

Classification: Official

Publication approval reference: PR1963\_i



# **Network Contract Directed Enhanced Service**

Contract specification 2022/23 – PCN  
Requirements and Entitlements

**30 September 2022**

## Contents

1. Introduction .....	3
2. Commonly used terms .....	3
3. Relationship between the Network Contract DES and the primary medical services contract .....	5
4. Eligibility for and participation in the Network Contract DES .....	6
5. PCN Organisational Requirements .....	17
6. Changes to a PCN .....	25
7. Additional Roles Reimbursement Scheme .....	34
8. Service Requirements .....	42
9. Contract management.....	62
10. Network financial entitlements.....	64
Annex A - Network Contract DES Participation and Notification of Change Form .....	89
Annex B - Additional Roles Reimbursement Scheme - Minimum Role Requirements .....	90
B.1. Clinical Pharmacist.....	90
B.2. Pharmacy Technicians .....	92
B.3. Social Prescribing Link Workers.....	94
B.4. Health and Wellbeing Coach .....	96
B.5. Care Coordinator.....	99
B.6. Physician Associates.....	101
B.7. First Contact Physiotherapists.....	102
B.8. Dietitians .....	105
B.9. Podiatrists .....	106
B.10. Occupational Therapists.....	108
B.11. Nursing Associate .....	109
B.12. Trainee Nursing Associate (TNA).....	111
B.13. Paramedics .....	113
B.14. Mental Health Practitioners .....	114
B.15. Advanced Practitioners .....	115
B.16 General Practice Assistants .....	116
B.17 Digital and Transformation Lead .....	117
Annex C - Investment and Impact Fund Calculation of Achievement .....	119
Annex D - Investment and Impact Fund Indicators .....	129

**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.**

## 1. Introduction

- 1.1. The Network Contract Directed Enhanced Service (the “**Network Contract DES**”) was first introduced in the Directed Enhanced Services Directions 2019<sup>1</sup>.
- 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**”).
- 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. It is intended that there will be a Network Contract DES each financial year until at least 31 March 2024 with the requirements of the Network Contract DES evolving over time.
- 1.6. This document sets out:
  - 1.6.1. how commissioners must offer to primary medical services contractors the opportunity to participate in the Network Contract DES;
  - 1.6.2. the eligibility requirements and process for primary medical services contractors to participate in the Network Contract DES; and
  - 1.6.3. 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 2022 to 31 March 2023.
- 1.7. 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).

## 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:

---

<sup>1</sup> The Network Contract DES Directions can be found at <https://www.gov.uk/government/publications/nhs-primary-medical-services-directions-2013>

- 2.2.1. the “**Network Contract DES**” refers to the Network Contract DES for the financial year commencing 1 April 2022 and ending on 31 March 2023 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 2022 to 31 March 2023 issued on a national basis by NHS England;
- 2.2.3. the “**subsequent year’s Network Contract DES**” refers to the Network Contract DES commencing on the 1 April 2023;
- 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 either NHS England or a clinical commissioning group (“**CCG**”) or 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<sup>2</sup> 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 2022;
- 2.2.10. the “**Nominated Payee**” refers to a 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;

---

<sup>2</sup> The Network Agreement and Schedule can be found at <https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-network-agreement/>

- 2.2.13. the “**PCN’s Patients**” refers collectively to the persons on a PCN’s Core Network Practices’ lists of patients;
- 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 Part 1 of 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 “**CCG Extended Access Service**” refers to the extended access services originally commissioned by CCGs;
- 2.2.21. 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 CCG primary medical care allocation formula. Such a figure is periodically calculated and published for PCNs and commissioners; and
- 2.2.22. the “**SFE**” is the General Medical Services Statement of Financial Entitlements Directions 2021, as amended from time to time.

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

- 3.1.1. 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.
- 3.1.2. 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.

- 3.1.3. The provisions of this Network Contract DES Specification therefore become part of the practice's primary medical services contract.
- 3.1.4. 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 2021/22 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 2022), 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 DES commencing on 1 April 2022) will automatically participate in the 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](#).
- 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 2023; 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 2023 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.

### 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 2022 and on or before the 30<sup>th</sup> 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 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<sup>3</sup>, 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 14<sup>th</sup> 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 8.4.1.a 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.

## 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 2022 and on or before the 30<sup>th</sup> day following the date the Network Contract DES Variation is published, using the form at Annex A:
- a. the names and ODS codes<sup>4</sup> of the proposed PCN's Core Network Practices<sup>5</sup>;

---

<sup>3</sup> The PCN ODS Change Instruction Notice is available [here](#).

<sup>4</sup> <https://digital.nhs.uk/services/organisation-data-service>

<sup>5</sup> This may be a single super practice.

- b. the number of the PCN's Patients as at 1 January 2022<sup>6</sup>;
  - 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<sup>7</sup> 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:
- a. complete the PCN ODS Change Instruction Notice<sup>8</sup> 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

---

<sup>6</sup> 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.

<sup>7</sup> Payment nomination would only apply where there is more than one primary medical care contractor in the PCN.

<sup>8</sup> The PCN ODS Change Instruction Notice is available [here](#).

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 8.4.1.a 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 2022 and on or before the 30<sup>th</sup> 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 2022 and 31 March 2023, 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.

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 30<sup>th</sup> 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<sup>9</sup>, 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<sup>10</sup>. The commissioner must submit the notice by the last working day on or before the 14<sup>th</sup> day of the month for the change to take effect by the end of that month.
- 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.

---

<sup>9</sup> <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>

<sup>10</sup> The PCN ODS Change Instruction Notice is available [here](#).

## 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;
  - 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 the subsequent Network Contract DES (which means the Network Contract DES commencing on 1 April 2023) 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 sections 4.9.1.a, 4.9.1.b or 4.9.1.c apply, 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 8.4.1.a 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 4.2.4.b 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 2022 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 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 the subsequent Network Contract DES**

- a. A Core Network Practice of a PCN may choose not to participate in the subsequent Network Contract DES (which means the Network Contract DES commencing on 1 April 2023) in which case that Core Network Practice must notify the commissioner of its intention to opt out and follow the process set out in the 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;
  - 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 2023 as a result of any of the provisions of this Network Contract DES, then section 4.2.4.b applies.

## 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<sup>11</sup>) serving an identified Network Area with a minimum population of 30,000 people.
- 5.1.2. The criteria for a PCN is:
- 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 as at 1 January 2022 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

---

<sup>11</sup> 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.

requirement. For the avoidance of doubt, the PCN will still be required to have one Nominated Payee.

- iii. 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 5.7.1 to achieve the optimal benefits of PCN working.
- c. that the PCN has a Nominated Payee;
- d. 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<sup>1213</sup>.
- e. that the PCN has at all times an accountable Clinical Director;
- f. that the PCN has in place appropriate arrangements for patient record sharing in line with data protection legislation honouring patient opt-out preferences<sup>1415</sup>.

#### 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 System (ICS) 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

---

<sup>12</sup> 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.

<sup>13</sup> 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/>

<sup>14</sup> <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>

<sup>15</sup> A template data controller/data processor agreement and a template data controller/data controller agreement can be found at <https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-data-templates/>

- 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.
- 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 Contract DES and section 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<sup>16</sup>, that are compliant with data protection legislation to support the delivery of all service requirements set out

---

<sup>16</sup> Optional data sharing agreement and data processing agreement can be found at <https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-data-templates/>

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 2022.
- 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 2022. 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, 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, 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**")<sup>17</sup>, 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.

### 5.3. PCN Clinical Director

- 5.3.1. A PCN must have in place a Clinical Director who:
  - a. is accountable to the PCN members;
  - b. provides leadership for the PCN's strategic plans, working with PCN members to improve the quality and effectiveness of its delivery of the Network Contract DES;
  - c. is a direct and integral component of the overall Network Contract DES;
  - d. is a practicing clinician from within the PCN's Core Network Practices;

---

<sup>17</sup> 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](#).

- e. is able to undertake the responsibilities of the role and represent the PCN's collective interests;
  - f. works collaboratively with Clinical Directors from other PCNs within the ICS area, playing a critical role in shaping and supporting their ICS, helping to ensure full engagement of primary care in developing and implementing local system plans;
- 5.3.2. A PCN must ensure its Clinical Director has overall responsibility for the following key requirements<sup>18</sup>:
- a. strategic and clinical leadership for the PCN, developing and implementing strategic plans, leading and supporting quality improvement and performance across Core Network Practices (including professional leadership of the Quality and Outcomes Framework Quality Improvement activity across the PCN). The Clinical Director is not solely responsible for the operational delivery of services - this is a collective responsibility of the PCN;
  - b. strategic leadership for workforce development, through assessment of clinical skill-mix and development of a PCN workforce strategy;
  - c. completing the workforce planning template and agree, on behalf of the PCN, the estimate as referred to in section 7.5;
  - d. supporting PCN implementation of agreed service changes and pathways and work closely with Core Network Practices and the commissioner and other PCNs to develop, support and deliver local improvement programmes aligned to national priorities;
  - e. developing local initiatives that enable delivery of the PCN's agenda, working with commissioners and other networks to reflect local needs and ensuring initiatives are coordinated;
  - f. developing relationships and work closely with other Clinical Directors, clinical leaders of other primary care, health and social care providers, local commissioners and LMCs;
  - g. facilitating participation by practices that are members of the PCN in research studies and act as a link between the PCN and local primary care research networks and research institutions; and
  - h. representing the PCN at place-level clinical meetings and the ICS, contributing to the strategy and wider work of the ICS.

---

<sup>18</sup> This section sets out the high-level minimum responsibilities of the Clinical Director. The detailed requirements will vary according to the characteristics of the PCN, including its maturity and local context and should be set out in the PCN's Network Agreement.

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 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<sup>19</sup> across the Core Network Practices to enable it to carry out these requirements.

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

---

<sup>19</sup> 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).

the indicators related to the Network Contract DES and other PCN activity, some of which will be included in the Network Dashboard<sup>20</sup>.

- 5.4.7. The relevant SNOMED codes, as published in the supporting Business Rules<sup>21</sup> on the NHS Digital website, 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), and to manually input data into CQRS where required. The commissioner will monitor services and calculate payments under the Network Contract DES using CQRS and/or PCSE Online.

## 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<sup>22</sup> to engage patients in the provision of and/or reconfiguration of services where applicable to the PCN's Patients.

---

<sup>20</sup> The Network Dashboard was introduced during 2020/21. It includes key PCN metrics to support population health management, including prevention, urgent and anticipatory care, prescribing and hospital use. To access the Dashboard, please either [register](#) on the Insights Platform, or login in using your existing [Insights Platform account](#), and then select the NHS ViewPoint product. A [user guide](#) is available to help navigate the dashboard.

<sup>21</sup> The applicable SNOMED codes are available in the relevant business rules published by NHS Digital under the relevant years '[Enhanced Services, Vaccinations and Immunisations and Core Contract components](#)' page.

<sup>22</sup> Section 14Z2 of the 2006 NHS Act.

## 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, 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 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).

## 5.7. Collaboration with non-GP providers

- 5.7.1. A PCN must agree with local community services providers, mental health providers and community pharmacy providers how they will work together.
- 5.7.2. A PCN must ensure that compliance with this requirement is evidenced through setting out in Schedule 7 of the Network Agreement:
  - a. the specifics of how, where required by this Network Contract DES Specification or otherwise deemed appropriate, the service requirements

will be delivered through integrated working arrangements between the PCN and other providers; and

- b. how providers will work together, including agreed communication channels, agreed representatives, and how any joint decisions will be taken.
- 5.7.3. A PCN must detail the arrangements with its local community services provider(s) in Schedule 7 of the Network Agreement. The commissioner will use reasonable endeavours to facilitate the agreement of arrangements between the local community services provider(s) and the PCN.
- 5.7.4. A PCN must detail its arrangements with community mental health providers, and community pharmacy (via the community pharmacy nominated Pharmacy PCN Lead) in Schedule 7 of the Network Agreement.

## **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 the identity of 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 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 to enable the commissioner to determine whether the proposed Nominated Payee meets the requirement of section 5.1.2.c.
- 6.3.3. Where the commissioner is satisfied that the proposed Nominated Payee meets the requirement of section 5.1.2.c:
- a. it shall provide its written consent to the PCN; and
  - b. complete the PCN ODS Change Instruction Notice<sup>23</sup>.
- 6.3.4. The commissioner must also ensure this information aligns to the information contained within the relevant GP payment systems.
- 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 14<sup>th</sup> 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

---

<sup>23</sup> The PCN ODS Change Instruction Notice is available [here](#). The commissioner must submit the notice by the end of the last working day on or before the 14<sup>th</sup> day the month for the change to take effect by the end of that month.

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, 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 Sum<sup>24</sup>. 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 Sum.
- 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 Digital'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<sup>25</sup>. The commissioner must submit the notice by the last working day on or before the 14<sup>th</sup> 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.
- 6.5.8. 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<sup>26</sup> provided that the commissioner submits the notice by the last working day on or before the 14<sup>th</sup> 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.

---

<sup>24</sup> Refer to section 7.2 for details of baselines.

<sup>25</sup> The PCN ODS Change Instruction Notice is available [here](#).

<sup>26</sup> The PCN ODS Change Instruction Notice is available [here](#).

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 2023, then that Core 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 2022.
- 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<sup>27</sup>.
- 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 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.

---

<sup>27</sup> The PCN ODS Change Instruction Notice is available [here](#).

- 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
  - c. the commissioner must complete and submit the PCN ODS Change Instruction Notice<sup>28</sup>.

## 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.

---

<sup>28</sup> The PCN ODS Change Instruction Notice is available [here](#).

- 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<sup>29</sup>. The commissioner must submit the notice by the last working day on or before the 14<sup>th</sup> 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:
- 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,

---

<sup>29</sup> The PCN ODS Change Instruction Notice is available [here](#).

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<sup>30</sup>. The commissioner must submit the notice by the last working day on or before the 14<sup>th</sup> 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. 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<sup>31</sup> of the proposed PCN's Core Network Practices<sup>32</sup>;
- b. the number of the PCN's Patients as at 1 January 2022<sup>33</sup>;
- c. a map clearly marking the geographical area covered by the Network Area of the proposed PCN;
- d. the Nominated Payee<sup>34</sup> and details of the relevant bank account that will receive funding on behalf of the PCN;

---

<sup>30</sup> The PCN ODS Change Instruction Notice is available [here](#).

<sup>31</sup> <https://digital.nhs.uk/services/organisation-data-service>

<sup>32</sup> This may be a single super practice.

<sup>33</sup> 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.

<sup>34</sup> Payment nomination would only apply where there is more than one primary medical care contractor in 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 8.4.1.a; and
  - g. details of its view of the impact (if any) of the change on the PCN's baseline for the Additional Roles Reimbursement Sum<sup>35</sup>. 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 Sum.
- 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 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<sup>36</sup>. The commissioner must submit the notice by the last working day on or before the 14<sup>th</sup> 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<sup>37</sup> provided that the commissioner submits the notice by the last working day on or before the 14<sup>th</sup> 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;

---

<sup>35</sup> Refer to section 7.2 for details of baselines.

<sup>36</sup> The PCN ODS Change Instruction Notice is available [here](#).

<sup>37</sup> The PCN ODS Change Instruction Notice is available [here](#).

- 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.

## 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 4.7.1 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 associates, pharmacy technicians and paramedics. Two baselines were established<sup>38</sup> 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 as at 31 March 2019. The PCN baseline will be fixed until 31 March 2024.
  - b. A Clinical Commissioning Group (CCG) baseline declared by the CCG. It is comprised of the whole time equivalent (WTE) patient facing or first contact time of staff across the six reimbursable roles deployed to support general practice or primary medical care services - either in a specific practice or in the wider community - funded<sup>39</sup> by the CCG as 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 2024, 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 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,

---

<sup>38</sup> See [Network Contract DES: Additional Roles Reimbursement Scheme Guidance](#) 2019/20 for further information.

<sup>39</sup> The six reimbursable roles funded include those directly employed by the CCG.

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 health and wellbeing coaches, care coordinators, dietitians, podiatrists, occupational therapists, nursing associates, training nursing associates, advanced practitioners, mental health practitioners, general practice assistants or digital and transformation leads. While the PCN baseline will not include these eleven roles, the additionality principles will still apply as per the additionality principles above. For the avoidance of doubt, this means that a PCN acknowledges that where it claims reimbursement in respect of these eleven roles, the PCN is confirming that:
- a. the reimbursement is for additional staff engaged or employed since 31 March 2019; and
  - b. the reimbursement is not being used to subsidise practice-funded roles that existed as at 31 March 2019.
- 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**”)<sup>40</sup> transferred to become PCN staff will be exempt from the additionality principles. For this exemption to apply:
- a. clinical pharmacists previously employed via the national *Clinical Pharmacist in General Practice Scheme* must have either:

---

<sup>40</sup> This will include some pharmacy technicians currently funded by CCGs.

- 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<sup>41</sup>; 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

---

<sup>41</sup> Full details on the transfer arrangements for clinical pharmacists is available in the [2019/20 Network Contract DES Guidance](#).

referred to in this 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 Table 2.
- 7.3.3. A PCN may claim 50 per cent reimbursement for an adult mental health practitioner (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 2a and 2b. The adult MHP 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.
- 7.3.4. A PCN's entitlement (for which it can claim as set out in section 7.3.3) is to one WTE adult MHP where the PCN's patient list is 99,999 or fewer, and to two where it is 100,000 or over. Where a PCN and Community Mental Health Provider agree, with discussions supported by their commissioner, ICS and regional primary care and mental health teams, this will be increased to two WTE adult MHP where the PCN's patient list is 99,999 or fewer, and to four where it is 100,000 or over. Where the PCN has identified a need for additional MHP, it is expected that all parties will use all reasonable endeavours to agree the appropriate arrangements.
- 7.3.5. The PCN and Mental Health Community Provider may additionally agree to the provision of a service to support child and young people's (CYP) mental health. Where this is agreed locally, the PCN will be entitled to claim 50 per cent reimbursement for the provision of a CYP MHP service from within the allocated Additional Roles Reimbursement Scheme Sum and in accordance with the terms set out in this section 7.3, section 10 and Table 2a and 2b. The 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. A limit of one WTE CYP MHP will apply where the PCN's list size numbers 99,999 or fewer, and a limit of two will apply where the PCN's list size numbers 100,000 or over.
- 7.3.6. 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, section 10 and Table 2. A limit of two WTE Advanced Practitioners will apply where the PCN's list size numbers 99,999 or fewer, and a limit of four will apply where the PCN's list size numbers 100,000 or over. The Advanced Practitioner reimbursement is only applicable to the

designated roles of Clinical Pharmacists, First Contact Physiotherapists, Dietitians, Podiatrists, Occupational Therapists and Paramedics, and the additional role requirements are outlined in Annex B.

7.3.7. A PCN may claim reimbursement for one Digital and Transformation Lead, 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 2 and 3.

#### 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;
- 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, in the National Workforce Reporting Service (“NWRS”) in line with the existing or updated requirements for general practice staff.
- 7.4.4. The commissioner must complete and return the six-monthly workforce report to [england.primarycareworkforce@nhs.net](mailto:england.primarycareworkforce@nhs.net)<sup>42</sup>.

## 7.5. PCN Additional Roles planning and redistribution of Additional Roles Reimbursement Scheme funding

- 7.5.1. A PCN must complete and return to the commissioner a workforce plan, using the agreed national workforce planning template<sup>43</sup>, providing details of its updated plans for 2022/23 by 31 August 2022 and indicative intentions through to 2023/24 by 31 October 2022.
- 7.5.2. The commissioner must explore, and must endeavour to procure that the local ICS explores, different ways of supporting the PCN to implement the workforce plan through:
  - 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.
- 7.5.3. The commissioner must:
  - a. have shared with the PCN and relevant LMCs; and
  - b. have agreed with the PCN,by 30 September 2022 an estimation of the amount of financial entitlements in relation to the PCN under the Additional Roles Reimbursement Scheme that

---

<sup>42</sup> Further information is available in the [Network Contract DES Guidance](#).

<sup>43</sup> The workforce planning template will be available at <https://www.england.nhs.uk/gp/investment/gp-contract/>

the PCN is unlikely to claim by 31 March 2023. This amount is referred to in this Network Contract DES Specification as the “**Unclaimed Funding**”.

- 7.5.4. The commissioner must base its estimate of the Unclaimed Funding on the PCN’s workforce planning information that is returned to the commissioner by 31 August 2022.
- 7.5.5. Where the PCN agrees the estimate, the PCN acknowledges that the PCN will no longer have the right to claim the Unclaimed Funding and the commissioner may give other PCNs within the commissioner’s boundary the opportunity to bid for the Unclaimed Funding.
- 7.5.6. Where a commissioner provides the opportunity to PCNs within the commissioner’s boundary to bid for any PCN’s Unclaimed Funding, the commissioner will indicate when and how PCNs may bid.
- 7.5.7. A PCN acknowledges that if it bids for Unclaimed Funding and is successful, the Unclaimed Funding allocated to the PCN must be used for the purpose of recruiting or engaging further Additional Roles in accordance with this Network Contract DES Specification. The PCN and the commissioner acknowledge that any payment of the Unclaimed Funding to the PCN is in addition to the PCN’s allocated Additional Roles Reimbursement Sum.
- 7.5.8. Where there are one or more bids for the Unclaimed Funding, the commissioner will assess the bids in accordance with the following criteria:
  - a. evidence that a bidding PCN has a process in place ready to begin the recruitment or engagement of new Additional Roles to which the Unclaimed Funding relates;
  - b. evidence that a bidding PCN has the resources and capability to undertake further recruitment or engagement; and
  - c. whether a bidding PCN is a PCN which:
    - i. had previously indicated in the workforce planning information that it was unlikely to claim its full financial entitlement but considers it is now in a position to recruit or engage; and
    - ii. evidences that it is able to meet sections 7.5.8.a and 7.5.8.b
  - d. whether a bidding PCN currently has staff on paid leave e.g. parental leave or sickness leave;
  - e. evidence that a PCN is in an area of higher deprivation<sup>44</sup>; and

---

<sup>44</sup> Defined by the Indices of Deprivation (IoD), based on seven different domains or facets of deprivation – (1) income deprivation, (2) employment deprivation, (3) education, skills and training deprivation, (4)

- f. any other factor that the commissioner, acting reasonably, considers is relevant to its decision.
- 7.5.9. A bidding PCN acknowledges that:
- a. the above criteria are in descending order of preference. For the avoidance of doubt, this means that bids satisfying criteria at the top of the list will be preferred over bids that only satisfy criteria further down the list; and
  - b. the commissioner will give preference to a bid which satisfies the criteria in section 7.5.8.c. over all other bids.
- 7.5.10. The commissioner will notify each PCN of the outcome of its consideration and indicate to any successful bidding PCN the level of funding allocated to the successful bidding PCN.
- 7.5.11. Notwithstanding that any payments of Unclaimed Funding are not part of the PCN's allocated Additional Roles Reimbursement Sum and is in addition to the PCN's allocated Additional Roles Reimbursement Sum, payment of the Unclaimed Funding will be made on the same basis as payments of the PCN's Additional Roles Reimbursement Sum.
- 7.5.12. A successful bidding PCN acknowledges that any additional funding allocated to the PCN only relates to the period from the date the PCN was notified that it was successful to 31 March 2023 and that there is no right for the PCN to require a commissioner to continue paying the additional funding after 31 March 2023.
- 7.5.13. The commissioner will be responsible for monitoring any Additional Roles Reimbursement Scheme funding redistribution. Where there are repeated occurrences of redistribution from and/or to particular PCNs, the commissioner will be responsible for reviewing this in conjunction with the relevant PCNs and, where appropriate, the LMC and ICS, and take appropriate supportive actions.

## **8. Service Requirements**

### **8.1. Extended Hours Access and Enhanced Access**

- 8.1.1. In 2022/23 from 1 April 2022 to 30 September 2022 a PCN must provide extended hours access in accordance with sections 8.1 to 8.1.14. In addition to these requirements, the PCN must, between 1 April 2022 and 30

---

health deprivation and disability, (5) crime, (6) barriers to housing and services and (7) living environment deprivation. See <https://www.gov.uk/government/collections/english-indices-of-deprivation> and <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019>

September 2022, prepare for provision of Enhanced Access as set out in section 8.1.24 to 8.1.25. From 1 October 2022, the PCN must deliver Enhanced Access in accordance with sections 8.1.26 to 8.45.

A PCN must provide extended hours access in the form of additional clinical appointments in accordance with this Network Contract DES Specification regardless of whether any practices within the PCN are providing any CCG commissioned extended access services in 2022/23 (which are referred to in this Network Contract DES Specification as “**CCG Extended Access Services**”).

- 8.1.2. Where a commissioner is not satisfied that a PCN is delivering extended hours access in accordance with the requirements of this Network Contract DES specification then the commissioner may take action as set out in section 9. If a commissioner determines to withhold payment<sup>45</sup>, the amount withheld will be an appropriate proportion of the extended hours access payment and the Core PCN funding payment.
- 8.1.3. To provide extended hours access, a PCN must provide additional clinical appointments that satisfy all the requirements set out below:
- a. are available to all registered patients within the PCN;
  - b. may be for emergency, same day or pre-booked appointments;
  - c. are with a healthcare professional or another person employed or engaged by the PCN to assist that healthcare professional in the provision of health services;
  - d. are held at times outside of the hours that the PCN Core Network Practices’ primary medical services contracts<sup>46</sup> require appointments to be provided otherwise than under the Network Contract DES. For the avoidance of doubt, if a Core Network Practice was required under a General Medical Services (“**GMS**”) contract to provide core services at its premises until 6:30pm, the additional clinical appointments under this Extended Hours Access requirement could be provided after 6:30pm. If, however, another Core Network Practice in the PCN provided core services at its premises until 8pm, then:

---

<sup>45</sup> 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.

<sup>46</sup> For practices with PMS and APMS arrangements, the additional clinical appointments provided in accordance with this Extended Hours 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 Extended Hours Access offer to the PCN Contractor Registered Population. For practices with GMS arrangements, core hours are from 08:00 to 18:30.

- i. any additional clinical appointments provided after 6:30pm but before 8pm must not be provided at the later closing practice's premises (as these would not be additional hours appointments) but could be provided at the other practice's premises; and
    - ii. a proportion of the additional clinical appointments must be provided after 8pm;
  - e. are demonstrably in addition to any appointments provided by the PCN's practices under the CCG Extended Access Services;
  - f. are held at times having taken into account the PCN's patients' expressed preferences, based on available data at practice or PCN level and evidenced by patient engagement;
  - g. equate to a minimum of 30 minutes per 1,000 registered patients per week, calculated using the following formula:
 

additional minutes\* = the PCN list size\*\* ÷ 1000 × 30

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

\*\*this is the total number of persons on the lists of patients of all Core Network Practices of the PCN as at 1 January 2022;
  - h. are provided in continuous periods of at least 30 minutes;
  - i. are provided on the same days and times each week with sickness and leave of those who usually provide such appointments covered by the PCN; and
  - j. may be provided face to face, by telephone, by video or by online consultation provided that the PCN ensures a reasonable number of appointments are available for face-to-face consultations where appropriate.
- 8.1.4. A PCN must set out how the extended hours access appointments will be delivered in the Network Agreement.
- 8.1.5. A PCN must ensure that all practices in the PCN's membership actively engage in planning of the provision of the extended hours access requirements and acknowledges that nothing in this Network Contract DES Specification requires an individual clinician or practice within the PCN to deliver a particular share of the appointments. The exact number of extended hours access appointments delivered from each member practice premises

will be for the PCN to determine subject to complying with the minimum additional minutes set out in section 8.1.3.g.

- 8.1.6. A PCN's Core Network Practices must ensure that their registered patients are aware of the availability of extended hours access appointments, including any change to published availability, through promotion and publication of the days and times of these appointment through multiple routes. This may include the NHS website<sup>47</sup>, the practice leaflet, the practice website, on a waiting room poster, by writing to patients and active offers by staff booking appointments.
- 8.1.7. Where a PCN cancels any extended hours access appointments or where appointments cannot be offered on the usual days and times (for example, but not limited to, due to a bank holiday falling on the usual day), the PCN must make up the cancelled time by offering additional appointments within a two-week period, unless otherwise agreed with the commissioner. For the avoidance of doubt, any rescheduled appointments offered in a subsequent week are in addition to the minimum minutes that must be offered for that week as set out in section 8.1.3.g. The PCN must ensure that all patients within the PCN are notified of the cancelled and rescheduled appointments.
- 8.1.8. A commissioner must publicise information to help patients to identify which practices are offering appointments at given times.
- 8.1.9. Core Network Practices of a PCN must inform patients of any changes to the days and time at which extended hours access appointments are offered, providing reasonable notice to patients.
- 8.1.10. 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 the Extended Hours Access service provision offer routine extended hours access appointments in addition to the out of hours service.
- 8.1.11. A PCN must ensure that:
  - a. no Core Network Practice of the PCN will be closed for half a day on a weekly basis, except where a Core Network Practice has prior written approval from the commissioner; and
  - b. the PCN's Patients are able to access essential services, which meet the reasonable needs of patients during core hours, from their own practice or from any sub-contractor.

---

<sup>47</sup> <https://www.nhs.uk/>

- 8.1.12. 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.
- 8.1.13. The term “prior written approval” in section 8.1.11.a 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 2023
- 8.1.14. 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 - in line with Schedule 3, Part 5 para 44 of the GMS Regulations<sup>48</sup> or Schedule 2, Part 5 para 43 of the PMS Regulations<sup>49</sup>, as applicable – so that patients continue to have access to essential services which meet their reasonable<sup>50</sup> needs during core hours.

### 8.1.15. Preparatory Arrangements for Enhanced Access – 1 April 2022 to 30 September 2022

- 8.1.16. From 1 October 2022, PCNs will be required to 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 the requirements set out in 8.1.27 – 8.1.45.
- 8.1.17. In preparation for the implementation of Enhanced Access from 1 October 2022, a PCN - working collaboratively with the commissioner - must produce an **Enhanced Access Plan**. The draft Enhanced Access Plan must be submitted to the commissioner for agreement on or before 31 July 2022, by the method the commissioner has indicated. The draft Enhanced Access Plan

---

<sup>48</sup> National Health Service (General Medical Services Contracts) Regulations 2015

<sup>49</sup> National Health Service (Personal Medical Services Agreements) Regulations 2015

<sup>50</sup> 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.

must set out how the PCN is planning to deliver Enhanced Access from October 2022, in order to meet the requirements as set out in 8.1.27 – 8.1.45 and include the PCN's intentions in relation to the following matters:

- i. how the PCN will engage or has engaged with its patient population and will or has considered patient preferences, including consideration of levels of capacity and demand;
- ii. what mix of services will be provided during the Network Standard Hours;
- iii. what appointment types and channels will be available to patients during the Network Standard Hours, including how the PCN will meet the requirement to ensure a reasonable number of appointments for face-to-face consultations are available;
- iv. what the proposed staffing or skill mix will be to deliver services during the Network Standard Hours;
- v. where the PCN intends the site location(s) to be situated for patients to access in person face-to-face services, taking account of reasonable travel times for local patients as agreed with the commissioner;
- vi. proposals for how the PCN will deliver the necessary system interoperability to support delivery of Enhanced Access; and
- vii. any planned sub-contracting arrangements in respect of the Enhanced Access.

8.1.18. A commissioner must review the draft Enhanced Access Plan and agree a final iteration of the Enhanced Access Plan with the PCN's Core Network Practices on or before 31 August 2022. In reviewing the PCNs' Enhanced Access Plans, the commissioner will need to ensure they form part of a cohesive ICS approach.

8.1.19. The period between 1 August 2022 and 31 August 2022 provides a period of co-operation in which the PCN and commissioner must work together to agree how Enhanced Access will be provided from October 2022 and to ensure it meets the requirements for Enhanced Access that will apply from October 2022 as set out in section 8.1.27 – 8.1.45.

8.1.20. Following agreement of the Enhanced Access Plan, any significant changes will require approval from the commissioner. Changes that will be considered significant include but are not limited to:

- i. the PCN site(s) from which physical services will be delivered;
- ii. sub-contracting arrangements;
- iii. the staffing mix which will be available during the Network Standard Hours where the change significantly reduces the availability of a type of clinician, for example GPs, or other members of the team; and
- iv. timings for when the minimum 60 minutes of appointments per 1000 PCN adjusted patients per week is delivered.

8.1.21. In preparing their Enhanced Access Plan, a PCN must:

- i. inform and/or involve the PCN's patients in the planning of Enhanced Access, specifically seeking engagement on the mix of services that would be available, when they would be available across the Network Standard Hours and how they will be accessed by patients, including the locations from where in person face-to-face services will be delivered; and
- ii. provide reasonable support and assistance to the commissioner in the performance of its duties to engage patients on the reconfiguration of the CCG Extended Access Service and Network Contract DES Extended Hours Access into Enhanced Access from October 2022.

8.1.22. A commissioner will use reasonable endeavours to support the PCN's Core Network Practices in informing and/or involving the PCN's patients where any changes in Enhanced Access would have an impact on the manner in which services are delivered to patients or the range of services available.

8.1.23. A commissioner will use reasonable endeavours to support the PCN's Core Network Practices in managing the process for service transfer due to decommissioning of the CCG's Extended Access Service, where the capacity and resources of the commissioner permit.

8.1.24. A PCN must ensure that appropriate data sharing and, where required data processing arrangements will be in place to support the delivery of Enhanced Access from 1 October 2022.

8.1.25. From 1 October 2022, a PCN will be required to deliver Enhanced Access in accordance with requirements of this Network Contract DES Specification in the manner which has been set out in the PCN's agreed Enhanced Access Plan. The PCN must, where requested, provide the commissioner with reasonable information to assure the commissioner that provision of the Extended Access is in accordance with the agreed Enhanced Access Plan

8.1.26. **Enhanced Access**

**8.1.27.** From 1 October 2022 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 Enhanced Access Plan.

8.1.28. 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 member 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.

8.1.29. 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<sup>51</sup>, the amount withheld will be an appropriate proportion of the enhanced access payment and the Core PCN funding payment.

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;
- 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;

---

<sup>51</sup> 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.

- vi. in line with published guidance, 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 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 minimise 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 CCG Primary Medical Care weighted population as at 1 January 2022



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 or agreed timeframe are in addition to the minimum minutes that must be offered for that week as set out in section 8.1.29 g. The PCN must ensure that all patients within the PCN are notified of the cancelled and rescheduled appointments.

- 8.1.34. 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.
- 8.1.35. 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<sup>53</sup>. Further guidance on IT interoperability will be made available.
- 8.1.36. 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:
- i. enable practice and PCN staff to book appointments in Standard Network Hours; and
  - ii. enable patients to book appointments online where appropriate, including up until as close to the slot time as possible;
- 8.1.37. A PCN must set out how enhanced access will be delivered in the Network Agreement.
- 8.1.38. 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

---

<sup>53</sup> 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.

nothing in this Network Contract DES Specification require an individual clinician or practice within the PCN to deliver a particular share of the appointments.

- 8.1.39. 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 in the Network Standard Hours take into account patient preferences, to meet the requirements set out in section 8.1.29 e.
- 8.1.40. 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.
- 8.1.41. A PCN must ensure that:
- i. no Core Network Practice of the PCN will be closed for half a day on a weekly basis, except where a Core Network Practice has prior written approval from the commissioner; and
  - ii. 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.
- 8.1.42. 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.
- 8.1.43. The term "prior written approval" in section 8.1.42 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:
- i. it is pursuant to the Network Contract DES Specification; and
  - ii. it will expire no later than 31 March 2023.
- 8.1.44. 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:
- i. be open for that half a day in the same way that it is open on other days of the week, or
  - ii. 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<sup>54</sup> needs during core hours.

8.1.45. 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.

## 8.2. Medication Review and Medicines Optimisation

8.3. A PCN is required to:

- a. use appropriate tools to identify and prioritise the PCN's Patients who would benefit from a structured medication review (referred to in this Network Contract DES Specification as a "**SMR**"), which must include patients:
  - i. in care homes<sup>55</sup>;
  - ii. with complex and problematic polypharmacy, specifically those on 10 or more medications;
  - iii. on medicines commonly associated with medication errors<sup>56</sup>;
  - iv. with severe frailty<sup>57</sup>, who are particularly isolated or housebound patients, or who have had recent hospital admissions and/or falls; and
  - v. using one or more potentially addictive medications from the following groups: opioids, gabapentinoids, benzodiazepines and z-drugs;

---

<sup>54</sup> 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.

<sup>55</sup> Patients in a 'care home' are those resident in services registered by CQC as care home services with nursing (CHN) and care home services without nursing (CHS).

<sup>56</sup> See NHS Business Services Authority (2019) Medication Safety Indicators Specification: <https://www.nhsbsa.nhs.uk/sites/default/files/2019-08/Medication%20Safety%20-%20Indicators%20Specification%20%28Aug19%29.pdf> This document sets out 20 indicators that have been developed to help reduce medications errors and promote safer use of medicines. The 'denominator' section for each of the indicators lists medicines commonly associated with prescribing errors, which PCNs should use to help identify individuals to invite for a SMR.

<sup>57</sup> Severe frailty is defined as a person having an eFI score of >0.36. <https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/efi/>

- b. offer and deliver a volume of SMRs determined and limited by the PCN's clinical pharmacist capacity, and the PCN must demonstrate reasonable ongoing efforts to maximise that capacity;
- c. ensure invitations for SMRs provided to patients explain the benefits of, and what to expect from SMRs;
- d. ensure that only appropriately trained clinicians working within their sphere of competence undertake SMRs. The PCN must also ensure that these professionals undertaking SMRs have a prescribing qualification and advanced assessment and history taking skills, or be enrolled in a current training pathway to develop this qualification and skills;
- e. clearly record all SMRs within GP IT systems;
- f. actively work with its CCG in order to optimise the quality of local prescribing of:
  - i. antimicrobial medicines;
  - ii. medicines which can cause dependency;
  - iii. metered dose inhalers, where a lower carbon device may be appropriate; and
  - iv. nationally identified medicines of low priority;<sup>58</sup>
- g. work with community pharmacies to connect patients appropriately to the New Medicines Service which supports adherence to newly prescribed medicines; and
- h. in complying with this section 8.1.14.b, have due regard to NHS England guidance on Structured Medication Reviews and Medicines Optimisation<sup>59</sup>.

## 8.4. Enhanced Health in Care Homes

### 8.4.1. A PCN is required to:

- a. have agreed with the commissioner the care homes for which the PCN will have responsibility (referred to as the “**PCN's Aligned Care Homes**” in this Network Contract DES Specification). The commissioner will hold ongoing responsibility for ensuring that care homes within their geographical area are aligned to a single PCN and may, acting

---

<sup>58</sup> See the Recommendation (section 5, pp.14-39) of 'Items which should not routinely be prescribed in primary care' <https://www.england.nhs.uk/wp-content/uploads/2019/08/items-which-should-not-routinely-be-prescribed-in-primary-care-v2.1.pdf>

<sup>59</sup> [NHS England and NHS Improvement guidance on Structured Medication Reviews and Medicines Optimisation](#)

reasonably, allocate a care home to a PCN if agreement cannot be reached. Where the commissioner allocates a care home to a PCN, that PCN must deliver the Enhanced Health in Care Homes service requirements in respect of that care home in accordance with this Network Contract DES Specification;

- b. have in place with local partners (including community services providers) a simple plan about how the Enhanced Health in Care Homes service requirements set out in this Network Contract DES Specification will operate;
  - c. 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
  - d. ensure a lead GP (or GPs) with responsibility for these Enhanced Health in Care Homes service requirements is agreed for each of the PCN's Aligned Care Homes.
- 8.4.2. 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.
- 8.4.3. A PCN must:
- a. 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**”) to deliver these Enhanced Health in Care Homes service requirements; and
  - b. have established arrangements for the MDT to enable the development of personalised care and support plans with people living in the PCN's Aligned Care Homes.
- 8.4.4. A PCN must have in place established protocols between the care home and with system partners for information sharing, shared care planning, use of shared care records, and clear clinical governance.
- 8.4.5. A PCN must:
- a. deliver a weekly ‘home round’ for the PCN's Patients who are living in the PCN's Aligned Care Home(s). In providing the weekly home round a PCN:
    - i. must prioritise residents for review according to need based on MDT clinical judgement and care home advice (a PCN is not required to deliver a weekly review for all residents);
    - ii. must have consistency of staff in the MDT, save in exceptional circumstances;

- iii. must include appropriate and consistent medical input from a GP or geriatrician, with the frequency and form of this input determined on the basis of clinical judgement; and
  - iv. may use digital technology to support the weekly home round and facilitate the medical input;
- b. using the MDT arrangements referred to in section 8.4.3 develop and refresh as required a personalised care and support plan with the PCN's Patients who are resident in the PCN's Aligned Care Home(s). A PCN must:
- i. aim for the plan to be developed and agreed with each new patient within seven working days of admission to the home and within seven working days of readmission following a hospital episode (unless there is good reason for a different timescale);
  - ii. develop plans with the patient and/or their carer;
  - iii. base plans on the principles and domains of a Comprehensive Geriatric Assessment<sup>60</sup> including assessment of the physical, psychological, functional, social and environmental needs of the patient including end of life care needs where appropriate;
  - iv. draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals; and
  - v. make all reasonable efforts to support delivery of the plan;
- c. identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows; and
- d. support with a patient's discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 27<sup>61</sup>.
- 8.4.6. For the purposes of this section 8.4, a 'care home' is defined as a CQC-registered care home service, with or without nursing<sup>62</sup>.

---

<sup>60</sup> [https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-03-12/CGA%20Toolkit%20for%20Primary%20Care%20Practitioners\\_0.pdf](https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-03-12/CGA%20Toolkit%20for%20Primary%20Care%20Practitioners_0.pdf)

<sup>61</sup> <https://www.nice.org.uk/guidance/ng27>

<sup>62</sup> 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. A monthly directory of registered care home services that meet these categories is available at <https://www.cqc.org.uk/about-us/transparency/using-cqc-data>

8.4.7. A PCN's Core Network Practices must ensure the coding of care home residence is accurately recorded on a continuous basis, using the relevant SNOMED codes as published in the supporting Business Rules<sup>63</sup>.

## 8.5. Early Cancer Diagnosis

8.5.1. A PCN is required to:

- a. review referral practice for suspected and recurrent cancers, and work with its community of practice to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas where early diagnosis rates are lower;
- b. work with local system partners– including the NHS England Regional Public Health Commissioning team and Cancer Alliance – to agree the PCN's contribution to local efforts to improve uptake in cervical and bowel NHS Cancer Screening Programmes and follow-up on non-responders to invitations. This must build on any existing actions across the PCN's Core Network Practices and include at least one specific action to engage a group with low participation locally;
- c. work with its Core Network Practices to adopt and embed:
  - i. the requesting of FIT tests where appropriate for patients being referred for suspected colorectal cancer; and
  - ii. where available and appropriate, the use of teledermatology to support skin cancer referrals (teledermatology is not mandatory for all referrals).
- d. focusing on prostate cancer, and informed by data provided by the local Cancer Alliance, develop and implement a plan to increase the proactive and opportunistic assessment of patients for a potential cancer diagnosis in population cohorts where referral rates have not recovered to their pre-pandemic baseline; and
- e. review use of their non-specific symptoms pathways, identifying opportunities and taking appropriate actions to increase referral activity.

## 8.6. Social Prescribing Service

---

<sup>63</sup> The applicable SNOMED codes are available in the relevant business rules published by NHS Digital under the relevant years '[Enhanced Services, Vaccinations and Immunisations and Core Contract components](#)' page.

8.6.1. A PCN must provide the PCN's Patients with access to a social prescribing service.

8.6.2. To comply with this, a PCN may:

- a. directly employ Social Prescribing Link Workers; or
- b. sub-contract provision of the service to another provider, in accordance with this Network Contract DES Specification.

## 8.7. Cardiovascular Disease (CVD) Prevention and Diagnosis

8.7.1. A PCN must:

- a. improve diagnosis of patients with hypertension, in line with [NICE guideline NG136<sup>64</sup>](#), by ensuring appropriate follow-up activity is undertaken to confirm or exclude a hypertension diagnosis where a blood pressure of  $\geq 140/90$ mmHg in a GP practice, or  $\geq 135/85$  in a community setting, is recorded. This will include proactive review of historic patient records, to identify patients who have had a previous elevated blood pressure reading but have not had an appropriate diagnostic follow up; and
- b. undertake activity to improve coverage of blood pressure checks, by:
  - i. increasing opportunistic blood pressure testing where patients do not have a recently recorded reading;
  - ii. undertaking blood pressure testing at suitable outreach venues, agreeing the approach with local partners and targeting need as informed by local data on health inequalities and potentially at-risk groups; and
  - iii. working pro-actively with community pharmacies to improve access to blood pressure checks, in line with the NHS community pharmacy hypertension case finding service.

8.7.2. In addition a PCN must:

- a. improve the identification of those at risk of atrial fibrillation, in line with [NICE guideline NG196](#), through opportunistic pulse checks alongside blood pressure checks undertaken in a clinical setting
- b. undertake network development and quality improvement activity to support CVD prevention including:

---

<sup>64</sup> NICE guideline: <https://www.nice.org.uk/guidance/ng136>

- i. reviewing outputs from CVD intelligence tools (including CVDPREVENT, when available) and sharing key learning amongst PCN staff
  - ii. supporting the development of system pathways for people at risk of CVD through liaison with wider system partners
  - iii. collaboration with commissioners to improve levels of diagnostic capacity for 'ABC' testing, including availability of ambulatory blood pressure monitors (ABPMs) and electrocardiogram (ECG) monitors; and
  - iv. ensuring processes are in place to support the exchange of information with community pharmacies, including a process for accepting and documenting referrals between pharmacies and GP practices for the Community Pharmacy Blood Pressure Check Service.<sup>65</sup>
- c. identify patients at high risk of Familial Hypercholesterolaemia (as defined in NICE guideline CG71, section 1.1), and make referrals for further assessment where clinically indicated. This should include systematic searches of primary care records to identify those aged 30+ with Chol > 9mmol/L or with Chol > 7.5mmol/L aged less than 30;
  - d. offer statin treatment to patients with a QRISK2&3 score  $\geq$  10%, where clinically appropriate, and in line with NICE guideline CG181; and
  - e. support the earlier identification of heart failure (HF), through building awareness among PCN staff around the appropriate HF diagnostic pathway, and early identification processes for HF including the timely use of N-terminal pro B-type natriuretic peptide (NTProBNP) testing.

## 8.8. Tackling Neighbourhood Health Inequalities

### 8.8.1. A PCN must<sup>66</sup>:

- a. identify and include all patients with a learning disability on the learning disability register, and make all reasonable efforts to deliver an annual learning disability health check and health action plan for at least 75% of these patients who are aged over 14;

---

<sup>65</sup> Formerly the NHS Community Pharmacy Hypertension Case Finding Service

<sup>66</sup> As a part of its health and care system, to support delivery of the five key priorities to address health inequalities outlined in [NHS England's 2021/22 operational planning guidance](#), p.11.

- b. identify and include all patients with a severe mental illness on the severe mental illness register, and make all reasonable efforts to deliver comprehensive physical health checks for at least 60% of these patients;
  - c. record the ethnicity of all patients registered with the PCN (or record that the patient has chosen not to provide their ethnicity); and
  - d. appoint a lead for tackling health inequalities within the PCN.
- 8.8.2. A PCN must have identified a population within the PCN experiencing inequality in health provision and/or outcomes, and have developed a plan to tackle the unmet needs of that population.
- 8.8.3. To develop that plan, a PCN and commissioner must have jointly:
- a. utilised available data on health inequalities to identify that selected population, working in partnership with their ICS, including local medical or pharmaceutical committees, and local authority commissioners;
  - b. held discussions with local system partner organisations who have existing relationships with the selected population to agree an approach to engagement;
  - c. held engagement with the selected population to understand the gaps in, and barriers to their care; and
  - d. defined an approach for identifying and addressing the unmet needs of this population.
- 8.8.4. The PCN's finalised plan to tackle the unmet needs of the selected population must have included:
- a. locally defined measures agreed with local commissioners in line with, and co-ordinated between, wider system strategies to tackle drivers of inequalities;
  - b. delivery of relevant interventions or referrals to services that provide these interventions for the selected population; and
  - c. ongoing engagement with the selected population.
- 8.8.5. The PCN must be delivering the plan referred to in section 8.7.4.

## 8.9. Anticipatory Care

- 8.9.1. ICSs have a responsibility to design and plan Anticipatory Care for their system.
- 8.9.2. PCNs must contribute, working with other providers with whom Anticipatory Care will be delivered jointly, to ICS-led conversations on the local development and implementation of Anticipatory Care.

## 8.10. Personalised Care

### Proactive Social Prescribing – community development

- 8.10.1. By 30 September 2022, as part of a broader social prescribing service, a PCN and commissioner must jointly work with stakeholders including local authority commissioners, VCSE partners and local clinical leaders, to design, agree and put in place a targeted programme to proactively offer and improve access to social prescribing to an identified cohort with unmet needs. This plan must take into account views of people with lived experience.
- 8.10.2. From 1 October 2022, a PCN must commence delivery of the proactive social prescribing service for the identified cohort.
- 8.10.3. By 31 March 2023, a PCN must review cohort definition and extend the offer of proactive social prescribing based on an assessment of the population needs and PCN capacity.

### Shared Decision Making (SDM)

- 8.10.4. Not used.
- 8.10.5. By 31 March 2023, a PCN must audit a sample of the PCN's Patients' current experiences of shared decision making through use of a validated tool and must document their consideration and implementation of any improvements to SDM conversations made as a result

## 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,
- 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) acknowledge 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 be 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.
- 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 2022 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 2022. 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 2022 and 31 March 2023, 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 2022, 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 (except for the Extended Hours Access DES Payment, Enhanced Access Payment, and Capacity and Access Support Payment, each of which is split into six 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 2022 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. For the purposes of the PCN Leadership and Management payment, and the Capacity and Access Support Payment, the relevant figure will be taken from the registration system approved by NHS England as at 1 January 2022.

- 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 2023 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 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 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 10.6.
- 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 14<sup>th</sup> day of that month. If submitted after the end of the last working day on or before the 14<sup>th</sup> 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 (except for the Extended Hours Access DES Payment, the Enhanced Access Payment and the Capacity and Access Support Payment, each of which are split into six 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.

## 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 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<sup>67</sup> 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 2022 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
- 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

---

<sup>67</sup> 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.

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 2022 to 31 March 2023 is calculated as £1.761 multiplied by the practice's "**Contractor Weighted Population**" as at 1 January 2022.
- 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 2022, the first payment will include payment of instalments backdated to 1 April 2022.
- 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 2022. The change will take effect from the month following the month in which the Core Network Practice leaves the PCN.

#### 10.4. **Clinical Director Payment, Core PCN Funding, Extended Hours Access Payment, Care Home Premium, PCN Leadership and Management Payment, Enhanced Access Payment and Capacity and Access Support Payment**

- 10.4.1. Subject to sections 10.1.4, 10.4.1A and 10.4.1B, the amount calculated for each of the following payments (Clinical Director, Core PCN Funding, Care Home Premium, and PCN Leadership & Management Payment) in this section 10.4 are payable in 12 equal monthly instalments and the commissioner must arrange for the payments to be made no later than the last day of the month in which the payments apply and taking into account local payment arrangements.

10.4.1A Subject to section 10.1.4 the amount calculated for the Extended Hours Access Payment in this section 10.4 is payable in 6 equal monthly instalments from April 2022 to September 2022, and for the Enhanced Access Payment and Capacity and Access Support Payment in this section 10.4 is payable in 6 equal monthly instalments from October 2022 to March 2023. The commissioner must arrange for the payment to be made no later than the last day of the month in which the payment applies and taking into account local payment arrangements.

10.4.1B A PCN is entitled to the Capacity and Access Support Payment for the period 1 October 2022 to 31 March 2023.

10.4.1C A PCN must commit in writing to the commissioner to reinvest any Capacity and Access Support Payment into additional workforce and increased clinical capacity to support additional appointments and access for patients.

10.4.2. Subject to section 10.1.9 and local payment arrangements, for a Previously Approved PCN with membership changes each of the following payments (Clinical Director, Core PCN Funding, Extended Hours Access Care Home Premium, Leadership and Management Payment and Enhanced Access Payment) 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 2022, the first payment will include instalments backdated to 1 April 2022 (except for the Enhanced Access Payment and Capacity and Access Support Payments which will not be payable until October 2022).

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 10.4.

**Table 1: PCN Payments for 2022/23**

<b>Financial Entitlement</b>	<b>Payment provisions and calculation</b>
<b>Clinical Director Payment</b>	The clinical director payment for the period 1 April 2022 to 31 March 2023 is £0.736 <sup>68</sup> per registered patient per annum (which equates to £0.061 per patient per month).
<b>Core PCN Funding</b>	The Core PCN Funding for the period 1 April 2022 to 31 March 2023 is calculated as £1.50 multiplied by the PCN registered list size (equating to £0.125 per patient per month).  The Commissioner must provide the Core PCN Funding from its Primary Medical Care allocations
<b>Extended Hours Access Payment</b>	The extended hours access payment for the period 1 April 2022 to 30 September 2022 is calculated as £0.720 multiplied by the PCN registered list size (equating to £0.120 per patient per month).
<b>Enhanced Access payment</b>	The Enhanced Access payment for the period 01 October 2022 to 31 March 2023 is calculated as £3.764 multiplied by the PCN's

<sup>68</sup> The additional 6 per cent employer's superannuation will be met centrally.

	Adjusted Population (equating to £0.627 per PCN Adjusted Population per month).
<b>Care Home Premium</b>	<p>The payment is calculated on the basis of £120 per bed for the period 1 April 2022 to 31 March 2023.</p> <p>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<sup>69</sup>.</p> <p>The commissioner must arrange for payment to be made to the PCN on a monthly basis from 1 April 2022 at a rate of £10 per bed per month for the period 1 April 2022 to 31 March 2023 based on the number of relevant beds in the PCN's Aligned Care Homes.</p> <p>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<sup>70</sup>.</p> <p>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:</p> <ol style="list-style-type: none"> <li>a. 160734000 – Lives in a nursing home;</li> <li>b. 394923006 – Lives in a residential home; and</li> <li>c. 248171000000108 – Lives in care home (finding).</li> </ol>
<b>PCN Leadership and Management Payment</b>	The PCN leadership and management payment for the period 1 April 2022 to 31 March 2023 is calculated as £0.699 multiplied by the PCN Adjusted Population (equating to £0.058 multiplied by the PCN Adjusted Population per month) as at 1 January 2022.
<b>PCN Capacity and Access Support Payment</b>	The Capacity and Access Support Payment for the period 1 October 2022 to 31 March 2023 is calculated £0.602 per PCN Adjusted Population for the six months October 2022 to March 2023, (which equates to £0.100 per PCN Adjusted Population at 1 January 2022 per month over these six months).

## 10.5. Workforce

<sup>69</sup> 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.

<sup>70</sup> 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.

- 10.5.1. Subject to sections 10.5.6 to 10.5.10, a PCN is entitled to claim 100 per cent reimbursement of the aggregate WTE actual<sup>71</sup> salary (including employer on-costs for NI and pension<sup>72</sup>) up to the maximum amount per role as outlined in Table 2a and 2b 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 10.5.10, a PCN is entitled to claim 50 per cent reimbursement of the aggregate WTE actual<sup>73</sup> salary (including employer on-costs for NI and pension<sup>74</sup>) for adult MHPs (or CYP MHPs if agreed locally), up to the maximum amount per role as outlined in Table 3 and within that PCN's overall Additional Roles Reimbursement Sum, for the delivery of health services.
- 10.5.3. Subject to sections 10.5.6 to 10.5.10, a PCN within the London Region is entitled to claim the inner or outer London maximum reimbursement rate for its engaged Additional Roles:
- a. up to the relevant maximum reimbursable amount per role as outlined in Tables 2 and 3 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 outwith the outer 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 £16.696 multiplied by the PCN Contractor Weighted Population as at 1 January 2022. 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. The PCN acknowledges that any relevant maximum amount

---

<sup>71</sup> If relevant the percentage will be appropriately apportioned to PCN related activity.

<sup>72</sup> This does not include the additional 6 per cent employer contributions.

<sup>73</sup> If relevant the percentage will be appropriately apportioned to PCN related activity.

<sup>74</sup> This does not include the additional 6 per cent employer contributions.

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.

- 10.5.6. The following conditions apply to any claim made pursuant to sections 10.5.1, 10.5.2 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 Nominated Payee 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 2022 is to be made on or by the end May 2022).
  - d. The claim must relate to reimbursement of costs referred to in sections 10.5.1, 10.5.2 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

transferred<sup>75</sup> 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. Tables 2a, 2b, 3a and 3b set out the figures for the maximum annual reimbursement rate for each role. Tables 2a and 3a set out the figure that applies to all workforce claims made pursuant to this section 10.5 that relate to any month within the period 1 April 2022 to 30 September 2022. Tables 2b and 3b set out the figure that applies to all workforce claims made pursuant to this section 10.5 that relate to any month within the period 1 October 2022 to 31 March 2023. For the avoidance of doubt, the existence of the updated maximum reimbursement rates does not affect the overall value of a PCN's overall Additional Roles Reimbursement Sum.
- 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 2a and 2b and 3a and 3b, 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:

---

<sup>75</sup> Information regarding the transition arrangements is available in the [Network Contract DES guidance](#).

- 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 2a. For the avoidance of doubt, the contribution towards additional costs charged by the sub-contracted provider is included when considering whether the total annual amount is within the maximum reimbursable amount.

Table 2a: Maximum reimbursement amounts per role for 2022/23 (1 April – 30 September)

<b>Role</b>	<b>AfC band</b>	<b>Annual maximum reimbursable amount per role</b>	<b>Annual maximum reimbursable amount per role plus <u>inner HCAS</u></b>	<b>Annual maximum reimbursable amount per role plus <u>outer HCAS</u></b>
		<b>£</b>	<b>£</b>	<b>£</b>
Clinical pharmacists	7-8a	57,318	66,414	63,684
Pharmacy technicians	5	36,428	43,958	42,076
Social prescribing link worker	Up to 5	36,428	43,958	42,076
Health and wellbeing coaches	Up to 5	36,428	43,958	42,076
Care co-ordinators	4	29,987	36,228	34,983
Physician associates	7	55,313	64,410	61,680
First contact physiotherapists	7-8a	57,318	66,414	63,684
Dieticians	7	55,313	64,410	61,680
Podiatrists	7	55,313	64,410	61,680
Occupational therapists	7	55,313	64,410	61,680
Nurse Training Associates	3	26,418	32,325	31,415
Nursing Associates	4	29,987	36,228	34,983
Community Paramedics	7	55,313	64,410	61,680
Advanced Practitioners	8a	63,243	72,340	69,610

Table 2b: Maximum reimbursement amounts per role for 2022/23 (from 1 October 2022 to 31 March 2023)

	Indicative band	Annual maximum reimbursable amount per role	Annual maximum reimbursable amount per role plus inner HCAS	Annual maximum reimbursable amount per role plus outer HCAS
Clinical pharmacists	7-8a	£59,312	£68,768	£65,948
Pharmacy technicians	5	£38,187	£46,076	£44,104
Social prescribing link worker	Up to 5	£38,187	£46,076	£44,104
Health and wellbeing coaches	Up to 5	£38,187	£46,076	£44,104
Care co-ordinators	4	£31,746	£38,346	£37,011
Physician associates	7	£57,465	£66,921	£64,101
First contact physiotherapists	7-8a	£59,312	£68,768	£65,948
Dieticians	7	£57,465	£66,921	£64,101
Podiatrists	7	£57,465	£66,921	£64,101
Occupational therapists	7	£57,465	£66,921	£64,101
Nurse Training Associates	3	£28,177	£34,442	£33,443
Nursing Associates	4	£31,746	£38,346	£37,011
Community Paramedics	7	£57,465	£66,921	£64,101
Advanced Practitioners	8a	£65,002	£74,457	£71,638
General Practice Assistant	4	£31,746	£38,346	£37,011
Digital and Transformation Lead	8a	£65,002	£74,457	£71,638

Table 3a: Maximum reimbursement amounts per role for 2022/23 (1 April – 30 September)

Role	AfC band	Annual maximum reimbursable amount per band	Annual maximum reimbursable amount per role plus <u>inner HCAS</u>	Annual maximum reimbursable amount per role plus <u>outer HCAS</u>
		£	£	£
Adult Mental Health Practitioner	4	£14,993	£18,114	£17,492
	5	18,214	21,979	21,038
	6	22,637	27,186	25,820

CYP Mental Health Practitioner	7	27,657	32,205	30,840
	8a	31,622	36,170	34,805

Table 3b: Maximum reimbursement amounts per role for 2022/23 (from 1 October 2022 to 31 March 2023)

	<b>AfC Band</b>	<b>Annual maximum reimbursable amount per role</b>	<b>Annual maximum reimbursable amount per role plus inner HCAS</b>	<b>Annual maximum reimbursable amount per role plus outer HCAS</b>
Adult Mental Health Practitioner and CYP Mental Health Practitioner	4	£15,873	£19,173	£18,506
	5	£19,094	£23,038	£22,052
	6	£23,551	£28,279	£26,869
	7	£28,733	£33,460	£32,050

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 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 Achievement Payment”) in relation to any IIF indicators listed in Annex D.
- 10.6.3. A PCN acknowledges that:
  - a. it will earn 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 earn a number of points for each Indicator between zero and the maximum number of points allocated to that Indicator;
  - d. there are a total of 989 points across all Indicators; and
  - e. each point is worth £200.00.
- 10.6.4. In relation to the Indicators, a PCN acknowledges that each indicator will be classed as ‘Qualitative’ or ‘Quantitative’.
- 10.6.5. In relation to Qualitative indicators, a PCN acknowledges that:
  - a. Each indicator consists of:
    - i. a criterion or set of criteria that must be met.
    - ii. the number of points that can be earned (A).
  - b. If the criterion or set of criteria is met a PCN will earn all of the points available for that indicator. If the criterion or set of criteria are not met, a PCN will earn zero points for that indicator. For avoidance of doubt, this means that, if a Qualitative indicator establishes a set of criteria and only a subset of these criteria are met, a PCN will earn zero points for that indicator.
- 10.6.6. In relation to the Quantitative Indicators, a PCN acknowledges that these will be further classed as ‘Binary’, ‘Standard’, ‘Improvement’ or ‘Composite’ in relation to how performance is assessed.

10.6.7. A PCN acknowledges that Quantitative indicators can additionally be classed as ‘Standardised’,<sup>76</sup> meaning that indicator performance is adjusted at PCN level to account for differences in patient demographic characteristics that may affect indicator performance. The adjustment is made to the indicator numerator, and unless stated otherwise, all references to the numerator for standardised indicators will be in relation to the adjusted numerator, following standardisation, rather than the ‘raw’ numerator extracted from the data source. Standardised indicators are indicators that have the word ‘Standardised’ in the indicator wording, set out in Annex D.

10.6.8. In relation to each Binary Quantitative indicator, a PCN acknowledges that:

- a. Performance and earnings depend on:
  - i. a numerator (N);
  - ii. a denominator (D);
  - iii. a prevalence numerator (E);
  - iv. a performance threshold (T); and
  - v. a maximum number of points that can be earned (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 earned (A) will have an integer value.
- 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.

---

<sup>76</sup> For some indicators, observed performance will be significantly influenced by the demographic characteristics of registered patients. For example, rates of admission to hospital will be higher in areas with older populations and an indicator incentivising lower admission rates will therefore, without adjustment, be harder to achieve for PCNs with an older-than-average mix of patients. Standardising calculates what the PCN performance would be if all PCNs had the same ‘standard’ population, usually based on a specific age and gender demographic, although other factors such as deprivation, ethnicity and casemix can also be included. The details of how each relevant indicator is standardised are provided in the Investment and Impact Fund Guidance.

- g. If a PCN's performance (X) is equal to or better than the performance threshold (T), it will earn all the points available for that Indicator.
- h. If a PCN's performance (X) is worse than the performance threshold (T), it will earn no points for that Indicator.
- i. The performance threshold will be the same for all PCNs.

10.6.9. In relation to each Standard Quantitative indicator, a PCN acknowledges 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 earned (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 earned (A) will have an integer value. The points earned 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.

10.6.10. In relation to Improvement Quantitative indicators, a PCN acknowledges that:

- a. Performance and earnings depend on:
  - i. a baseline numerator (N0);
  - ii. a baseline denominator (D0);
  - iii. a numerator (N);
  - iv. a denominator (D);

- v. a prevalence numerator (E);
  - vi. a lower performance threshold (L);
  - vii. an upper performance threshold (U); and
  - viii. a maximum number of points that can be earned (A).
- b. The Indicator value, also referred to as performance (X), equals the numerator divided by the denominator minus the baseline numerator divided by the baseline denominator ( $X = N/D - N0/D0$ ).
  - c. The maximum number of points that can be earned (A) will have an integer value. The points earned 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.
- 10.6.11. In relation to Composite Quantitative indicators, a PCN acknowledges that:
- a. Performance and earnings depend on:
    - i. a baseline numerator (N0);
    - ii. a baseline denominator (D0);
    - iii. a numerator (N);
    - iv. a denominator (D);
    - v. a prevalence numerator (E);
    - vi. a lower Standard performance threshold (L1);
    - vii. an upper Standard performance threshold (U1);
    - viii. a lower Improvement performance threshold (L2);
    - ix. an upper Improvement performance threshold (U2); and
    - x. a maximum number of points that can be earned (A).
  - b. The Indicator has two values of performance, Standard performance (X1) and Improvement performance (X2).

- c. Standard Performance ( $X_1$ ) equals the numerator divided by the denominator ( $X_1 = N/D$ )
- d. Improvement Performance ( $X_2$ ) equals the numerator divided by the denominator minus the baseline numerator divided by the baseline denominator ( $X_2 = N/D - N_0/D_0$ ).
- e. The maximum number of points that can be earned (A) will have an integer value. The points earned by each PCN in relation to each indicator will be calculated exactly, based on their performance.
- f. 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.
- g. 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.
- h. 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.

10.6.12. In relation to Standard and Improvement Quantitative Indicators, a PCN acknowledges that:

- a. It will earn points depending on how its performance relates to the lower and upper performance thresholds.
- b. If a PCN's performance is worse than or equal to the lower performance threshold, it will not earn any points for that indicator.
- c. If a PCN's performance is equal to or better than the upper performance threshold, it will earn the maximum points available for that Indicator.
- d. A PCN will incrementally earn additional points for each improvement in performance from the lower performance threshold to the upper performance threshold.
- e. If the desired direction of performance is upwards, the upper performance threshold will be greater than the lower performance threshold. If the desired direction of performance is downwards, the upper performance threshold will be smaller than the lower performance threshold.
- f. The lower performance threshold will be the same for all PCNs, and the upper performance threshold will be the same for all PCNs.

10.6.13. In relation to Composite Quantitative Indicators, a PCN acknowledges that:

- a. In relation to Standard performance:
  - i. It will be assigned points (P1) depending on how its Standard performance (X1) relates to the lower and upper Standard performance thresholds (L1 and U1).
  - ii. If a PCN's Standard performance (X1) is worse than or equal to the lower Standard performance threshold (L1) then the assigned points (P1) will be zero.
  - iii. If a PCN's Standard performance (X1) is equal to or better than the upper Standard performance threshold (U1) then the assigned points (P1) will equal the maximum points available for the indicator (A)
  - iv. A PCN will incrementally be assigned additional points (P1) for each improvement in Standard performance (X1) from the lower Standard performance threshold (L1) to the upper Standard performance threshold (U1).
- b. In relation to Improvement performance:
  - i. It will be assigned points on the Improvement performance scale (P2) depending on how its Improvement performance (X2) relates to the lower and upper Improvement performance thresholds (L2 and U2)
  - ii. If a PCN's Improvement performance (X2) is worse than or equal to the lower Improvement performance threshold (L2) then the assigned points (P2) will be zero.
  - iii. If a PCN's Improvement performance (X2) is equal to or better than the upper Improvement performance threshold (U2) then the assigned points (P2) will equal the maximum points available for the indicator (A).
  - iv. A PCN will incrementally be assigned additional points (P2) for each improvement in Improvement performance (X2) from the lower Improvement performance threshold (L2) to the upper Improvement performance threshold (U2).
- c. It will earn the greater of the points (P1) and (P2) assigned to them i.e.
  - i. It will earn P1 points where P1 is greater than P2 ( $P1 > P2$ ).
  - ii. It will earn P2 points where P2 is greater than P1 ( $P2 > P1$ )
  - iii. Where  $P1 = P2$ , it will earn  $P1 = P2$  points.
- d. If the desired direction of performance is upwards:

- i. The upper Standard performance threshold (U1) will be greater than the lower Standard performance threshold (L1).
  - ii. The upper Improvement performance threshold (U2) will be greater than the lower Improvement performance threshold (L2).
- e. If the desired direction of performance is downwards:
  - i. The upper Standard performance threshold (U1) will be smaller than the lower Standard performance threshold (L1).
  - ii. The upper Improvement performance threshold (U2) will be smaller than the lower Improvement performance threshold (L2).
- f. The Standard and Improvement performance thresholds (L1, L2, U1 and U2) will be the same for all PCNs.

10.6.14. The commissioner will calculate a PCN's Total 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 Quantitative Indicator<sup>77</sup>, 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. In addition, for each Improvement and Composite Quantitative Indicator, a baseline numerator and baseline denominator will be calculated for the PCN by adding up the corresponding practice-level baseline numerators and baseline denominators for the Core Network Practices of the PCN.
- b. Step 2: For each Indicator, the performance of the PCN will be calculated. For Composite Quantitative Indicators there will be two values of performance for each PCN (X1 and X2).
- c. Step 3: For each Indicator, the number of points ("Achievement Points") earned 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 Achievement Payment for the PCN (the sum of Achievement Payments across all Indicators) will be calculated.

---

<sup>77</sup> For Standardised indicators, the adding up of practice level numerators occurs prior to standardisation i.e. to the unadjusted numerator.

- 10.6.15. The commissioner will calculate the Total Achievement Payment in respect of a PCN after 31 March 2023.
- 10.6.16. The commissioner will, in a timely manner after 31 March 2023, make available to a PCN a summary of the data and calculations (including Achievement Points and Achievement Payments) in relation to it.
- 10.6.17. To be eligible to receive the Total Achievement Payment, a PCN must review and declare the data and calculations provided under section 10.6.16 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 2023, if declaration is made available before 16 April 2023.
    - ii. 14 calendar days after declaration is made available, if declaration is made available on or after 16 April 2023.
  - 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 10.6.16 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.
- 10.6.18. 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 10.6.16 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 10.6.16 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.

10.6.19. Except where specifically mentioned in this paragraph, the declaration process described in section 10.6.17 does not apply to indicators constructed using data sources other than GP IT systems.

- a. Specifically, the following indicators will not be subject to declaration: AC-02 and ES-02. Exceptionally, ACC-07 will be subject to declaration even though it is not constructed using data extracted from GP IT systems.
- b. For indicators not subject to declaration, PCNs will not have the opportunity to resubmit data that they believe to be incorrect, but will instead be referred to existing routes for querying and correcting errors in such data.

10.6.20. Where a Total Achievement Payment in respect of IIF is due to a PCN, the commissioner will make that payment by 31 August 2023. 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.

10.6.21. To be eligible to receive the Total 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<sup>78</sup>. In the 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.

10.6.22. If the conditions set out in section 10.6.21 are not met, the commissioner may withhold payment of all or part of the Total Achievement Payment that is otherwise payable.

---

<sup>78</sup> Network Contract DES Service Business rules are available in the relevant business rules published by NHS Digital under the relevant years '[Enhanced Services, Vaccinations and Immunisations and Core Contract components](#)' page.



## **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<sup>79,80</sup>); 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;
  - 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 the elderly, 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);

---

<sup>79</sup> <https://www.cppe.ac.uk/career/clinical-pharmacists-in-general-practice-education#navTop>

<sup>80</sup> <https://www.cppe.ac.uk/wizard/files/general-practice/clinical-pharmacists-in-general-practice-education-brochure.pdf>

- 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 pharmacist<sup>81</sup>;
  - ii. the senior clinical pharmacist must receive a minimum of one supervision session every three months by a GP clinical supervisor;
  - iii. each clinical pharmacist will have access to an assigned GP clinical supervisor for support and development; and

---

<sup>81</sup> This does not need to be a senior clinical pharmacist within the PCN but could be part of a wider local network, including from secondary care or another PCN.

- iv. a ratio of one senior clinical 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<sup>82</sup> 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:

- 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

---

<sup>82</sup> 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>

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 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<sup>83</sup> hosted by Health Education England eLearning for health platform;
  - b. is enrolled in, undertaking or qualified from appropriate training as outlined by the Personalised Care Institute Core Curriculum and social prescribing link worker competency framework<sup>84</sup>; and
  - c. attends the peer support networks delivered at place or system by the ICS and/or NHSE/I in the region
- in order to deliver the key responsibilities outlined in section B3.3.
- 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<sup>85</sup> 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;

---

<sup>83</sup> <https://www.e-lfh.org.uk/programmes/social-prescribing/>

<sup>84</sup> <https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/>

<sup>85</sup> 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.

- 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<sup>86</sup>;
  - 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;
  - 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 GP 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).

---

<sup>86</sup> Including considering if the persons needs are met (for example, reasonable adjustments, interpreter etc).

- 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 and local authorities;
  - 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;
- 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 appropriate health coaching training covering topics outlined in the NHS England Implementation and Quality Summary Guide,<sup>87</sup> with the training delivered by a training organisation listed by the Personalised Care Institute<sup>88</sup>;
- b. adheres to a code of ethics and conduct in line with the NHS England Health coaching Implementation and Quality Summary Guide;
- 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

in order to deliver the key responsibilities outlined in section B4.2.

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;

---

<sup>87</sup> <https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/>

<sup>88</sup> <https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/>

- 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 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 GP to provide supervision for the PCN's Health and Wellbeing Coach(es). This could be provided by one or more named individuals within the PCN. The Health and Wellbeing Coach must have access to regular supervision from a health coaching mentor. In addition to this, formal and individual group coaching supervision must come 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.
- 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<sup>89</sup>; 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.
- 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;

---

<sup>89</sup> <https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/>

- 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;
- 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.

B5.4. 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.
- B5.5. A PCN's Core Network Practices must identify a first point of contact for general advice and support and (if different) a GP to provide supervision for the PCN's Care Coordinator(s). This could be provided by one or more named individuals within the PCN.
- B5.6. 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.
- B5.7. 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 Care Coordinator(s).

## **B.6. Physician Associates**

- B6.1. Where a PCN employs or engages a Physician Associate under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Physician Associate:
- a. has completed a post-graduate physician associate course (either PG Diploma or MSc);
  - b. has maintained professional registration with the Faculty of Physician Associates and/or the General Medical Council following implementation of statutory regulation, working within the latest code of professional conduct (CIPD);
  - c. has passed the UK Physician Associate (PA) National Re-Certification Exam, which needs to be retaken every six years;
  - 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), and
  - e. is working under supervision of a doctor as part of the medical 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 Associates under the Additional Roles Reimbursement Scheme, the PCN must ensure that each

Physician Associate has the following key responsibilities, in delivering health services:

- a. provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems by utilising history-taking, physical examinations and clinical decision-making skills to establish a working diagnosis and management plan in partnership with the patient (and their carers where applicable);
  - b. support the management of patient's conditions through offering specialised clinics following appropriate training including (but not limited to) family planning, baby checks, COPD, asthma, diabetes, and anticoagulation;
  - c. provide health/disease promotion and prevention advice, alongside analysing and actioning diagnostic test results;
  - d. develop integrated patient-centred care through appropriate working with the wider primary care multi-disciplinary team and social care networks;
  - e. utilise clinical guidelines and promote evidence-based practice and partake in clinical audits, significant event reviews and other research and analysis tasks;
  - f. participate in duty rotas; undertaking face-to-face, telephone, and online consultations for emergency or routine problems as determined by the PCN, including management of patients with long-term conditions;
  - g. undertake home visits when required; and
  - h. develop and agree a personal development plan (PDP) utilising a reflective approach to practice, operating under appropriate clinical supervision.
- B6.3. A PCN's Core Network practices must identify a suitable named GP supervisor for each physician associate, to enable them to work under appropriate clinical supervision.

## **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:
- a. has completed an undergraduate degree in physiotherapy;
  - b. is registered 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, 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;
- 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:

- 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);
- d. is a registered member of the Health and Care Professionals Council (HCPC);
- e. is able to operate at an advanced level of practice; and
- f. 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:

- 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
- g. 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:

- a. has a BSc or pre-reg MSc in Podiatry under a training programme approved by the College of Podiatry;
- b. is a registered member of 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 the elderly 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 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 member of 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;
- 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:

- 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<sup>90</sup>;
- 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;
- l. advise patients on general healthcare and promote self-management where appropriate, including signposting patients to

---

<sup>90</sup> For example, as set out in the [NMC Standards for Nursing Associates](#)

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. Trainee Nursing Associate (TNA)**

B12.1. Where a PCN employs or engages a training nursing associate (TNA) 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.

B12.2. Where a PCN employs or engages one or more TNAs under the Additional Roles Reimbursement Scheme, the PCN must ensure that each TNA 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 Nursing Associate Training Programme; and
- d. develop by the end of the 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 TNA 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**

- 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 registered with the Health and Care Professions Council (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:
  - i. perform specialist health checks and reviews within their 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 elderly 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 IAPT 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 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;
  - 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 and Paramedics.
- 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:
- a. has a master's degree level in the relevant area of expertise;

- b. is working at a master's level aware or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competencies<sup>91</sup>; and
- c. for clinical pharmacists only, has qualified from an approved 18 month training pathway or equivalent and qualified as an independent prescriber 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;
- 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.

## **B.16 General Practice Assistants**

**B16.1** General Practice Assistants (GPAs), 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. PCNs can immediately start recruiting to the role, predominately through trainee positions. Staff can be trained in-practice, with on-job training and

---

<sup>91</sup> [Multi-professional framework for advanced clinical practice in England](#)

development led by GPs, in line with the role outline and [national competency framework](#).

Trainee GPAs may also complete HEE's accredited training 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:

- Arranging appointments, referrals, tests and follow up appointments of patients.
- Completing simple clinical observations /investigations as directed locally, such as dipstick urine, taking blood pressure, ECG, phlebotomy.
- Supporting the GP with immunisations/wound care.
- Preparing patients prior to going in to see the GP, taking a brief history and basic readings in readiness for the GP appointment.
- 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.
- Explaining treatment procedures to patients.
- 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).
- Sorting clinical post and prioritising for the GP. Signposting some post to other members of staff.
- Extracting information from clinical letters that needs coding; adding this to patient notes. Supporting with QOF reviews.

B16.4 GPAs should also:

- Participate in an annual individual performance review.
- Track and record evidence of their experience against the national competency framework.
- Inform the lead GP of any concerns regarding their role and request professional development as needed.
- 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

- supporting the adoption of new technology and other initiatives to improve the care offer, and
- 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:
  - 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.

## Annex C - Investment and Impact Fund Calculation of Achievement<sup>92</sup>

### C1. Step 1: For each Quantitative Indicator, aggregate practice-level numerators and denominators to PCN level

- C1.1 For each Quantitative 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 Quantitative 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 Quantitative 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 Quantitative 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 Quantitative Indicator, a numerator will be collected for each Core Network Practice in the PCN.
- a. For Quantitative Indicators with a desired direction of upwards, the numerator will capture the extent to which a desired intervention or event has occurred.
  - b. For Quantitative 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 Quantitative Indicator<sup>93</sup>, a PCN-level numerator (N) will be calculated by adding up all the numerators for the Core Network Practices of the PCN.

---

<sup>92</sup> 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.

<sup>93</sup> For Standardised indicators, the adding up of practice level numerators occurs prior to standardisation i.e. to the unadjusted numerator.

C1.5 For all Improvement and Composite Quantitative indicators set out in Annex D, a PCN-level baseline numerator<sup>94</sup> (N0) and denominator (D0) will be calculated by adding, respectively, up all the baseline numerators and baseline denominators for the Core Network Practices of the PCN.

## **C2. Step 2: For each Quantitative Indicator, calculate performance for the PCN**

C2.1 For each Binary or Standard Quantitative Indicator, the performance of the PCN (X) will be calculated by dividing the PCN-level numerator (N) by the PCN-level denominator (D):  $X=N/D$ .

C2.2 For each Improvement Quantitative Indicator, the performance of the PCN (X) will be calculated by dividing both the PCN-level numerator (N) by the PCN-level denominator (D) and the PCN-level baseline numerator (N0) by the PCN-level baseline denominator (D0), and then subtracting the latter from the former:  $X = N/D - N0/D0$ .

C2.3 For each Composite Quantitative Indicator, two values of performance will be calculated for the PCN based on both the calculation described in paragraph C2.1 (X1) and the calculation described in paragraph C2.2 **Error! Reference source not found.** (X2).

## **C3. Step 3: For each Indicator, calculate Achievement Points for the PCN**

C3.1 For each Qualitative Indicator, if the criterion or set of criteria is met, a PCN will earn all the points available for that indicator. If the criterion or set of criteria are not met, a PCN will earn zero points for that indicator. For avoidance of doubt, this means that, if a Qualitative indicator establishes a set of criteria and only a subset of these criteria are met, a PCN will earn zero points for that indicator.

C3.2 For Binary Quantitative Indicators, where the desired direction is upwards:

- a. If the PCN's performance is worse than the performance threshold ( $X<T$ ), the PCN will earn zero points for the indicator:  $Q=0$ .
- b. If the PCN's performance is better than or equal to the performance threshold ( $X>T$  or  $X=T$ ), the PCN will earn the points available for the indicator:  $Q=A$ .

---

<sup>94</sup> For Standardised indicators, the adding up of practice level numerators occurs prior to standardisation i.e. to the unadjusted numerator.

- C3.3 For Binary Quantitative Indicators, where the desired direction is downwards:
- a. If the PCN's performance is worse than the performance threshold ( $X > T$ ), the PCN will earn zero points for the indicator:  $Q = 0$ .
  - b. If the PCN's performance is better than or equal to the performance threshold ( $X < T$  or  $X = T$ ), the PCN will earn all the points available for the indicator:  $Q = A$ .
- C3.4 For Standard or Improvement Quantitative 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 ( $U$ ).
- C3.5 For Standard or Improvement Quantitative Indicators where the desired direction is upwards ( $L < U$ ):
- a. If the PCN's performance is worse than or equal to the lower performance threshold ( $X < L$  or  $X = L$ ), the PCN will earn 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 earned 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 earned by the PCN will then be equal to the number of points available ( $A$ ), multiplied by  $V$ , divided by  $W$ :  $Q = A * V / W$ .
  - c. If the PCN's performance is better than or equal to the upper performance threshold ( $X > U$  or  $X = U$ ), the PCN will earn the maximum points available for the indicator:  $Q = A$ .
- C3.6 For Standard or Improvement Quantitative Indicators where the desired direction is downwards ( $L > U$ ):
- a. If the PCN's performance is worse than or equal to the lower performance threshold ( $X > L$  or  $X = L$ ), the PCN will earn 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 earned by the PCN will be calculated as follows:
    - i. Subtract performance from the lower performance threshold, and call this number  $V$ :  $V = L - X$ .

- ii. Subtract the upper performance threshold from the lower performance threshold, and call this number  $W$ :  $W=L-U$ .
  - iii. The points earned by the PCN will then be equal to the number of points available ( $A$ ), multiplied by  $V$ , divided by  $W$ :  $Q=A*V/W$ .
- c. If the PCN's performance is better than or equal to the upper performance threshold ( $X<U$  or  $X=U$ ), the PCN will earn the maximum points available for the indicator:  $Q=A$ .

C3.7 For Composite Quantitative Indicators:

- a. points assigned to the PCN for Standard performance ( $P1$ ) will be calculated on a linear sliding scale between a lower Standard performance threshold ( $L1$ ) and an upper Standard performance threshold ( $U1$ ).
- b. Points assigned to the PCN for Improvement performance ( $P2$ ) will be calculated on a linear sliding scale between a lower Improvement performance threshold ( $L2$ ) and an upper Improvement performance threshold ( $U2$ ).
- c. The points then achieved ( $Q$ ) will equal the greater of the points assigned ( $Q = P1$  where  $P1>P2$ ;  $Q = P2$  where  $P1<P2$ ; and  $Q = P1 = P2$  where  $P1=P2$ ).

C3.8 For Composite Quantitative Indicators where the desired direction is upwards ( $L<U$ ):

- a. In relation to Standard performance:
  - i. If the PCN's Standard performance ( $X1$ ) is worse than or equal to the lower Standard performance threshold ( $X1<L1$  or  $X1=L1$ ), the PCN will be assigned zero points:  $P1 = 0$ .
  - ii. If the PCN's Standard performance ( $X1$ ) is strictly between the lower and upper Standard performance thresholds ( $L1<X1<U1$ ), the points assigned to the PCN ( $P1$ ) will be calculated as follows:
    1. Subtract the lower Standard performance threshold from Standard performance and call this number  $V$ :  $V1=X1-L1$ .
    2. Subtract the lower Standard performance threshold from the upper Standard performance threshold and call this number  $W$ :  $W1=U1-L1$ .
    3. The points assigned for Standard performance ( $P1$ ) to the PCN will then be equal to the number of points available ( $A$ ), multiplied by  $V$ , divided by  $W$ :  $P1=A*V1/W1$ .

- iii. If the PCN's Standard performance ( $X_1$ ) is better than or equal to the upper Standard performance threshold ( $X_1 > U_1$  or  $X_1 = U_1$ ), the PCN will be assigned the maximum points available for the indicator:  $P_1 = A$ .
  - b. In relation to Improvement performance:
    - i. If the PCN's Improvement performance ( $X_2$ ) is worse than or equal to the lower Improvement performance threshold ( $X_2 < L_2$  or  $X_2 = L_2$ ), the PCN will be assigned zero points:  $P_2 = 0$
    - ii. If the PCN's Improvement performance ( $X_2$ ) is strictly between the lower and upper performance thresholds ( $L_2 < X_2 < U_2$ ), the points assigned to the PCN ( $P_2$ ) will be calculated as follows:
      1. Subtract the lower Improvement performance threshold from Improvement performance and call this number  $V$ :  $V_2 = X_2 - L_2$ .
      2. Subtract the lower Improvement performance threshold from the upper Improvement performance threshold and call this number  $W$ :  $W_2 = U_2 - L_2$ .
      3. The points assigned for Improvement performance ( $P_2$ ) to the PCN will then be equal to the number of points available ( $A$ ), multiplied by  $V$ , divided by  $W$ :  $P_2 = A * V_2 / W_2$ .
    - iii. If the PCN's Improvement performance ( $X_2$ ) is better than or equal to the upper Improvement performance threshold ( $X_2 > U_2$  or  $X_2 = U_2$ ), the PCN will be assigned the maximum points available for the indicator:  $P_2 = A$
  - c. The points achieved ( $Q$ ) will equal the greater of the points assigned ( $Q = P_1$  where  $P_1 > P_2$ ;  $Q = P_2$  where  $P_1 < P_2$ ; and  $Q = P_1 = P_2$  where  $P_1 = P_2$ ).

C3.9 For Composite Quantitative Indicators where the desired direction is downwards ( $L > U$ ):

- a. In relation to Standard performance:
  - i. If the PCN's Standard performance ( $X_1$ ) is worse than or equal to the lower Standard performance threshold ( $X_1 > L_1$  or  $X_1 = L_1$ ), the PCN will be assigned zero points for the indicator:  $P_1 = 0$ .

- ii. If the PCN's Standard performance ( $X_1$ ) is strictly between the lower and upper Standard performance thresholds ( $L_1 > X_1 > U_1$ ), points assigned to the PCN ( $P_1$ ) will be calculated as follows:
    1. Subtract Standard performance from the lower Standard performance threshold and call this number  $V$ :  $V_1 = L_1 - X_1$ .
    2. Subtract the upper Standard performance threshold from the lower Standard performance threshold and call this number  $W$ :  $W_1 = L_1 - U_1$ .
    3. The points assigned for Standard performance ( $P_1$ ) to the PCN will then be equal to the number of points available ( $A$ ), multiplied by  $V$ , divided by  $W$ :  $P_1 = A * V_1 / W_1$ .
  - iii. If the PCN's Standard performance ( $X_1$ ) is better than or equal to the upper Standard performance threshold ( $X_1 < U_1$  or  $X_1 = U_1$ ), the PCN will be assigned the maximum points available for the indicator:  $P_1 = A$ .
- b. In relation to Improvement performance:
- i. If the PCN's Improvement performance ( $X_2$ ) is worse than or equal to the lower Improvement performance threshold ( $X_2 > L_2$  or  $X_2 = L_2$ ), the PCN will be assigned zero points for the indicator:  $P_2 = 0$ .
  - ii. If the PCN's Improvement performance ( $X_2$ ) is strictly between the lower and upper Improvement performance thresholds ( $L_2 > X_2 > U_2$ ), points assigned to the PCN ( $P_2$ ) will be calculated as follows:
    1. Subtract Improvement performance from the lower Improvement performance threshold and call this number  $V$ :  $V_2 = L_2 - X_2$ .
    2. Subtract the upper Improvement performance threshold from the lower Improvement performance threshold and call this number  $W$ :  $W_2 = L_2 - U_2$ .
    3. The points assigned for Improvement performance ( $P_2$ ) to the PCN will then be equal to the number of points available ( $A$ ), multiplied by  $V$ , divided by  $W$ :  $P_2 = A * V_2 / W_2$ .
  - iii. If the PCN's Improvement performance ( $X_2$ ) is better than or equal to the upper Improvement performance threshold ( $X_2 < U_2$  or  $X_2 = U_2$ ), the PCN will be assigned the maximum points available for the indicator:  $P_2 = A$

- c. The points achieved (Q) will equal the greater of the points assigned (Q = P1 where P1>P2; Q = P2 where P1<P2; and Q = P1 = P2 where P1=P2).

#### **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. For each Quantitative Indicator, payments earned by the PCN will also incorporate a Prevalence Adjustment, which may in some cases be equal to 1 for all PCNs i.e. there is no 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 a Quantitative 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 Quantitative Indicator is defined in Annex D.
- C4.3 For each Quantitative 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 Quantitative 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.
- 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 Quantitative Indicator, payments earned by the PCN (M) will be calculated by multiplying points earned (Q), by the value of an IIF point (P), by the Prevalence Adjustment (C/K), by the List Size Adjustment (S/T):  
 $M=Q*P*(C/K)*(S/T)$ .
- C4.8 For each Qualitative Indicator, payments earned by the PCN (M) will be calculated by multiplying points earned (Q), by the value of an IIF point (P), by the List Size Adjustment (S/T):  $M=Q*P*(S/T)$ .

#### **C5. Step 5: For the PCN, calculate Total Achievement Payment**

- C5.1 For the PCN the Total 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 Investment and Impact Fund Implementation Guidance 2021/22):

- a. VI-01, VI-02, VI-03: Clinically unsuitable, Patient chose not to receive the intervention, Patient did not reply to two invitations for the intervention in their preferred method of communication.
- b. HI-01, PC-01: Patient chose not to receive the intervention.
- c. CVD-01: Patients newly identified whose follow-up period encompasses the end of the financial year; Patient chose not to receive the intervention.
- d. EHCH-02: Patient chose not to receive the intervention, Specific service is not available
- e. EHCH-04: Specific service is not available
- f. CVD-03, SMR-01A-D, CVD-04, CAN-01: Clinically unsuitable, Patient chose not to receive the intervention.
- g. CVD-05: Clinically unsuitable, Patient chose not to receive the intervention, Patient newly diagnosed with the condition of interest in the preceding 3 months and has not achieved the defined clinical standards
- h. RESP-01: Clinically unsuitable, The patient has been newly diagnosed with the condition of interest in the preceding 9 months and has not achieved the defined clinical standards

## 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 2022 to 31

March 2023. 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 at 31 March 2023.

This definition also applies to the calculation of baseline PCN-level numerators and denominators (N0 and D0) for Improvement Quantitative indicators and Composite Quantitative Indicators in relation to Improvement performance, i.e. N0 and D0 shall be constructed from the underlying practice-level data based on PCN membership as at 31 March 2023. 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.

- c. 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 at 1 January 2023:
  - i. The Prevalence Adjustment for each Quantitative indicator.
  - ii. The List Size Adjustment.
- d. For all Qualitative indicators (defined in Annex D), data on achievement will be manually submitted via the Calculating Quality Reporting System (CQRS).
- e. For all Quantitative indicators (defined in Annex D):
  - i. The denominators will be measured on 31 March 2023 (or where unavailable, the latest available date prior to 31 March 2023)..
  - ii. The numerators will be defined with respect to the denominator defined on 31 March 2023 and, except where explicitly noted in the indicator definition, will count all activity undertaken between 1 April 2022 and 31 March 2023.

## **C8. Impact of PCN changes on calculation of Total 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 2023:

- 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 2022, and remains a Core Network Practice of that PCN on 31 March 2023, then that Core Network Practice's performance in relation to the Indicators for the entire period from 1 April 2022 to 31 March 2023, where specified in Section C7) will enter into the calculation of that PCN's Achievement Points and Achievement Payments, including that portion of the period from 1 April 2022 to 31 March 2023 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 2022, and remains a Core Network Practice of that PCN on 31 March 2023 then that practice's performance in relation to the Indicators from the period it became a New Practice to 31 March 2023 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 2022 to it becoming a New Practice.

C8.4 If a new PCN is approved (for whatever reason) in the period 1 April 2022 to 31 March 2023, 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 2022 to 31 March 2023 will enter into the calculation of that PCN's Achievement Points and Achievement Payments, including that portion of the period from 1 April 2022 to 31 March 2023 during which the PCN did not exist.

## Annex D - Investment and Impact Fund Indicators

### D1. Prevention and Tackling Health Inequalities domain

D1.1 A PCN is able to earn up to 510 points in the Prevention and Tackling Health Inequalities domain. The following indicator definitions apply for this domain.

ID	Description	Numerator (N)	Denominator (D)	Prevalence numerator (E)	Indicator Type; Points; Desired Direction; Thresholds; Data source
<b>Vaccination &amp; immunisation (VI) area</b>					
VI-01	Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	Of the denominator, the number who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	Number of patients aged 65 and over	Indicator denominator	Standard Quantitative; 40; Upwards; 80% (LT) / 86% (UT); GPES
VI-02	Percentage of patients aged 18 to 64 years and in a clinical at-risk group <sup>95</sup> who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	Of the denominator, the number who received a seasonal influenza vaccination between 1 September 2022 and 31 March 2023	Number of patients aged 18 to 64 years and in a clinical at-risk group	Indicator denominator	Standard Quantitative; 88; Upwards; 57% (LT) / 90% (UT); GPES
VI-03	Percentage of children aged two or three years on 31 August 2022 who received a seasonal influenza vaccination	Of the denominator, the number who received a seasonal influenza vaccination	Number of children aged two or three years on 31 August 2022	Indicator denominator	Standard Quantitative; 14; Upwards; 45% (LT) / 82% (UT); GPES

<sup>95</sup> "At-risk" refers to patients in the following cohorts (those subject to national call and recall system): Chronic respiratory disease, Chronic heart disease, Chronic kidney disease, Chronic liver disease, Chronic neurological disease, Learning disabilities (as captured by being on the QOF Learning Disability register), Diabetes, Immunosuppression, Asplenia or dysfunction of the spleen, Morbid obesity, People in long stay residential or homes. For further information, see: <https://www.england.nhs.uk/publication/annual-seasonal-flu-vaccination-programme-and-reimbursement-guidance/>.

	between 1 September 2022 and 31 March 2023	between 1 September 2022 and 31 March 2023			
<b>Tackling health inequalities (HI) area</b>					
HI-01	Percentage of patients on the QOF Learning Disability register aged 14 years or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan	Of the denominator, the number who received an annual Learning Disability Health Check and have a completed Health Action Plan	Number of patients on the QOF Learning Disability register aged 14 years or over	Indicator denominator	Standard Quantitative; 36; Upwards; 60% (LT) / 80% (UT); GPES
HI-02	Percentage of registered patients with a recording of ethnicity on their GP record	Of the denominator, the number with a recording of ethnicity on their GP record	Total number of registered patients	Indicator denominator	Standard Quantitative; 45; Upwards; 81% (LT) / 95% (UT); GPES
<b>CVD prevention (CVD) area</b>					
CVD-01	Percentage of patients aged 18 or over with an elevated blood pressure reading ( $\geq 140/90\text{mmHg}$ ) <sup>96</sup> and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up <sup>97</sup> to confirm or exclude a diagnosis of hypertension	Of the denominator, the number for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension	Number of patients aged 18 or over with an elevated blood pressure reading ( $\geq 140/90\text{mmHg}$ ) and not on the QOF Hypertension Register	Number of patients on the QOF Hypertension Register (2022/23)	Standard Quantitative; 71; Upwards; 25% (LT) / 50% (UT); GPES
CVD-02	Percentage of registered patients on the QOF	Of the denominator, the number on the	Total number of registered patients	Indicator denominator	Improvement Quantitative; 35,

<sup>96</sup> Either (i) a last recorded blood pressure reading in the two years prior to 1 April 2022  $\geq 140/90\text{mmHg}$ , or (ii) a blood pressure reading  $\geq 140/90\text{mmHg}$  on or after 1 April 2022.

<sup>97</sup> Occurrence of one of the following (by 31 March 2023 (cohort i) or within six months of the first elevated blood pressure reading after 1 April 2022 (cohort ii)): (1) Ambulatory Blood Pressure Monitoring; (2) Home Blood Pressure Monitoring; (3) Change of medication followed by subsequent non-elevated reading; (4) Addition to QOF Hypertension Register alongside same day referral for specialist assessment; (5) Addition to QOF Hypertension Register alongside either subsequent commencement of antihypertensive therapy or a record that the patient declined antihypertensive therapy.

	Hypertension Register	QOF Hypertension Register			Upwards; 0.4 percentage point increase (LT) / 0.8 percentage point increase (UT); GPES
CVD-03	Percentage of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins	Of the denominator, the number who are currently treated with statins	Number of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent	Indicator denominator	Standard Quantitative; 31; Upwards; 48% (LT) / 58% (UT); GPES
CVD-04	Percentage of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total cholesterol greater than 9.0 who have been (i) diagnosed with secondary hyperlipidaemia; or (ii) clinically assessed for familial hypercholesterolaemia; or (iii) referred for assessment for familial hypercholesterolaemia; or (iv) genetically diagnosed with familial hypercholesterolaemia	Of the denominator, the number who have been (i) diagnosed with secondary hyperlipidaemia; or (ii) clinically assessed for familial hypercholesterolaemia; or (iii) referred for assessment for familial hypercholesterolaemia; or (iv) genetically diagnosed with familial hypercholesterolaemia	Number of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total cholesterol greater than 9.0	Indicator denominator	Standard Quantitative; 18; Upwards; 20% (LT) / 48% (UT); GPES
CVD-05	Percentage of patients on the QOF Atrial Fibrillation register and with a CHA <sub>2</sub> DS <sub>2</sub> -VASc score of 2 or more	Of the denominator, the number who were prescribed a direct-acting oral anticoagulant (DOAC), or,	Number of patients on the QOF Atrial Fibrillation register and with a CHA <sub>2</sub> DS <sub>2</sub> -VASc	Indicator denominator	Standard Quantitative; 66; Upwards; 70% (LT) / 95% (UT);

	(1 or more for patients that are not female), who were prescribed a direct-acting oral anticoagulant (DOAC), or, where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist	where a DOAC was declined or clinically unsuitable, a Vitamin K antagonist	score of 2 or more (1 or more for patients that are not female)		GPES
--	---	--	---	--	------

CVD-06	Number of patients who are currently prescribed Edoxaban, as a percentage of patients on the QOF Atrial Fibrillation register with a CHA <sub>2</sub> DS <sub>2</sub> -VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a direct-acting oral anticoagulant (DOAC)	Of the denominator, the number who are currently prescribed Edoxaban	Number of patients on the QOF Atrial Fibrillation register with a CHA <sub>2</sub> DS <sub>2</sub> -VASc score of 2 or more (1 or more for patients that are not female) and who are currently prescribed a direct-acting oral anticoagulant (DOAC)	Indicator denominator	Standard Quantitative; 66; Upwards; 25% (LT) / 35% (UT); GPES
--------	--	--	---	-----------------------	---

## D2. Providing High Quality Care domain

D2.1 A PCN is able to earn up to 408 points in the Providing High Quality Care domain. The following indicator definitions apply for the indicators in this domain.

ID	Description	Numerator (N)	Denominator (D)	Prevalence numerator (E)	Indicator Type; Points; Desired Direction; Thresholds; Data source
<b>Personalised Care (PC) area</b>					
PC-01	Percentage of registered patients referred to a social prescribing service	Of the denominator, the number referred to a social	Total number of registered patients	Indicator denominator	Standard Quantitative; 20; Upwards; 0.8% (LT) /

		prescribing service			1.2% (UT); GPES
<b>Access (ACC) area</b>					
ACC-07	Number of pre-referral Specialist Advice requests across twelve specialties <sup>98</sup> identified for accelerated delivery per outpatient first attendance	Number of Specialist Advice requests across twelve specialties identified for accelerated delivery.	Number of outpatient pre-referral first attendances across twelve specialties identified for accelerated delivery.	Number of registered patients (i.e. no prevalence adjustment)	Standard Quantitative; 44; Upwards; 0.066 (LT) / 0.19 (UT) ; System Elective Recovery Outpatient Collection (EROCC)/ HES/SUS Outpatient
ACC-09	Number of referrals to the Community Pharmacist Consultation Service per registered patient	Number of referrals to the Community Pharmacist Consultation Service to patients in the denominator	Total number of registered patients.	Indicator denominator	Binary Quantitative; 27; Upwards; 0.034; GPES
<b>Enhanced health in care homes (EHCH) area</b>					
EHCH-01	Number of patients aged 18 years or over and recorded as living in a care home, as a percentage of care home beds aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service	Number of patients aged 18 years or over and recorded as living in a care home	Number of care home beds aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service	Indicator denominator	Standard Quantitative; 18; Upwards; 30% (LT) / 85% (UT); CQRS manual entry/ GPES
EHCH-02	Percentage of care home residents aged 18 years or over who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	Of the denominator, the number who had a personalised care and support plan agreed or reviewed	Number of care home residents aged 18 years or over	Indicator denominator	Standard Quantitative; 18; Upwards; 80% (LT) / 98% (UT); GPES
EHCH-04	Mean number of patient contacts as	Number of general practice	Number of care home residents	Indicator denominator	Standard Quantitative;

	part of weekly care home round per care home resident aged 18 years or over	appointments categorised as 'Patient contact during Care Home Round'	aged 18 years or over		13; Upwards; 6 (LT) / 8 (UT); GPAD/ GPES
--	---	--	-----------------------	--	--

<b>Anticipatory Care (AC) area</b>					
AC-02	Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions <sup>99</sup> per registered patient	Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions for patients in the denominator	Total number of registered patients	Indicator denominator	Composite Quantitative; 111; Downwards; Improvement Reduction of; 0 (LT)/ 0.001 (UT) Absolute: 0.01 (LT)/ 0.008 (UT); HES APC / NHAIS/PDS

<b>Cancer (CAN) area</b>					
CAN-01	Percentage of lower gastrointestinal two week wait (fast track) cancer referrals accompanied by a faecal immunochemical test result, with the result recorded either in the twenty one days leading up to the referral, or in the fourteen days after the referral	Of the denominator, the number accompanied by a faecal immune-chemical test, with the result recorded either in the twenty one days leading up to the referral, or in the fourteen days after the referral	Number of lower gastrointestinal two week wait (fast track) referrals for suspected cancer	Indicator denominator	Standard Quantitative; 22; Upwards; 40% (LT) / 80% (UT); GPES

<b>Structured medication reviews and medicines optimisation (SMR) area</b>					
SMR-01A	Percentage of patients at risk of harm due to medication errors who received a Structured Medication Review	Of the denominator, the number who received at least one Structured Medication Review	Number of patients at risk of harm due to medication errors	Indicator denominator	Standard Quantitative; 26; Upwards; 44% (LT) / 62% (UT); GPES
SMR-01B	Percentage of patients living with	Of the denominator,	Number of patients living	Indicator denominator	Standard Quantitative;

<sup>99</sup> ACSCs in scope: COPD, Diabetes complications, Convulsions and Epilepsy, Asthma, Congestive Heart Failure, Hypertension, Influenza and Pneumonia, Ear Nose and Throat Infections, Pyelonephritis, Cellulitis.

	severe frailty who received a Structured Medication Review	the number who received at least one Structured Medication Review	with severe frailty		9; Upwards; 44% (LT) / 62% (UT); GPES
SMR-01C	Percentage of patients using potentially addictive medicines who received a Structured Medication Review	Of the denominator, the number who received at least one Structured Medication Review	Number of patients using potentially addictive medicines	Indicator denominator	Standard Quantitative; 9; Upwards; 44% (LT) / 62% (UT); GPES
SMR-01D	Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review	Of the denominator, the number who received at least one Structured Medication Review	Number of permanent care home residents aged 18 years or over	Indicator denominator	Standard Quantitative; 9; Upwards; 44% (LT) / 62% (UT); GPES
SMR-02A	Percentage of patients aged 18 years or over prescribed both a Non-Steroidal Anti-Inflammatory Drug (NSAID) and an oral anticoagulant in the last three months of the previous financial year, who in the three months to the reporting period end date, were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to both an NSAID and an oral anticoagulant	Of the denominator, the number who, in the three months to the reporting period end date, were either (i) No longer prescribed an NSAID OR (ii) Prescribed a gastro-protective in addition to an NSAID	Number of patients aged 18 years or over concurrently prescribed a non-steroidal anti-inflammatory drug (NSAID) and an oral anticoagulant in the last three months of the previous financial year	Indicator denominator	Standard Quantitative; 4; Upwards; 85% (LT) / 90% (UT); GPES
SMR-02B	Percentage of patients aged 65 years or over prescribed a Non-Steroidal Anti-Inflammatory Drug (NSAID) and not an oral anticoagulant in	Of the denominator, the number who, in the three months to the reporting period end date, were either:	Number of patients aged 65 years or over prescribed a non-steroidal anti-inflammatory drug (NSAID) without a	Indicator denominator	Standard Quantitative; 4; Upwards; 85% (LT) / 90% (UT); GPES

	the last three months of the previous financial year, who in the three months to the reporting period end date, were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to an NSAID	(i) No longer prescribed an NSAID OR (ii) Prescribed a gastro-protective in addition to an NSAID	concurrent oral anticoagulant in the last three months of the previous financial year		
SMR-02C	Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the last three months of the previous financial year, who in the three months to the reporting period end date, were either (i) no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both an oral anticoagulant and an anti-platelet	Of the denominator, the number who, in the three months to the reporting period end date, were either: (i) No longer prescribed an anti-platelet OR (ii) Prescribed a gastro-protective in addition to an anti-platelet.	Number of patients aged 18 years or over concurrently prescribed an oral anticoagulant and an anti-platelet in the last three months of the previous financial year.	Indicator denominator	Standard Quantitative; 4; Upwards; 75% (LT) / 90% (UT); GPES
SMR-02D	Percentage of patients aged 18 years or over prescribed aspirin and another anti-platelet in last three months of the previous financial year, who in the three months to the reporting period end date, were either (i) no longer prescribed aspirin and/or no longer prescribed an anti-platelet or (ii) prescribed a	Of the denominator, the number who, in the three months to the reporting period end date, were either: (i) No longer prescribed aspirin and/or no longer prescribed an anti-platelet OR (ii) Prescribed a gastro-protective in addition to both aspirin and	Number of patients aged 18 years or over prescribed both aspirin (irrespective of dose/strength) and another anti-platelet in the last three months of the previous financial year.	Indicator denominator	Standard Quantitative; 4; Upwards; 75% (LT) / 90% (UT); GPES

	gastroprotective in addition to both aspirin and another anti-platelet.	another anti-platelet.			
SMR-03	Percentage of patients prescribed a direct-acting oral anti-coagulant (DOAC), who received a renal function test and have a recording of their weight and Creatinine Clearance Rate, along with a recording that their DOAC dose was either changed or confirmed (not changed)	Of the denominator, the number who received a renal function test and have a recording of weight and Creatinine Clearance Rate, along with a recording that their DOAC dose was either changed or confirmed (not changed)	Number of patients prescribed a direct-acting oral anticoagulant (DOAC)	Indicator denominator	Standard Quantitative; 13; Upwards; 50% (LT) / 75% (UT); GPES
RESP-01	Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months	Of the denominator, the number who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months	Number of patients on the QOF Asthma Register	Indicator denominator	Standard Quantitative; 31; Upwards; 71% (LT) / 90% (UT); GPES
RESP-02	Percentage of patients on the QOF Asthma Register who received six or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions over the previous 12 months	Of the denominator, the number who received 6 or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions in the previous 12 months	Number of patients on the QOF Asthma Register	Indicator denominator	Standard Quantitative; 22; Downwards; 25% (LT) / 15% (UT); GPES

### D3. A Sustainable NHS domain

D2.2 A PCN is able to earn up to 71 points in the A Sustainable NHS domain. The following indicator definitions apply for the indicators in this domain.

ID	Description	Numerator (N)	Denominator (D)	Prevalence numerator (E)	Indicator Type; Points; Desired Direction; Thresholds; Data source
<b>Environmental sustainability (ES) area</b>					
ES-01	Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 years or over	Of the denominator, the number of prescriptions for metered dose inhalers	Number of prescriptions for non-salbutamol inhalers issued to patients aged 12 years or over	Indicator denominator	Standard Quantitative; 27; Downwards; 44% (LT) / 35% (UT); GPES
ES-02	Mean carbon emissions per salbutamol inhaler prescribed (kg CO <sub>2</sub> e)	Total carbon emissions from all inhalers in the denominator (kg CO <sub>2</sub> e)	Number of salbutamol inhalers prescribed	Number of patients prescribed salbutamol inhalers	Standard Quantitative; 44; Downwards; 22.1kg (LT) / 18.0kg (UT); BSA prescribing data