**Primary Care Networks (PCNs)**

**Commissioning Principles for approving a change in Core Network Practice Membership**

1. **Purpose of Report**
   1. The purpose of this report is to provide a brief background on the impact of changes to core network practice membership when practices move to a different PCN. This is in relation to commissioned services and the provision of patient services.
   2. The report recommends adopting a set of commissioning principles to underpin stability to PCNs and enable improved integration and delivery of population health needs at a neighbourhood level. It also sets out plans to adopt the same set of principles when considering an application to merge GMS contracts.
2. **Context** 
   1. The Network Contract Directed Enhanced Service (DES) was introduced in 2019. At the time the concept of practices working together as a group was relatively new; it was a commissioning requirement aimed at delivering the objectives of the long-term plan. Practices were encouraged to come together at pace.
   2. Since the inception of PCNs following the COVID-19 pandemic and the focus on integrated care systems, the commissioning priorities for health care have changed with the emphasis on geographical areas and local population health inequalities with a priority to commission services that ‘level up’ at a community and local neighbourhood footprint.
   3. There are an increasing number of providers outside of general practice that are commissioned through national and local contracts that are required to operate at neighbourhood, place and system level. Primary care commissioning, including PCNs, needs to support this to ensure the system health care provision and workforce are stable to focus on local health inequalities and are not distracted from constant change in local PCN reconfigurations.
   4. Primary care provision and commissioning intentions should support a stable PCN platform around which integrated care involving multi-disciplinary teams can be delivered. However, some existing PCN footprints are configured based on a business model or were allocated together to form a PCN rather than a geographically contiguous footprint.
   5. Whilst there are plans for the development of a primary care strategy in 2022, the release of the amendments to the DES on 31 March opens the 30-day window for practices to request changes in their PCN membership/configuration.
   6. In view of this it is crucial that these criteria are identified and will therefore be applied to any potential application received within this period.
   7. It is important to note, at any time in the year, a practice has the right to apply to move PCNs if relationships irretrievably breakdown. This is discussed later in the document.
3. **Decision making** 
   1. As set out above, the annual contract refresh opens an opportunity for PCNs to request a change in their core network practice membership. However, the evolving objectives to deliver at a ‘contiguous’ local level has not been defined nationally or consideration given to the implications that moves have on the current services.
   2. The CCG are required to consider applications and the final decision remains the right of the commissioner.
4. **Principles**

The following principles are for consideration by the Committee to be applied for any request to change membership of the PCN. The criteria also include the relevant extract from the DES for information.

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| Principles | Rationale/guidance |
| Any practice move must remain within the existing ‘place’ local authority boundary. | Clause 5.1.3. The Network Area must align with a footprint which would best support delivery of services to patients in the context of the relevant Integrated Care System (ICS) |
| Practices must be geographically contiguous to each other (as determined by the commissioner) i.e., their registration boundaries should connect/overlap without a break and there must be a contiguous connection between the *majority* of registered population areas they serve | Clause 5.1.3. The Network Area must cover a geographically contiguous area |
| The stability of the leaving PCN must not be compromised including a membership of 30,000 registered patients, financial viability or negative workforce implications | Clause 5.1.1. A PCN can be broadly defined as a practice or practices (and possibly other providers) serving an identified Network Area with a minimum population of 30,000 people. |
| No negative impact on the services provided by wider community-based providers who have configured their teams and services e.g., community, acute, third sector, pharmacy, social enterprise | Clause 5.1.3. The Network Area must cover a boundary that makes sense to other community-based providers which configure their teams accordingly |
| Branch surgeries must meet the contiguous criteria for core registered patients, where this is not met, they must be a none core member of a PCN that is local to them, this may be different to the main practice site | Clause 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. |
| The move must meet the national and local Primary Care commissioning intentions/ objectives |  |

1. **Population health** 
   1. In addition to meeting the core principles practices will need to consider their population health needs as part of neighbourhood working and align to national and local strategies at the time of application.
   2. Each practice will need to consider their population health needs as part of neighbourhood working improving prevention and tackling health inequalities in the delivery of primary care
2. Supporting better patient outcomes in the community through proactive primary care
3. Supporting improved patient access to primary care services
4. Delivering better outcomes for patients on medication
5. Helping create a more sustainable NHS
   1. The proposed Network area must satisfy the commissioner that it 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.

1. **Patient engagement** 
   1. In view of the impact on the patient population, it is crucial for any changes in PCN membership to be effectively shared through a patient consultation exercise. This approach needs to be fully quantified in the expression of interest document, found in appendix A.
2. **Consequences/impact of practice changes** 
   1. The detail below sets out the potential impact of a practice request to change. The principles set about above should prevent these issues from occurring.
   2. Finance

The allocations to PCNs are based upon the populations that they serve. Changes in PCN membership will affect the level of investment that flows into the PCN the practice will be leaving. Requests to change PCN in this short time window will not give sufficient time for the PCN to review their business plans to be able to manage their core business in line with their reduced income.

* 1. PCN viability

The contract requires a minimum PCN population base of 30,000. In some instances where practice/practices wish to leave a PCN this number would be undermined. Where numbers drop below 30,000 the remaining PCN practice membership may not be able to continue as a PCN. This would mean dispersing the PCN with practices joining other PCNs. This would therefore de-stabilise other established PCNs.

* 1. System partner teams

ICS partners e.g. social care, community services, voluntary services, acute trusts and health visitors are likely to have configured their community service teams to work in geographical contiguous areas or aligned to a particular PCN. Changes in PCN membership may therefore require partners to review their current configuration of services changing to ensure resources are aligned appropriately.

* 1. Workforce

There are an increasing number of staff employed through the Additional Roles Reimbursement Scheme (ARRSs). The funding for these roles is based on the weighted population of the PCN so any practice movements impact on workforce funding and employment.

* 1. There will be some staff where TUPE applies and this has potential to impact on delivery. If staff are unwilling to move/decide to leave because of change then the PCN they propose to join may not be able to backfill that particular role for the practice that moves. Where TUPE does not apply, there may be a requirement to reduce contracted hours.
  2. Some services may be subcontracted/outsourced to other providers who require a period of notice to change or withdraw resource. Where ARRS staff are employed directly by a practice there is potential for redundancy if the resource does not follow the function.
  3. The stability of ARRSs workforce is a key component to delivering the DES and many requests for change do not take in to account the legal rights of this workforce (TUPE, redundancy).
  4. PCNs are required to submit recruitment plans; any movements may require a rework of those plans for leaving and receiving PCNs.
  5. Requests for the change in a PCN Core Practice Membership impacts upon a number of areas for both the leaving and the receiving PCN. Both elements should be considered to ensure stability in the system and to reflect the changes as we move to an Integrated Care System (ICS).
  6. Patient pathways

There are a number of services that are required as part of the DES. These include the delivery of enhanced access. it is crucial that the implications of changing PCN is fully considered to prevent increased travel times/difficulties for patients in accessing PCN delivered services.

1. **Irreparable breakdown in relationships**
   1. Where relationships have totally broken down the viability of the leaving PCN must be considered. The implications and process for the management of these situations has been set down in previously agreed guidance.
   2. The practice has the right to terminate their DES contract and leave.
   3. In these circumstances the commissioner has the responsibility to ensure the delivering of DES services to the population of the practice.
   4. The commissioner reserves the right to commission the DES services from the PCN from which the practice has left.
2. **Process** 
   1. The Practice must complete the expression of interest form **Appendix A** and submit to the CCG on or before 30 April 2022 and on or before the 30th calendar day following the date the Network Contract DES Variation is published.
   2. The expression of Interest will be considered by a Panel comprising of:

* The Director of Primary Care or Associate Director of Primary Care
* Head of Primary Care (Strategic Commissioning and Contracting)
* Lay member
* Managing Director (Place) or CCG Head of Primary Care Commissioning (Place)
* Independent GP
  1. The CCG will notify the Practice within one month of receipt of the expression of interest whether the practice move has been approved.
  2. If the CCG does not give approval to the practice move, the Practice may refer the matter to the local NHS England team.

1. **Applications to merge GMS Contracts**

On receipt of an application from two practices to merge GMS Contracts, in addition to following the process laid down in the NHSEI Primary Medical Care Policy and Guidance Manual these core principles will also need to be applied. This will prevent de-stabilisation of PCN and PCN delivered services.

1. **Risks**

Any requests for changes that are not approved may result in a practice deciding not to participate in the Network DES. Whilst this is not ideal the CCG are able to contract the PCN services from other providers including the PCN from which the practice has left, reducing the risk of destabilising them.