as a local enhanced service but is delivered by practices as a routine unfunded service in other areas. Neither DHSC nor NHSE would want to suggest that if a practice was voluntarily doing spirometry as part of their NHS service delivery, but the service was not commissioned as a LES by the CCG, that this was no longer covered by the scheme.

 However, clearly if this is un-commissioned work then there is no requirement for the practice to deliver it if they have any doubts about indemnity cover. LMCs and practices can use the dedicated NHS Resolution email address to seek formal confirmation on this and any other related issue - cnsgp@resolution.nhs.uk

**What if a group of rural practices, who on a subcontracting arrangement are delivering the CCG Increased Access Service, they could form a PCN, but they do not want to deliver another outside core hours service (i.e. Extended Hours) for significantly less money than the Access Service? They do not think they will be able to find clinicians to deliver it for the money. They understand it could be delivered concurrently, at the same geographical location(s). They just don’t want to give up the GP increased Access Service for a less well remunerated alternative, this could be a bar to the group forming a PCN at all.**

There is no intention to replace the Increased Access Service (£6pp) with the Extended Hours service – they are both to be commissioned and GPC negotiators want to retain both amounts of funding. The Extended Hours Service is part of the PCN DES and therefore must be delivered by the PCN; the Increased Access service does not have to be delivered by the PCN and if it is, it should be done in addition to, rather than replacing the Extended Hours Service.

This is significant as the funding agreed in the national negotiations is based on both services being fully funded. Remember also that there is no requirement for the Extended Hours service to only be GP appointments. Practices and PCNs can determine what type of appointments they provide as per the DES requirements.

**Data**

**The PCN Data Sharing Agreement; will this apply to practices who do not join the PCN; I understand their registered list will receive PCN services, so can anticipate there will be a desire to ensure data can be shared in relation to PCN delivered services about such patients. How would this be managed if the practice (Data Controller) isn’t signed up to the PCN DES, since the DSA seems to be written into the DES?**

The DSA is designed to cover anyone sharing data within and out with those signed up to the DES, therefore practices who are not signed up but whose population may be covered by the PCN will be able to sign up to the DSA.

**Staff Employment**

**Who employs the extended workforce funded under the DES?**

The network workforce could be employed in a number of ways, depending upon the structure of the Network, and how its member practices wish it to operate. For example, the Network may wish for the practice which has been nominated to hold the funding to use that funding to directly employ the staff that can then be utilised across the Network. Alternatively, employment of staff could be spread across the member practices, with funding redistributed from the fundholding practice as required.

**Will we be able to claim reimbursement for existing staff under the DES?**

The scheme is designed to grow additional capacity through new roles, not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care, whether funded by a practice, a CCG or a local NHS provider. Reimbursement through this route will only be for demonstrably additional people (or, in future years, replacement of those additional people as a result of staff turnover). The only exception to the ‘additionality’ rule is existing clinical pharmacists reimbursed under either (i) the national Clinical Pharmacists in General Practice scheme, or (ii) the national Pharmacists in Care Homes scheme. Both schemes have tapered funding. Both will be subsumed into the new more generous arrangement.

**How is the funding for extra staff (pharmacists, social prescribers, etc.) worked out, i.e. is it based on a population of a care community or by PCN?**

For the first year only each PCN will get funding for one pharmacist and one social prescriber. From the second year onwards the funding allocation is based on the population size of the PCN.

**Is there clarity on how the money can be used? For example using the Pharmacist funding proposal - is it a requirement that a new member of staff is employed for the network (i.e. someone who doesn’t current work within that setting) or could the funding be used to pay for existing pharmacists within the practices who are part of the PCN?**

The funding is for new employees, with the exception of pharmacists on the current national schemes that can be transferred across to the new 70% recurrent reimbursement scheme. This doesn't apply to pharmacists already employed directly by the practice who are not part of the national schemes.

**Who funds the other 30% of PCN employed staff?**

The remaining 30% comes from the PCN practices. It's for the PCN to decide who employs the new staff and further guidance about the different options will be issued shortly. The governance arrangements and Network Agreement should also cover this.

**What happens to the unspent money if a PCN has difficulty recruiting in to their network?**

A PCN will only be reimbursed for the workforce they have employed. However, if recruitment proves difficult for certain groups or specific areas of the country, there is a shared wish between GPC England and NHSE to use unspent workforce expansion funding. If this proves to be the case GPC England and NHSE will discuss how to ensure the funding is retained within general practice.

**Funding, Liabilities and Costs**

**Will practices own the PCN?**

As a PCN is based on a DES, which is part of the GMS/PMS contract, it is for practices to lead and shape them.

**How will the funding work in the network contract?**

Practices will receive recurrent payment of £1.50 per patient as an entitlement for networks, from CCG central allocations, to assist in the general administration costs of the Network. Precisely how this funding is utilised will be for the Network collectively to decide. The first payment will be received on 1 July 2019, paying 4 months in arrears and monthly thereafter.

From 2019/20 the requirements and funding of the Extended Hours DES will be transferred to Networks. This will provide approximately £1.45 per patient. Following an Access Review in 2019, a more coherent set of access arrangements will start being implemented in 2020, including transferring the £6 per patient funding under the GPFV Improving Access scheme to Networks. There will be additional funding for workforce paid on a reimbursement basis.

**What will happen to any local funding we already receive to support collaboration?**

If there are current arrangements that have been funded for collaborative structures locally, then local discussions between the LMC, CCG and the PCNs should take place to decide if and how that needs to change to fit in to the structures of PCNs. This may involve previous funding being reinvested in new primary care activities.

**We have a LES which many practices rely on, how will this be impacted by PCNs?**

CCGs will want to avoid double payment for areas now covered by the national deal but the funding they currently spend locally should be retained in general practice. CCGs and LMCs should discuss how this funding is reinvested in general practice.

**What are the associated VAT and employment liabilities for the employing practices in a PCN?**

GPC will be issuing joint guidance with NHS England in the coming weeks.

**If the CCG wishes to commission additional service from the PCN, on top of those contained within the DES, will these require competitive procurement?**

As with current Locally Enhanced Services, there will be a reduced emphasis on competitive procurement as PCNs will be built through the GMS contract and PCNs will have entitlements to funding for specific service provision, and contracts can be awarded without competitive tendering if they are based on the Network list.

**Can a PCN make a loss, become insolvent or borrow money?**

The DES is an extension of the practice contract, so just as practices operate within a defined budget, that's the same for the wider PCN.

**Who is responsible for any debt a PCN develops?**

It is the responsibility of the practices within the PCN.

**Can a PCN make a profit, and if so can a PCN distribute profits to its Members?**

Again, this is the same as for practices and for the members of the PCN to decide how it uses its funding.

**If a core member practice leaves and the funding is reduced such that it is no longer possible to employ a similar number of staff, who pays the redundancy costs?**

The Network Agreement should make this clear.

**If there are Employment Tribunal/ Law findings against a PCN who pays the penalty?**

This will relate to the employer, as agreed within the PCN. The Network Agreement needs to be clear on employment issues.

**If there are extended periods of employee leave (e.g. Maternity/Sickness) is backfill funding available to a PCN or do members simply have to cover the workload?**

This is up to the practices to determine within the network agreement and is similar to how they manage practice staff leave.

**At the end of the 5 year term of the DES what happens to staff employed under the DES?**

The intention is to continue the funding commitments as the GPC intends for other areas of national funding within the contract.

**Who can hold the bank account for a PCN?**

The Network DES talks about the bank account holder having to hold a Primary Care Contract and elsewhere it mentions GMS, PMS or APMS Contract. Therefore a GP federation or other provider structure that holds an Extended Access Contract or OOH contract, or say a phlebotomy contract doesn’t qualify unless its APMS.

**Clinical Directors**

**How will the Clinical Lead of the Network be appointed?**

The appointment process for the role of the Network’s Clinical Lead is down to the respective Network to decide and will need to be outlined within the Network Agreement. Whilst this can be discussed with the commissioner and LMC, the decision ultimately lies with the PCN.

**How should PCNs appoint Clinical Directors?**

GPC are issuing guidance on various aspects of PCNs, and aiming to give practical advice on various things. The contract agreement is simply that the networks themselves will decide who the Clinical Director is, and therefore one of the guidance documents being drafted is about the Clinical Director, who should it be and how to decide – providing options for PCNs to decide how to proceed.

**To whom are the PCN clinical directors accountable?**

They will be accountable to the member practices. This will be set out in the Network Agreement and therefore, exactly how this is done will be decided by the practices within Network.

**Can the Clinical Director also be the Care Community lead?**

Yes. The LMC recommends that the two posts be kept separate in the early stages unless the Network is mature and can demonstrate a strong history of close, integrated working with other locality services and staff. We think the demands on the Network Director in the first year will be quite onerous and will probably expand. It is for the PCN to decide this issue.

**Time Line for Primary Care Network Establishment**

|  |  |
| --- | --- |
| **Date** | **Network DES Action** |
| **Jan-Apr 2019** | **PCNs prepare to meet the Network Contract registration requirements** |
| **By 29 Mar 2019** | **NHS England and GPC England jointly issue the Network Agreement and 2019/20 Network Contract** |
| **By 15 May 2019** | **All Primary Care Networks submit expression of interest and initial registration information to their CCG** |
| **By 31 May 2019** | **CCGs confirm network coverage and approve variation to GMS, PMS and APMS contracts** |
| **By 30 June** | **All Primary Care Networks submit mandatory registration details (schedules)** |
| **1 Jul 2019** | **Network Contract goes live across 100% of the country** |
| **Jul 2019-Mar 2020** | **National entitlements under the 2019/20 Network Contract start:****•year 1 of the workforce funding****•ongoing support funding for the Clinical Director** **•ongoing £1.50/head from CCG allocations**  |
| **Apr 2020 onwards** | **National Network Services start under the 2020/21 Network Contract** |

If you have any questions relating to the FAQs in this document please contact the LMCs Chief Executive WGreenwood@cheshirelmc.org.uk

Cheshire LMC is a member based organisation, independently funded by its member practices. It is the only representative voice in the local NHS that is recognised by statute. We exist to represent and support you.

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