

The primary care network handbook 2021-22



General practice
and PCN support

The primary care network handbook 2021-22

This handbook has been created to give advice and options to practices looking to establish and develop a primary care network (PCN). Most of the major elements are interdependent, so conversations and decisions should not be made in isolation; we recommend reading the whole document before proceeding.

The guidance has been fully revised following the 2021/22 contract agreement and incorporates all the relevant changes. It supersedes the previous handbooks and contains all the information practices will need from the setting up of a PCN to future developments of their network.

Further guidance and tools can be found on the [PCN hub](#) of the BMA website as well as on the BMA's app for PCN Clinical Directors.

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Background

The BMA GP (England) committee and NHS England have agreed, through the national contract negotiations, for the development and rollout of PCNs (primary care networks).

PCNs are groups of GP practices working more closely together, with other primary and community care staff and health and care organisations, providing integrated services to their local populations.

Since April 2019, individual GP practices have been able to establish or join PCNs covering populations of between 30,000 to 50,000 (with some flexibility). This is supported via a DES (directed enhanced service), which provides funding for the provision of additional workforce and services that the PCN will be required to provide.

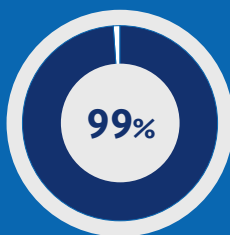
The BMA is working with NHS England to ensure PCNs allow for the retention of what constitutes the very best of how general practice and wider primary care currently operates, retaining and building on the national GMS contract and the partnership model, while finding improved ways to deliver care that offer tangible benefits and improvements to patients, clinicians and the wider primary care team.

As a result individual practices joining the network will retain their GMS or PMS contract, with the PCN building on it.

PCN fact sheet as of
31 March 2020

PCN fact sheet

PCNs established:
1 July 2019



Coverage
(% of practices
included within
a PCN)

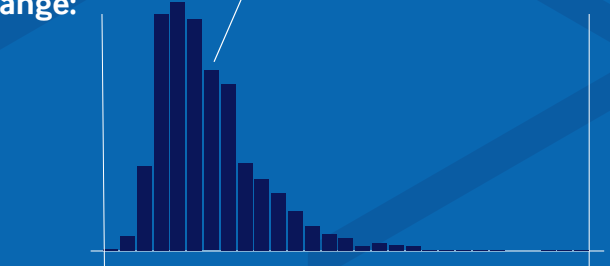
Average PCN size
(no of registered patients):

48,020

Total number of
PCNs in England:
1,250



Range:



Min: 14,605

Max: 263,827

Bringing care closer to community

Connecting the local primary care team

The intention behind changes inserted into the GP contract is to focus services around local communities and local GP practices to help rebuild and reconnect the primary healthcare team across the area they cover. PCN services will be delivered in the local area by the GP practices and multidisciplinary teams employed by the network. They will be commissioned and funded by CCGs through the network.

LMCs (Local Medical Committees) have an important role to work with CCGs to ensure that practices will lead and direct these networks, ultimately becoming a vehicle through which GPs and other primary care practitioners can deliver an effective and sustainable model of care for their patients and communities. PCNs will develop under GP leadership, with additional staff working as part of practice-based and practice aligned primary healthcare teams.

LMCs will also support PCNs' engagement with STPs (sustainability and transformation partnerships) and ICSs (integrated care systems) to shape their strategic direction and improve and align population care on a wider scale.

Non-GP organisations working within the locality will be party to the network agreement, but not party to the DES. Where they are to be a part of the network, their contribution in terms of funding, workforce and/or services will be agreed between the parties and recorded in the network agreement.

Bringing new benefits to patients

The development of PCNs will mean that patients and the public will be able to access:

- resilient high-quality care from local clinicians and health and care practitioners, with more services provided in the community
- a more comprehensive and coordinated set of services, that anticipate rising demand and support higher levels of self-care
- appropriate referrals and more 'one-stop shop' services where all of their needs can be met at the same time
- different care models for different population groups (such as frail older persons, adults with complex needs, children) that are person-centred rather than disease-centred.

Summary of Changes for 2021/22

The changes to the PCN DES for 2021/22 include a mixture of items agreed to be introduced this year as scheduled during previous negotiations, items previously agreed but with delayed implementation and new changes negotiated in response to changing circumstances

Previously agreed changes that will continue as planned for 2021/22

- ARRS increase in funding (£430m in 2020/21 to £746 in 2021/22)
- Expansion of ARRS roles (additional roles agreed in October 2020 to continue, and paramedics, AHPs and MHPs to commence from April 2021)
- IIF increase in funding (to £150m in 21/22, with at least £30m to incentivise access)

Previously agreed changes to be delayed

- Additional four service specifications will not be introduced from April 2021, given reprioritisation necessitated by the pandemic
- More phased approach to the introduction of new IIF indicators for 21/22
- Access offer to be developed over summer 2021 and implemented from April 22

New changes agreed for 2021/22

- The deadline for transferring clinical pharmacists from the Clinical Pharmacist in General Practice scheme has been extended from 1 April to 30 Sept 21
- PCNs will be entitled to an embedded mental health practitioner, employed and provided as a service by the PCN's local provider of community mental health services, funded under a local agreement; 50% of the funding will be provided from the mental health provider and 50% by the PCN
- For PCNs in the London region, the maximum reimbursement amounts per role within the ARRS will now include inner and outer London weighting on top of maximum current ARRS reimbursement amounts

Creating and establishing a PCN

Most PCNs will now be up and running following the confirmation process in June 2019. However, for any groups of practices that wish to sign up in future years the below will still be relevant.

To ensure that the whole of England benefits from the investment and service improvements that PCNs offer, CCGs must ensure 100% population coverage of PCNs. Existing practices have guaranteed preferential rights. But where they choose to opt-out, arrangements for alternative provision of PCN services will need to be commissioned by alternate means.

Equally, every practice has the right to sign up to the Network Contract DES and join a PCN. In unusual circumstances, a practice wanting to sign up to the Network Contract DES may be unable to find a PCN to join. Such occurrences will become rare over time as PCN membership stabilises.

Where agreement between a practice that wishes to sign up to the Network Contract DES and a PCN is difficult to secure, CCGs, with their LMC, will support the parties involved through mediation to come to agreement on the practice joining the PCN. Where a local arrangement cannot be reached, the issue will be escalated to GPCE and NHSE/I. From April 2020 CCGs will be able, in the unlikely circumstances that agreement cannot be secured through the mediation process, to assign such a practice to a PCN. This will require the CCG to work closely with the LMC on the decision given its sensitivity.

Geography

The geographic coverage of the PCN is up to the member practices to decide through discussions with their colleagues and neighbours. **The only involvement of the CCG in this process should be when there are gaps in the total PCN coverage of their area or if the PCN is struggling to meet the size criteria.** In this scenario the CCG, in collaboration with the relevant LMC(s), should act as liaison between the proposed PCN groupings in the area and the practice(s) that are not currently included in any such grouping, either by choice of the practice or the PCN. If a practice chooses not to sign up to the DES at all, the CCG will need to arrange for an appropriate PCN to take on provision of network-level services to the patients in that practice (along with the relevant funding).

The total population of the PCN should cover around 30,000–50,000 patients. While there is no maximum size of a PCN, and commissioners can sign off on PCN proposals that go over 50,000, it is at around this size that networks will best keep the features of traditional community-based general practice, combined with the benefits of integrated working across a locality.

Only in exceptional circumstances will networks be allowed to cover a population smaller than 30,000; for example, in rural areas where reaching a 30,000+ population causes geographic problems.

Prerequisites to becoming a PCN

To be recognised as a PCN, individual GP practices will need to make a brief joint submission outlining:

- the names and the ODS codes of the member practices
- the network list size (ie the sum of member practices' lists as of 1 January)
- a map clearly marking the agreed network area
- a copy of the initial network agreement signed by all member practices (see below)
- a named clinical director for the network (additional funding is provided for this role)
- the single practice or provider that will receive funding on behalf of the PCN.

Networks will need to complete a network agreement. The intention is that this will be a pro forma agreement with schedules that can be moulded to enable the individual parties to specify how they will handle network-specific issues such as:

- decision making, governance and collaboration arrangements
- arrangements regarding the delivery of different packages of care
- the agreement for distribution of funding between the practices
- arrangements regarding the employment of the expanded workforce
- internal governance arrangements (appointment processes, decision making process, etc).

The network agreement will have to be updated year on year as new services, workforce and funding are added.

The content of the network agreement is not within the remit of the CCG to challenge. As long as the practices have agreed, the CCG cannot refuse the DES based on its content.

Establishing and enabling sustainable networks

First steps

A nascent PCN will have to establish structure and governance arrangements before it can move towards setting up services and acquiring the necessary workforce.

All primary care networks will need management and administrative support structures. Practices that form the network will also need to seek advice on any proposed legal agreements and financial matters, and will need to establish a regular meeting of their representatives to ensure that things are developing as planned.

Early stage delivery and maintenance

Following the establishment of their structure of governance and administration, networks will be expected to begin service delivery, primarily focused on developing expanded practice-based and connected teams to deliver the provision of workload support of the member practices by:

- working alongside the existing practice team and taking responsibility for some services of the member practices (to be decided by the network), focusing on extended-hours delivery in the first instance
- restructuring some service delivery (to be decided by the network)
- offering access to the extended PCN team (extending the workforce).

As the workforce expands and services reconfigure, networks may find a need for additional or restructured premises and infrastructure. The Premises Cost Directions will remain the mechanism for funding for changes to premises.

Mature stage delivery and maintenance

When a PCN is established and has begun to deliver services at the level of the network, it should start to enjoy the benefits of the scheme and the impact of the expanded workforce on workload sustainability.

Only then is it able to build upon the foundations to expand its scope further and qualify to provide any PCN-specific services developed through the DES specification.

Any additional work should be linked to additional funding, to deliver a sustainable service of appropriate quality.

The DES will provide a menu of options in this regard, to enable PCNs to discuss and agree which services the network should provide to best fit the needs of its member practices and local patient population.

Mature stage – workforce expansion and development

At this stage there will be a continued development and expansion of services, including an enhanced offering of services in the community, learning from best practice and evidence from around the country. The network will receive long-term recurrent resources to ensure sustainability and require a willingness from practice members to invest their time and commitment into this.

At this stage, relying on the confidence and mutual trust built up through shared working, the network will become a mature forum for shared learning and quality improvement.

The network will need to organise regular meetings of its membership, keep receiving relevant legal and HR advice on maintenance and day-to-day running. Premises and infrastructure will need to be regularly reviewed to ensure best use of space and facilities.

PCN internal governance and decision making

Whichever organisational structure that practices chose to develop for their network, they will need to ensure there are robust and appropriate governance structures in place. In doing so, practices will need to consider a number of key questions regarding how they wish the network to operate on a day-to-day basis.

Examples of possible governance articles to be included within the network agreement are available on the [PCN hub of the BMA website](#).

Key considerations

Governing/representative body

Practices will need to set out a clear decision-making process for the network. This should identify the relevant agents acting on behalf of network members (eg one representative from each practice, a selection of individuals from across the network, all partners from each practice, sessional representation, etc), the weighting of votes (eg one per practice or according to size), and the quorum requirements.

The network may have a 'board' comprising one representative from each member practice. Alternatively, the network may have a board comprising all the partners from member practices. Each 'bloc' of partners gets a vote share in line with their respective practice list size.

There are many ways in which these can be constituted and, ultimately it is up to the member practices to decide what decision-making process they feel comfortable with.

Practices may wish to consider how similar staff working in different practices and settings might want to interact at network level (eg a board for nurses, a board for GPs, a board for practice managers) to share ideas, best practice, etc. However, this needs to be developed in line with available resources.

Whichever route practices take, the board should operate as the network's governing body, bringing all members together, overseeing joint decision making, the strategic direction of the network and the network's funding/financial layout. It is also the body to which the clinical director would be directly accountable.

Decision making

Once a structure of governance has been decided, decision-making processes for the network also need to be established.

These set out how network decisions are taken, and should cover:

- what is within the remit of the clinical director to act executively, what needs to go back to the practice representatives
- how the governing body makes decisions – does it require a simple majority, a

- conditional majority, unanimity, etc
- how often the governing body should meet
- how meetings are chaired (an elected chair, rotational chair, etc). As the clinical director will be accountable to the governing body, it may be better for the role to be excluded from chairing the governing body.

Accountability

Clear lines of accountability for all parts of the network should be agreed and established from the outset and practices should make sure they are all comfortable with the agreed systems.

For example, the clinical director could be accountable to the board, which is in turn accountable to the member practices, via the nominated representatives. There will also need to be a system in place to ensure individual practises are also accountable to each other, collectively, with respect of delivery of PCN services, under the DES specification and the network agreement. This could also be undertaken via the network board.

Finances

Governance procedures should also set out how the network's finances are handled. This will depend in part on how the network is constituted (ie is it using a 'lead provider' model, where one practice employs staff on the network's behalf, is it using a 'flat' model where employment is shared among member practices, etc) as well as how the services are reconfigured (ie if one practice provides all services to care homes in the area, they will be accountable for that care and may require additional funding from the other practices or the central PCN pot, or all care home patients may be encouraged to be registered with that one practice).

HR policies

Practices need to decide what HR policies apply to staff employed under the network. The simplest method may be to apply the policies from one of the member practices (the lead practice if that model is chosen) to these new staff, rather than draft an entirely new set of policies. This will be for the constituent practices to consider and decide.

Non-practice members

Over time PCNs will develop close working relationships with other primary and community care organisations, acting as the locus through which various aspects of non-hospital care come together. This could range from, for example, local community trusts to care homes, to the voluntary sector.

For this reason, practices also need to give consideration to how the network will interact with other healthcare bodies. They may wish to create seats on the governing body for these organisations, to allow them to be formally integrated into the network. Alternatively, the network could enter some form of agreement with the various bodies to identify (among other things) the services that are to be provided and by whom.

Potential PCN structures and employment options

There are a number of possible structures for PCNs operating under any potential DES. The way in which any PCN is structured will impact how it operates, including the relationship between participating practices, how funding flows under the DES, where any consequential liabilities sit and how any extended workforce is employed.

This section presents five potential structures for the interaction between the commissioner and the network, and between members of the network, in terms of the DES – including how funding, service reconfiguration and workforce might be affected. These structures are presented based on the most current information available at the time of publication and may be updated as further information is released.

Individual practices belonging to the network will have to carry out a risk assessment before agreeing the most appropriate structure – to include individual or collective liability

for the DES, for the funding associated with the DES, for the structure of the workforce within the network, legality of any structures for the network, financial implications, potential tax implications (eg VAT), and the workload and bureaucracy associated with setting up and maintaining a structure. It is advisable to seek independent legal and financial advice at a network level, to help decide the most appropriate structure.

When deciding on the preferred structure for the network, practices need to consider:

Employment liabilities

Over time the network-level workforce funded under the DES will expand, both in terms of the different roles eligible for funding, and the overall level of funding available to networks. Practices therefore need to give close consideration to the impact that such a workforce expansion will have on their exposure to employment liabilities (eg potential future redundancies). For this reason, they may wish to consider ways to limit their exposure to such liabilities through, for example, the use of limited liability vehicles or by sharing them equitably across members of the network.

Pensions

For healthcare staff to have access to the NHS pension scheme, the employing body must qualify as an 'employing authority' under the scheme. In short, this requires them to hold an NHS contract. For networks operating under a lead employer or flat practice model, or where staff are seconded from another NHS organisation such as a community trust, this will not be an issue. However, where the PCN is planning to set up or utilise an existing limited liability vehicle, such as a GP federation, the staff employed by that body under the DES may not be able to access the NHS pension scheme in the same way unless the body itself holds an NHS contract.

NHS Business Service Authority has now published guidance, which is available [here](#)

It's also possible for staff to access the NHS pensions scheme when the employing organisations is not a NHS employing authority (i.e. when they don't qualify outright, or if the NHS contract via which they qualified has lapsed). This requires the organisation to apply to the Secretary of State for Health for 'direction' status, which can be granted if they meet certain criteria, such as providing NHS related services and being from the voluntary or not for profit sectors.

Further guidance on this is available via the [BMA website](#).

VAT

Practices will need to be very careful that the structure they choose does not inadvertently attract VAT charges. While the supply of health **services** provided by registered health professionals are generally exempt from VAT, the provision of healthcare and back-office **staff** is not and it is possible that under some structures this interpretation could apply. Practices and PCNs therefore need to ensure their chosen network structure does not fall under the latter interpretation.

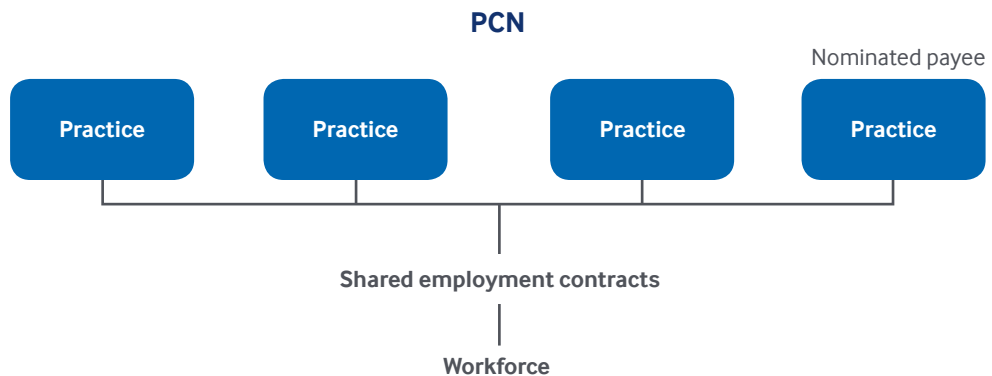
Some broad guidance on possible VAT issues within '[lead practice](#)' and '[federation](#)' base models is available from the [BMA website](#). NHS England have also produced an [information note](#) outlining how VAT applies to the provision of health services, and some items that practices should be aware of. However, we strongly recommend that networks take advice on their specific proposals in order to fully safeguard themselves in the future. In relation to clinical directors and VAT, we are encouraging HMRC to update their existing VAT notice 701/57 to explicitly include PCN clinical directors as an example where it says:

'General' payments and reimbursements of practice costs (for example, GMS global sum, Minimum Practice Income Guarantee correction factor, computer costs, notional rent) are also payments directly related to exempt services

Potential operating models

With each of the following potential models, practices will need to consider how their workforce will operate. For example, will they work within the policies of the individual practice where they are providing services on that particular day, or the lead practice, or the designated employer. It may be worth obtaining expert HR advice before deciding which model is most suitable for the network.

1. Flat practice network



While the DES requires that the network provides a nominated payee, this need only act effectively as the network's bank account, with responsibilities and funding spread across its members.

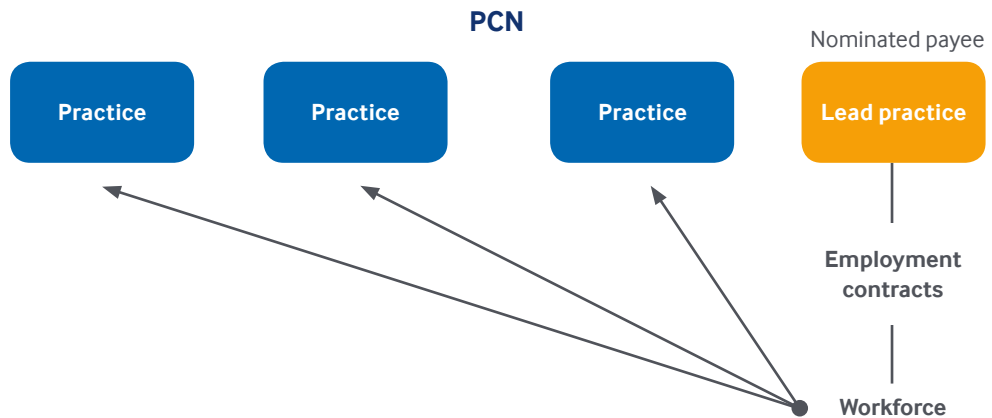
How this could work as a PCN

The practices within the network could utilise joint employment contracts in order to engage PCN staff. This will spread any subsequent employment liabilities across the network and practices will need to ensure there is a robust agreement between them as to how this is handled (covering, for example, what happens if a practice joins or leaves the network), as well as whose HR procedures apply under the contracts. This may require an additional agreement between member practices, akin to a partnership agreement.

At a glance: risk assessment

- Because a PCN is not an Employing Authority the non-GP staff only have access to the NHSPS (as Practice Staff) if they have 4 individual part-time contracts of employment, one with each of the 4 Practices.
- No subcontracting issues envisaged.
- No significant employment issues are envisaged beyond the necessity to jointly employ – the employees' 'place of work' is likely to be defined as all member practices and it is likely that the network will need a nominated set of HR policies to apply for disciplinary etc (potentially from the payee practices).
- No VAT issues envisaged.
- No CQC issues envisaged.
- Liabilities may well prove an issue as these will need to be shared among the constituent practices (which, to the extent operated as partnerships or by sole contractors, will have unlimited liability).
- To the extent that it is not adequately covered in the network agreement, the network must have a further overarching agreement setting out governance, how liability would be split, exit/entry, etc.

2. Lead provider



The network will have identified a leading practice to sign up to the DES on behalf of the network. This practice will work with one or more practices to provide services under the DES. This will require an MOU/collaboration agreement to be signed by providers within the network.

How this could work as a PCN

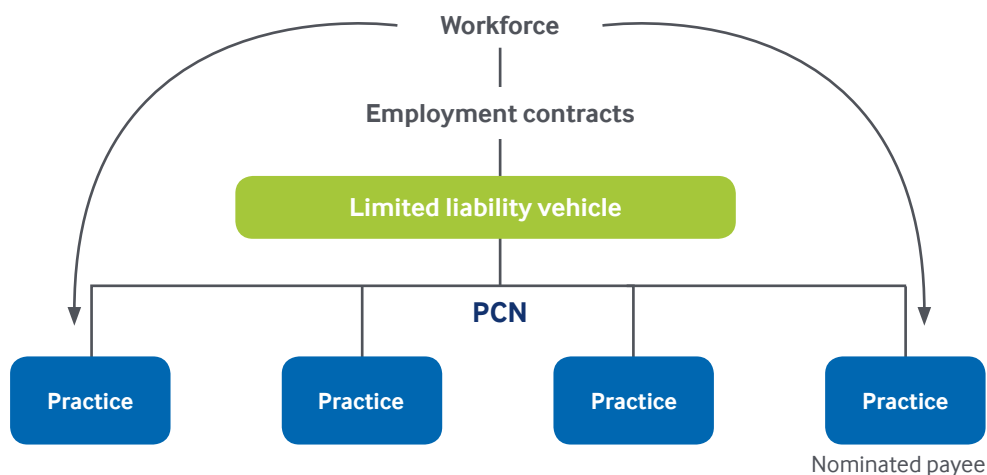
The lead provider could employ the network's staff and they will be seconded out to practices as required. Practices within the network will continue to employ their existing workforce. Funding under the DES will be provided directly to the lead provider on behalf of the network.

Under this structure, the lead practice will increase its exposure to unlimited liability as it employs the network workforce and HR obligations arise.

At a glance: risk assessment

- No pension issues envisaged.
- No significant employment issues are envisaged when it comes to the employment of workforce albeit it is anticipated that the 'place of work' will need to be defined as all member practices, and it's likely there will need to be assurances of appropriate safe working environments across the network. Lead practice HR processes may be applied.
- Liabilities may prove an issue (including, in particular, employment liabilities) as these are likely to lie with the lead practice (which, to the extent operated as partnerships or by a sole contractor, will have unlimited liability).
- Possible VAT issues caused by sharing staff.
- No CQC issues envisaged.
- Must have an overarching agreement beyond the network agreement setting out governance, how liability would be split, exit/entry, etc.
- Could involve the need for subcontracting between constituent parts of the network, depending on service arrangements.

3. GP federation/provider entity



The respective member practices would continue to employ their normal staff and provide their core GMS services, but the provider entity would be subcontracted to deliver services required by the DES and employ the range of staff necessary to do so. These services would be funded by the monies received via the DES.

Under such an arrangement funding would need to be paid to the member practices, to then be passed on to the federation. Theoretically, if the provider entity itself was party to a primary medical services contract, it could sign up to the DES itself, alongside its constituent practices, and receive the funding directly under a lead provider model.

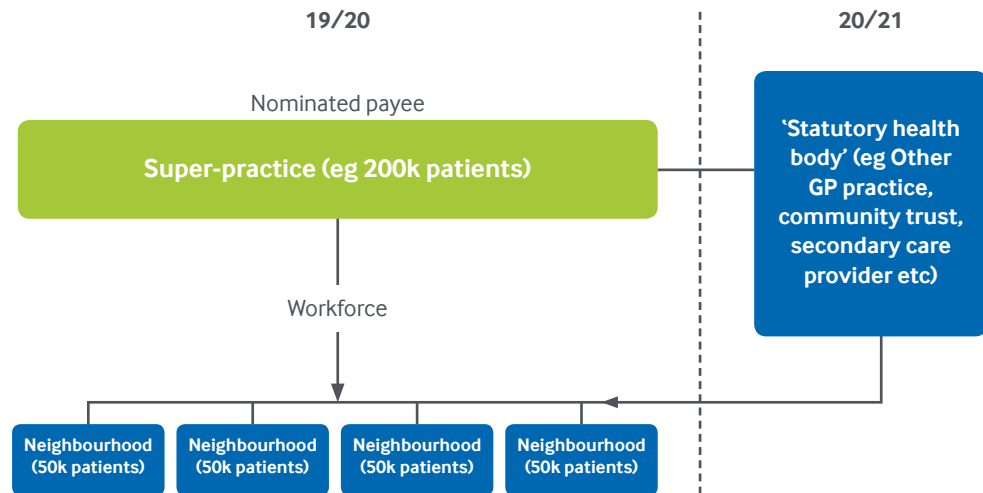
The provider entity could also operate as a cost sharing group for VAT purposes, with each of the practices as members (e.g. as shareholders within a limited company). Services provided from the provider entity to the network practices can then be charged at cost, and exempt from VAT, provided that there is no profit margin within those charges.

While this model limits the subsequent liabilities that practices are exposed to as the network workforce grows, staff employed by the limited liability vehicle are unlikely to be eligible to access the NHS pension fund, unless the employing organisation holds an NHS contract. This issue is currently under discussion with NHS England and we are hopeful of a resolution. However, it may be that practices decide to develop the network initially under a different model, with an expectation that they will change to a limited liability model once this and other potential issues are resolved.

At a glance: risk assessment

- Pension issues – staff employed by the limited liability vehicle are unlikely to be able to access the NHS pension scheme under the current access rules (unless it held an NHS contract in its own right).
- No employment issues envisaged.
- Employment liabilities are limited as the employer, being the provider entity, has limited liability.
- Possible need for CQC registration depending on who is providing the 'regulated activity'.
- Possible VAT issues.
- Is the provider entity or federation too big or far removed from the PCN to deliver as the DES intends?
- Is the provider entity or federation undertaking other services which are likely to impact on its ability to deliver under the DES?
- Care will be needed to ensure any subcontracting arrangements comply with the provisions of GMS regulations.

4. Super-practice as a network



It is possible under the DES for a single super-practice to sign up for the DES and develop a network itself, due to its existing size and patient population, particularly those with a patient population over 100,000. The details and viability of this may depend on the contractual and geographical status of the respective super-practice (eg how many sites does it have, what is its geography, does it hold one contract or multiple, etc).

How this could work as a PCN

As a single entity the super-practice would need to create an internal 'network' among its constituent sites, with each 'neighbourhood' of practices operating as a mini network in themselves.

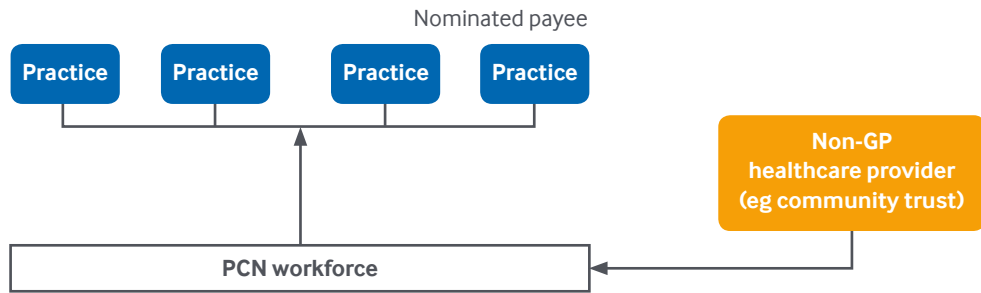
The super-practice would be the nominated payee and would then supply support and resources to its constituent neighbourhoods. Exactly how this internal 'network' operates is down to the super-practice itself to determine (ie will there be a single clinical director or will each neighbourhood have its own, how will the respective neighbourhoods interact, etc)?

Note that while in the first year the super-practice would be able to operate solely, from 2020/21 it is expected that such a model would require the sign-up of another health body in order to qualify for 'network' status.

At a glance: risk assessment

- No pension issues envisaged.
- No employment issues envisaged.
- Employment liabilities would exist for the super-practice (unless constituted as a limited company).
- No CQC problems envisaged.
- No VAT issues envisaged.

5. Non-GP provider employer models



Practices may wish to ally themselves with another local healthcare provider from the start, such as a community trust, which through signing up to the network agreement alongside the GP practices can provide network-level services on behalf of the PCN.

How this could work as a PCN

Under this arrangement the non-GP provider would be signed up to the network agreement, along with the GP practices. They could employ staff available under the DES on behalf of the network, as well as potentially using their own staff on its behalf to further enhance the potential workforce.

As the funding for staff reimbursement is provided under the DES, this would still need to be paid to the nominated payer practice. Arrangements would therefore need to be made within the network agreement as to how that could be passed on to the non-GP provider.

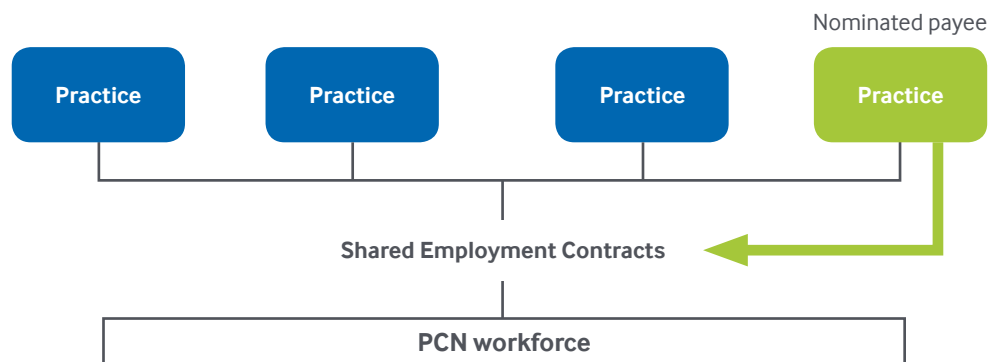
At a glance: risk assessment

- No pension issues envisaged.
- No employment issues envisaged.
- No employment liabilities for the constituent practices as staff are employed by the non-GP provider.
- No CQC problems envisaged.
- Possible VAT issues if the network agreement is structured incorrectly and the non-GP provider is deemed to be providing staff, rather than services.

Funding distribution

The organisational structure of a PCN will in part determine how its funding flows between the constituent parts of the network. In all cases, practices will need to nominate a lead provider to whom the PCN funding is paid. The nominated payee should take care to ensure this funding is kept separate from their practice accounts. This funding can then be used or redistributed across the network as required. The below diagrams (based on the five PCN structures outlined above) illustrate some ways in which this could operate, with possible funding flows in green. These are examples of just some of the ways networks can be structured, and in all cases it is essential to take your own legal and financial advice on the potential legal and tax implications.

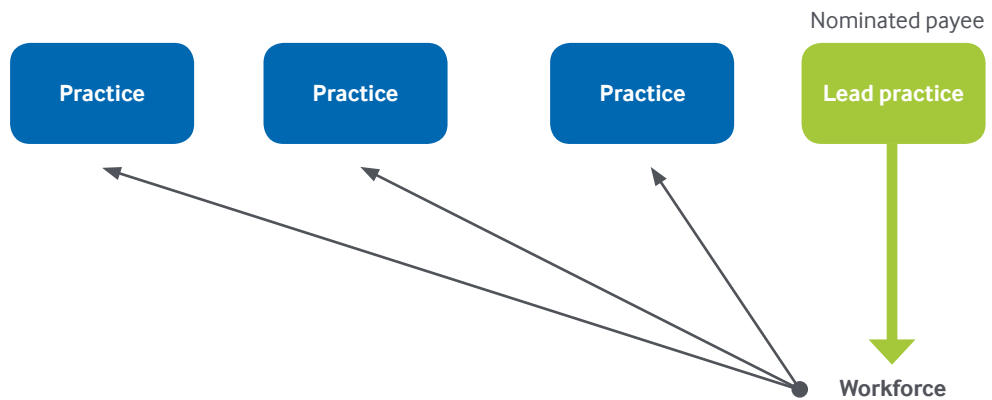
1. Flat practice model



In a 'flat practice model' network, workforce engagement and other expenses are shared across the member practices. This requires participant practices to have a clear agreement between them, setting out precisely how the workforce will be employed (e.g. individual contracts between each employee and each practice on a part time basis. Will one practice employ the clinical pharmacist and another the social prescriber, with each practice taking on a different part of the PCN workforce as they are introduced? Other considerations include how funding is shared across the network to cover each practice's expenses, and how any subsequent liabilities may be shared across the partner practices.

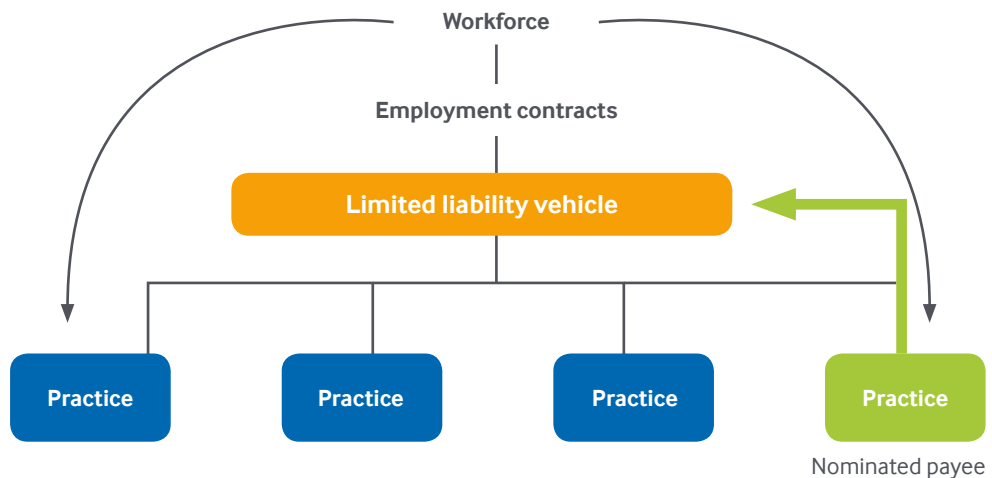
However practices decide to operate within this broad model, network-related payments will be paid by the commissioner to the nominated practice, as set out within the network agreement (excluding the network engagement funding, which is paid directly to the practices). The nominated practice then handles payment for the shared employment contracts.

2. Lead practice model



Under a 'lead practice model' a single constituent practice within the network, which is also the nominated payee in the network agreement, takes sole responsibility for the organisation of the PCN, including engaging and employing the additional workforce and the clinical director. In such a structure there will need to be appropriate governance arrangements between the member practices to ensure appropriate oversight of the funding and to avoid any potential conflict between practices over its use.

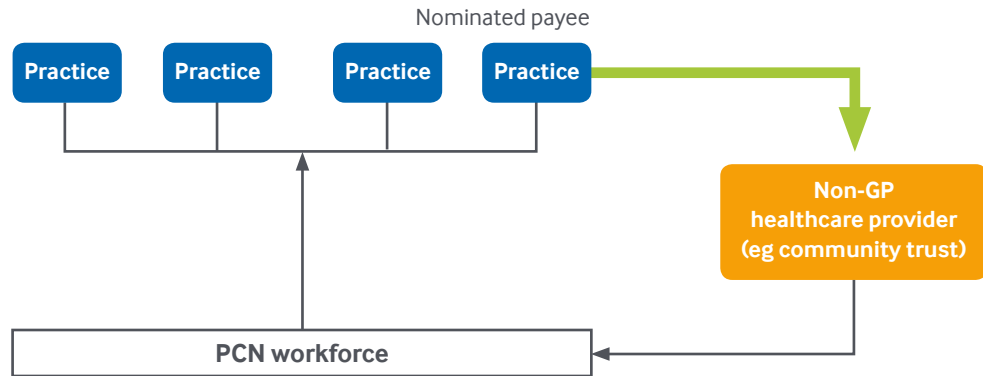
3. GP federation/provider entity



In this model, staff are engaged via a separate provider vehicle, which can be set up as a limited liability vehicle in order to minimise the potential increase in liability for member practices as the PCN workforce develops and grows over subsequent years.

Under this model the provider vehicle employs the network workforce and clinical director on behalf of the PCN. The nominated payee therefore needs to transfer funding to the provider vehicle as required to cover the workforce costs. Should the provider vehicle hold a GMS/PMS contract itself, however, as some provider entities/ federations do, this is not necessary as the provider entity/federation could be named as the nominated payee for the network.

4. Non-GP employer



If a non-GP provider is providing services or staff on behalf of the network, practices will need to set up a way for the workforce funding paid to the nominated payee to be passed on to the additional provider. As this funding is paid under a DES, even if the non-GP provider is formally included in the network agreement, the funding could not be paid directly to them – it would have to be paid to the nominated payee practice first. A subcontracting arrangement might be appropriate.

In producing this kind of arrangement, practices will need to be extremely careful that what is provided by the non-GP provider is a healthcare service, and not just staff, in order to avoid attracting VAT costs.

The PCN clinical director

While all networks must have a named clinical director, how that post is filled and by whom is up to the member practices, collectively, to decide. Selection and appointment could be undertaken in a number of ways – for example, by election among member practices or by an appointment process. Whichever method the network uses, it is highly recommended that appropriately robust governance procedures are put into place. This will ensure the appointment has been made with due diligence and the support of the network's membership.

The role profile for the clinical director is appended to the [contract agreement document](#) and outlines its responsibilities. It is expected that the clinical director will be selected from the GPs of the practices within the network, but any appropriate clinically qualified individual may be appointed, including individuals from within the PCN additional roles. The clinical director must know and understand the practices of the network, in order to provide the appropriate leadership required to establish and develop a successful network.

Networks may seek the support of the LMC in the appointment process, to provide a degree of separation and because LMCs have experience of running elections and appointment processes.

Consideration will need to be given to how the funding provided for the clinical director role is used. It could be given directly to the clinical director as a form of remuneration, or if the clinical director is a partner or employee of a member practice, it may be given to that practice to fund the necessary backfill to cover their absence from the practice while undertaking their PCN duties. In bigger PCNs, member practices may decide to provide additional staff support to their nominated clinical director, to reflect the increased scope of the role. However the funding is provided for the clinical director role, PCNs will need to be mindful of potential tax, national insurance and pension implications.

The clinical director's role includes:

- developing relationships and working closely with other PCN clinical directors, LMCs, local commissioners and clinical leaders of other health and social care providers
- working collaboratively with other PCN clinical directors, playing a critical role in helping to ensure full engagement of primary care in developing and implementing local system plans
- providing strategic and clinical leadership to the PCN, developing and implementing strategic plans, leading and supporting quality improvement and performance across member practices
- providing strategic leadership for workforce development through assessment of the clinical skill mix and development of a PCN workforce strategy
- supporting PCN implementation of agreed service changes and pathways, and working with member practices and the commissioner and other networks to develop, support and deliver local improvement programmes aligned to national priorities
- developing local initiatives that enable delivery of the PCN's agenda by working with commissioners and other networks to meet local needs and ensure comprehensive coordination
- facilitating member practices to take part in research studies and acting as a link between the PCN and local primary care research networks and research institutions
- representing the PCN at CCG, ICS and STP-level clinical meetings
- contributing to strategy development and the wider work of the ICS.

Appointing a clinical director

How the network's clinical director is selected is entirely at the discretion of the network. However, there are two methods that practices should consider:

Appointment

Practices may wish to select a clinical director based on a normal appointment process, as they would for any other role within a practice. This would require inviting applications for the role from among the network's membership, convening a selection panel from the member practices and coming to a collective decision on who to appoint, assessing the applications against an agreed person specification.

Election

Alternatively, practices may wish to select the clinical director by election. This can be undertaken by inviting expressions of interest, via submitting personal statements. An election process would then be held among the constituted network board, or across all partners in the network. If unsure as to how to hold the election, the relevant LMC can offer advice and support.

In both cases we highly recommend that there be an open and transparent process of selection, in which all interested candidates are able to participate, and which has the full support and sign-off of the constituent members of the network.

Practices may also want to ensure that those standing have the necessary competencies by using a prior assessment process. This would combine elements of both approaches, with assessment leading to a shortlist, from which candidates can then be put forward for election.

While there is no requirement for the clinical director to be appointed from within the network, we recommend that the first option should be to consider an appointment from within, as a failure to do so risks reducing the local ownership of leadership and decision making. Some practices may wish to recruit externally for someone to take on the role in the long term. Due to the need to be able to get various aspects of the network up and running in a relatively short space of time however, an internal appointment is strongly recommended at least initially.

Working with non-GP organisations

Whilst the focus for most PCNs so far will have been on delivering the DES requirements via the core GP membership, it's important for PCN's and their constituent practices to also give thought as to bringing in non-GP member organisations, such as local community pharmacies or community trusts.

'Non-core' members

Within the mandatory PCN agreement there is scope to include non-GP organisations as 'non-core members' of the PCN (in contrast to the 'core member' practices). If deciding to do so it's important to ensure that the network agreement clearly sets out the relationship between the core and non-core members. In doing so there are a number of questions that member practices should consider:

- What roles/duties will the respective non-core members fulfil within the PCN?
- What role will they have in decision making? i.e. will they be able to vote at PCN meetings?
- Will they bear any liability for PCN activities?
- When admitting other members, you will need to ensure that your network agreement clearly identifies the rights and obligations of non-core members and their role in the PCN.

Benefits

Bringing non-GP organisations into the PCN can provide a number of benefits both at a practice and PCN level.

Relationship management

The formalisation of the relationships between practices and other local health organisations via the PCN network agreement could help to develop and regulate local relationships in future years. Defining the role of each organisation and how it relates to the CN and its member practices can help to guide members and resolve disputes between local parties, particularly when it comes to service responsibilities and funding flows.

It's important to be aware that it will take time to develop a full working relationship between practices and their community partners and there will undoubtedly be some disagreements early on. In the first instances these relationships are likely to be focused between the respective leadership teams, and so they will need to play a central part in working to resolve any disputes.

Service delivery and workload management

As the new PCN services come into the DES, non-core PCN members could provide a viable route to support practice members in their delivery. This could in turn lead to such arrangements improving workload management for practices within the PCN. More formalised relationships could help to improve local care pathways, and improving patient referral into specialised care and reducing inappropriate workload shift from secondary into primary care

PCNs & VAT

When developing their PCN, practices will need to be very careful with regards to any potential tax implications of their funding or employment structure.

The provision of healthcare services by a 'registered health professional' is exempt from VAT. In addition, healthcare services which are wholly performed or directly supervised by a GP, physiotherapist, paramedic or qualified nurse (amongst others) will also qualify for exemption from VAT.

However, complications may arise depending upon how PCN staff, funded through the ARRS, are contracted and deployed across the respective member practices.

Whilst most 'supplies' to support the delivery of the Primary Care Network Contract DES (e.g. between members of a network or to a network from another organisation) should therefore generally be exempt from VAT, the situation will be more complicated and VAT is likely to be chargeable in situations when, for example, a member of staff is provided by one party to another for a charge (e.g. a secondment), as opposed to providing the services of a member of staff; and/or the services being provided are not considered to qualify as health services. In addition, there is also often a fine line between whether the supply is one of services or staff and the contractual and commercial reality will need to be considered carefully when identifying the nature of the supply.

Whilst [the BMA](#) and [NHS England](#) have produced some broad outlines of these issues to inform considerations **it remains extremely important that PCNs take professional advice on their respective arrangements in order to ensure that they are fully tax compliant and won't inadvertently attract additional tax charges.**

Data sharing

In order to operate effectively as an entity, data sharing agreements need to be set up between the constituent practices, as well as any non-GP organisations that are party to the network, to allow all parts of the network to access necessary patient data (medical records, etc

As part of the PCN DES, networks will need to have in place a relevant Data Sharing Agreement, to allow the sharing of data and information between members, and ensure that the PCN and it's constituent practices remain compliant with relevant data protection regulations.

To help facilitate this, NHS England and the BMA have previously agreed on a, non-mandatory, [high-level data sharing template](#) for use by PCNs.

To make things simpler for those practices and networks who may not have entered such an agreement before, the BMA has also produced a version of the agreed template, which expands on a number of areas within the template and allows for the addition of more complete schedules within the agreement, along with additional guidance to aid practices with a better idea of how they may wish to populate the template agreement, including proposed best practice when sharing and transferring data between partners within the network.

This expanded Data Sharing Agreement can be download from the [BMA website](#).

However, as these are only template data sharing agreements, the details of which need to be populated by the network itself, it is strongly recommended that the final proposed agreement is reviewed by a qualified professional to ensure it is compliant with the various aspects of data protection legislation.

Dispute resolution

Practices need to ensure that there are clear dispute resolution procedures for the PCN in place, so that any disagreements between constituent members of the network can be resolved appropriately and these should be set out within the Network Agreement. The Network agreement contains some standard clauses which set out a basic process for resolving disputes between parties within the PCN. However, some PCNs may have decided to implement their own procedures into the schedule of the agreement in order to provide a more comprehensive and exhaustive process. These will be set out within Schedule 2 of the Network Agreement and will replace the standard clauses.

All parties to the Agreement should be aware of the relevant procedures under their Network Agreement when raising disputes with their network partners.

PCNs are also advised to draw on their relevant LMC as an independent mediator in any such processes. LMCs will be able to utilise their local knowledge and experience in providing advice on dealing with disputes.

Should attempts at resolution fail, the PCN DES and the template Network Agreement and PCN DES specification do contain clauses by which individual practices within the PCN can be removed from the network. The process for expulsion is set out in paras [71-79 of the Network Agreement](#) and section 6.7 of the [PCN DES Specification](#).

Whilst this may in some cases be the only way to resolve such situations, it is highly recommended that this is only utilised as an option of last resort where all other options, such as the voluntary transfer of the practice(s) to an alternative suitable PCN, have failed. In such instances where a practice is expelled from a PCN and still wishes to partake in the PCN DES, the commissioner will be required to find a suitable alternative PCN for the practice. If no PCN is agreeable to taking on the practice(s), the commissioner will be required to allocate the practice(s) to a suitable alternative PCN.

Opting out of the PCN DES

From April 2021 the PCN DES operates on an opt-out basis, with participating practices automatically enrolled in each annual PCN DES (and any subsequent in year variation), unless they choose to opt-out. This saves participating practices from having to individually sign up to the service each year and helps to ensure the stability of the PCN during the contract year. However, as a departure from the manner in which GMS Enhanced Services normally operate, practices should be aware of the requirements should they wish to cease participating in the PCN DES for any reason.

Opt out windows

There will be a 30 day opt out window following any national variation of the PCN DES. Most commonly this will take place through each year following the introduction of the annual contract changes and the deadline for opting out of that year's DES will be laid out within the respective specification, with the window for 2021 lasting until the end of April that year. Practices who do not wish to continue participating in the DES for the following year must inform the commissioner of this before the stated deadline.

In addition to this, there will also be op-out windows should an in-year change to the DES be agreed. In this situation the opt-out window will run for 30 days from whenever the variation to the DES is published.

If choosing to opt out of the DES, a practice will also need to be removed from the respective Network Agreement. The process for this is set out in paras [60—70 of the Network Agreement](#) and the commissioner should be informed of the change via the [PCN DES participation form](#).

These opt-out windows do not affect the ability of a practices to cease its participation in the DES in cases of:

- expiry or termination of the primary medical services contract
- irreparable breakdown in relationship or expulsion
- a merger or split of the Core Network Practice (subject to approval of the commissioner)
- breach of the PCN DES requirements by a practice.

PCN funding 2021/22

Under the PCN DES, several different funding streams will be made available to networks to fund their workforce and services. When developing the network, practices need to consider how the funding will be used and distributed across the network, as while all funding will be paid to the nominated payee set out in the network agreement, the flow of funding between different parts of the network will vary depending on its structure. This guidance sets out the different funding streams available within the first year of the DES and gives examples of how funding may be distributed under different models. Practices should also look at the updated [ready reckoner](#) from NHSE

Overview of funding for 2021/22

Funding under the DES will be paid to a nominated provider within the network as set out in its network agreement (with the exception of network engagement funding, which will go direct to practices), and will consist of several streams:

Network engagement funding – to practices individually

Practices will receive an annual payment of £1.76 per patient (weighted) for engagement with the primary care network scheme, via the SFE. While paid in connection with the PCN DES, this is a practice payment and it is therefore up to practices to decide how they wish to use it (eg to cover core practice expenses).

Network core payment

There will be a recurrent payment of £1.50 per patient (registered) as an entitlement for networks, from CCG central allocations. This is an extension of the £1.50 per head previously available between 2017–19 via CCGs, which was used in various ways across the country. Provision of this funding is an entitlement under the DES and is no longer discretionary or subject to any further requirements than those laid out within the DES specification. Its use will be entirely for the network collectively to decide and is intended to support the day-to-day operation of the network.

Extended Hours funding

The funding currently associated with the Extended Hours DES will transfer (with the associated responsibilities) to the network. This will be provided as an entitlement to the network's nominated bank account of £1.45 per registered patient. The network will decide how this funding is distributed in line with the provision of services required to fulfil the requirements of extended hours.

Implementation of a combined access offer under the Network Contract DES, combining the funding currently in the Network Contract DES for extended hours access together with the wider CCG commissioned extended access service, has been postponed until 2022. A nationally consistent offer will be developed and discussed with GPC England and patient groups, reflecting what works best in existing local schemes, with the intention to bring together extended hours and extended access activity to reduce fragmentation and confusion for practices and patients.

Local commissioners should therefore continue with local arrangements until April 2022. Where the PCNs wish to take on the existing extended access service ahead of April 2022, they should approach the commissioners directly to discuss this.

Investment and impact fund

The Investment and Impact Fund (IIF) was introduced as part of the Network Contract DES in 2020, with PCNs rewarded for delivering objectives set out in the NHS Long Term Plan and the five-year agreement document.

IIF funding will rise to £150 million for 2021/22, as previously agreed. However, there will be a more phased approach to the introduction of new IIF indicators for 2021/22. Indicators on seasonal flu vaccination (including for over 65s, patients aged 18-64 in a clinically at-risk group, and children aged 2-3 years), annual Learning Disability Health Checks and Health Action Plans, and social prescribing referrals will continue for 2021/22.

From 2021/22, at least £30m of the £150m IIF will reward better access, rising in 2023/24 to at least £100m of the £300m.

Monies earned from the Fund must be used for workforce expansion and services in primary care. Each PCN will need to agree with their CCG how they intend to reinvest monies earned. This can take the form of a simple reinvestment commitment.

The new 'Care Home Premium' will provide a payment of £120 per bed per year. This was first introduced in 2020 at £60 for the first year as the requirement to deliver services to care homes did not start until October 2020.

The table below outlines the IIF indicators for 2021/22, the points and funding available for each indicator.

Indicator	Points available	Lower threshold	Upper threshold
Prevention and tackling health inequalities domain			
Vaccination & immunisation area			
VI-01: Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September and 31 March	32 points	80%	86%
VI-02: Percentage of patients aged 18 to 64 years and in a clinical at-risk group who received a seasonal influenza vaccination between 1 September and 31 March	72 points	57%	90%
VI-03: Percentage of children aged 2-3 who received a seasonal influenza vaccination between 1 September and 31 March	11 points	45%	82%
Health inequalities area			
HI-01: Percentage of patients on the Learning Disability register aged 14 or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan	29 points	49%	80%
Providing high quality care domain			
Personalised care area			
PC-01: Percentage of patients referred to social prescribing	16 points	0.8%	1.2%
Access area			
ACC-05: Confirmation that all practices in the PCN have mapped all active appointment slot types to the new set of national appointment categories, and are complying with the August 2020 guidance on recording of appointments	22 points		N/A

ARRS & workforce funding

The DES provides for workforce reimbursement for the network covering a number of specified health professions and is designed to allow the network to build up an expanded primary care team under the PCN Additional Roles Reimbursement Scheme (ARRS). The network will need to provide a monthly invoice with evidence of costs to its CCG, and will be reimbursed the required amount up to the maximum reimbursement, as set out below. The maximum reimbursable amount for each of these roles will be set at the weighted mid-point of the respective Agenda for Change salary band.

The maximum available funding for the ARRS will increase from a maximum of £430m in 2020/21 to a maximum of £746m in 2021/22.

The Network Contract DES Additional Roles Reimbursement Scheme has been expanded to include::

- Paramedics
- Advanced practitioners
- Mental health practitioners

Unlike the other ARRS roles, mental health practitioners will be employed and provided under a local service agreement by the PCN's local provider of community mental health services and embedded within the PCN. PCNs will be entitled to a service equivalent to one FTE practitioner for PCNs under or at 99,999 registered population; and two for PCNs larger than that. PCNs will contribute 50% of the salary and employers NI/pension costs associated with the individual(s) delivering the service. The remaining costs will be covered by the mental health provider. A model service level agreement, which can be adapted for local use is available on the ['NHS Futures'](#) website.

Further information on each of the workforce roles available under the ARRS can be found in the ['Workforce & Employment'](#) section of this handbook.

Additional Roles Reimbursement Sum

Each PCN is allocated an Additional Roles Reimbursement sum for the year, based upon the PCN's weighted population share of the total Additional Roles Reimbursement Scheme funding and PCNs are able to claim up to this maximum sum each year

Each PCN's Additional Roles Reimbursement Sum uses the combined Contractor Weighted Population¹ of all member practices, as of 1 January that year, and is calculated as follows:

$$\text{PCN's weighted population share} = \frac{\text{PCN's weighted population}}{\text{Total England weighted population}}$$

This is then used to calculate the PCN Additional Roles Reimbursement Sum:

$$\text{PCN's Additional Roles Reimbursement Sum} = \text{PCN's weighted population share} \times \text{total national workforce funding}$$

¹ Contractor Weighted Population as defined in Annex A of the Statement of Financial Entitlements (SFE) taken as at 1 January of the financial year preceding. The SFE confirms that this is the number of patients arrived at by the Global Sum Allocation Formula.

PCNs can use the [GMS Ready Reckoner](#) to calculate their Additional Roles Reimbursement Sum for the year.

2021/22 MAXIMUM ANNUAL REIMBURSEMENT RATES

Role	AfC band	Maximum reimbursable amount over 12 months (with on costs)
Advanced practitioner (Clinical pharmacist, Physiotherapist, Dietitian, Podiatrist, Occupational therapist, Paramedic)	8a	62,705
Care coordinator	4	29,726
Clinical pharmacist	7-8a	56,829
First contact physiotherapist	7-8a	56,829
Mental health practitioners *	5 / 6 / 7 / 8a (depending on the individual registered clinician providing the service)	18,057 -31,352*
Nursing Associate	4	29,726
Occupational therapist	7	54,841
Paramedic	7	54,841
Pharmacy technician	5	36,114
Podiatrist	7	54,841
Social prescribing link worker	Up to 5	36,114
Physician associate	7	54,841
Trainee Nursing Associate	3	26,188

*The maximum reimbursement rates are set at 50% of the standard levels, reflecting the 50%

PCN contribution to the salary and employer NI/pension costs of the individual(s) delivering the service. The rest of the costs are borne by the local community mental health provider.

Clinical director funding

Funding for the clinical director post is provided to each network on a basis of 0.25 WTE per 50,000 patients, at national average GP salary (including on-costs). This is provided on a sliding scale based on network size. The relevant WTE funded costs can be calculated using the [ready reckoner](#).

Additional funding

The funding entitlements for networks represent a baseline. Commissioners cannot remove or reduce the entitlements, but they can add to them. The planning guidance states real-terms investment in primary and community services 'should grow faster than CCGs overall revenue growth', as set out in the LTP, and further guidelines will be issued showing how to measure this.

Locally funded services

Where a LES/LIS already exists for a service that is duplicated by the DES requirements, no decommissioning of that service by the CCG should take place until the DES requirements commence. For the care homes service, for example this will be 1 October 2020. Where the requirements in an existing LES/LIS exceed those in the DES, commissioners must, engaging with PCNs and LMCs and taking account of the PCN employment liabilities directly linked to delivery of the LES/LIS, consider maintaining this higher level of service provision to their patients, alongside an appropriate portion of existing funding additional to the entitlements of the national contract. And all funding previously invested by CCGs in LES/LIS arrangements which are now delivered through the DES must be reinvested within primary medical care. LMCs should be fully engaged on reinvestment proposals and provided with an annual investment report – drawn from CCG annual accounts – of how the CCG has used its primary medical care funding allocation.

PCN Service Requirements

Extended Hours Access

As part of the initial 2019 5-year contract deal, it was agreed that the national extended hours DES and the local extended access schemes would both move to a new PCN based combined access scheme, within the PCN DES.

The Extended Hours DES (and its associated funding) was therefore incorporated into the PCN DES in 2019, with extended access scheme, and funding, scheduled to follow in 2021, once the last of the local contracts had expired. However, this has now been delayed until 2022/23.

The PCN Extended Hours Access requirements for 2021/22 therefore remain the same as in 2020/22. The full specification is available via [NHS England](#), and the core requirements are summarised below

Summary of core requirements

A PCN must provide extended hours access in the form of additional clinical appointments in accordance with the Network Contract DES Specification, regardless of whether any practices within the PCN are providing any CCG commissioned extended access services in 2020/21.

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 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 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:
 - 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 patient's 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:

$$\text{additional minutes}^* = (\text{the PCN list size}^{**} \div 1000) \times 30$$
- 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

How the PCN will deliver its extended hours access appointments must be set out within the PCN's Network Agreement. Whilst there is no requirement that every practice within the PCN delivers a particular share of the appointments, all member practices must be actively engaged with and agree to the PCN's access planning and provision. 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 within the service specification.

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 and must ensure that all patients within the PCN are notified of the cancelled and rescheduled appointments.

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.

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.

A PCN must also ensure that 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 that 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.

Early Cancer Diagnosis

NHS England's Long Term Plan contained an aim for improving cancer outcomes in England by increasing the proportion of cancers diagnosed at stages 1 and 2 to 75 per cent by 2028. The PCN ECD service requirements for PCNs seek to improve referral practice and screening uptake through network level activity by

1. improving referral processes for suspected cancers, with a focus on safety netting, ensuring that all patients receive information on their referral
2. Contributing to improving local uptake of National Cancer Screening Programmes working with local system partners
3. Supporting the delivery of 1) and 2) through a community of practice which supports peer to peer learning events, and engagement with local system partners

The below outlines the core requirements of the ECD service for PCNs, the full specification of which is available via [NHS England](#). Additional support resources are also available via the [Cancer Research UK website](#).

Summary of core requirements

PCNs are required to:

- a. Review referral practice for suspected cancers, including recurrent cancers. To fulfil this requirement, a PCN must:
 - i. review the quality of the PCN's Core Network Practices' referrals for suspected cancer, against the recommendations of NICE Guideline 12 and make use of:
 - clinical decision support tools;
 - practice-level data to explore local patterns in presentation and diagnosis of cancer; and
 - where available the Rapid Diagnostic Centre pathway for people with serious but non-specific symptoms;
 - ii. build on current practice to ensure a consistent approach to monitoring patients who have been referred urgently with suspected cancer or for further investigations to exclude the possibility of cancer ('safety netting'), in line with NICE Guidelines
 - iii. ensure that all patients are signposted to or receive information on their referral including why they are being referred, the importance of attending appointments and where they can access further support.
- b. Contribute to improving local uptake of National Cancer Screening Programmes. To fulfil this requirement, a PCN must:
 - i. work with local system partners – including the Public Health Commissioning team and Cancer Alliance – to agree the PCN's contribution to local efforts to improve uptake which should build on any existing actions across the PCN's Core Network Practices and must include at least one specific action to engage with a group with low-participation locally;
 - ii. provide the contribution agreed within timescales agreed with local system partners.
- c. Establish a community of practice between practice-level clinical staff to support delivery of the requirements set out in sections 7.4.1.a to 7.4.1.b of the Network Contract DES Specification. A PCN must, through the community of practice:
 - i. conduct peer to peer learning events that look at data and trends in diagnosis across the PCN, including cases where patients presented repeatedly before referral and late diagnoses;
 - ii. engage with local system partners, including Patient Participation Groups, secondary care, the relevant Cancer Alliance and Public Health Commissioning teams.

Enhanced Health in Care Homes

Definition of a care home

For the purposes of the EHCH service requirements in the Network Contract DES specification, a 'care home' is defined as a CQC-registered care home service, with or without nursing and whether each home is included in the scope of the service is therefore determined by its registration with CQC.

The [CQC website](#) contains a spreadsheet which can be filtered to show CQC registered care homes and all care homes in this directory are in the scope of the EHCH service

Alignment of Care Homes to PCNs

Commissioners hold overall responsibility for ensuring that each care home is aligned to a single PCN, and this is an ongoing obligation. Initial alignment of existing homes to PCNs should have been established by 31 July 2020.

This alignment should be in line with the following criteria:

- Where the home is located in relation to PCNs and their constituent practices
- The existing GP registration of people living in the home
- What contracts are already held between commissioner and practices to provide support to the home, or directly between the home and practices
- Existing relationships between care homes and practices

In instances where there are changes in circumstance after the initial alignment decision has been made - for example when new homes open, or if there is a change to the PCN such that one or more practices no longer participates in the Network Contract DES - the commissioner must align a PCN to that home within three months of becoming aware of the alignment not being in place.

Care home premium

To support practices in delivering this service, PCNs will receive a 'care home premium' which will provide an additional and specific contribution of £120 per bed per year to help cover the additional cost of providing services to patients in care homes.

Core requirements

The Enhanced Health in Care Homes service was introduced during 2020 in several stages, with full implementation required from October 2020. For 2021/2 the requirements remain unchanged.

By 31 July 2020

By the end of July 2020 PCNs needed 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 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.

30 September 2020

By the end of September 2020 PCNs needed to:

- 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.

1 October 2020

The service should have started in full form October 2020. This required the PCN to:

- 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, 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 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 Guidelines

Structured Medication Review and Medicines Optimisation

Core requirements

For the Structured Medication Review and Medicines Optimisation service 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 (SMR), which must include patients:
 - i. in care homes;
 - ii. with complex and problematic polypharmacy, specifically those on 10 or more medications;
 - iii. on medicines commonly associated with medication errors;
 - iv. with severe frailty, who are particularly isolated or housebound patients, or who have had recent hospital admissions and/or falls; and
- 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
- g. work with community pharmacies to connect patients appropriately to the New Medicines Service, which supports adherence to newly prescribed medicines; and
- h. have due regard to NHS England and NHS Improvement guidance on Structured Medication Reviews and Medicines Optimisation.

New PCN Services for 2021/22

It's been agreed between the BMA and NHS England that the four additional service specifications originally scheduled to be introduced in April 2021 (personalised care, anticipatory care, tackling neighbourhood inequalities and CVD diagnosis) will be delayed, as practices and PCNs prioritise their response to the Covid-19 pandemic and the subsequent vaccination programme.

Practices will be informed once the service specifications and their date of introduction have been agreed.

Workforce and employment

Introduction

PCNs will be supported in developing an expanded primary care team, with member practices also working alongside other organisations such as community trusts and the voluntary sector, to help deliver the PCN services and to alleviate workload pressures on practices and allow GPs to concentrate on the most complex patients. While the engagement of additional staff is not a requirement of the DES, an expanded primary care workforce will be necessary in order to undertake elements of the scheme as it is expanded over the coming years.

The workforce and employment elements of a network will depend on the structure of the network, and the reconfiguration of services.

What does the PCN DES mean for workforce and employment?

The DES provides 100% reimbursement for workforce engagement across the network, which includes on-costs (such as employer pension contribution and National Insurance costs), covers a number of specified health professions and is designed to allow the network to build an expanded primary care team.

The aim is to introduce over 26,000 additional staff under the Additional Roles Reimbursement Scheme to the primary care workforce over five years.

What counts as 'additional workforce'?

Core Network Practices and commissioners will be required to maintain existing funding for baseline staff levels measured as at 31 March 2019 against six of the reimbursable roles – clinical pharmacists, social prescribing link workers, first contact physiotherapists, physician associates, pharmacy technicians, and paramedics.

This is in order to ensure the PCN ARRS roles are truly additional staff, and not simply replacing existing practice staff. The intention of the scheme is to grow additional capacity through new roles, and by doing so, help to solve the workforce shortage in general practice. It is not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care, whether funded by a practice, a Clinical Commissioning Group (CCG) or a local NHS provider. Reimbursement through the Additional Roles Reimbursement Scheme will only be for demonstrably additional people (or replacement of those additional people as a result of staff turnover).

Under the current rules, where there is an unexpected vacancy in a practice-funded role counted within the Additional Roles Reimbursement Scheme baseline, this would automatically lead to a commensurate reduction in claims by the PCN for an additional such role. A three-month 'grace period' will operate for vacancies in these practice-funded baseline roles, from the point at which the role becomes vacant, before the commensurate reduction in Scheme funding is applied. It does not apply to vacancies funded within the ARRS scheme.

From 1 April 2020, PCNs have been able to substitute between clinical pharmacists, first contact physiotherapists and physician associates within their practice-funded baseline, with the agreement of their commissioner which will not be unreasonably withheld. This provides additional flexibility such that not only will there be a three month period to recruit to a practice role, but the roles does not necessarily need to be like-for-like.

Other than pharmacy technicians, for whom a baseline was established in March 2019, the other roles added to the scheme are currently only employed in small numbers in primary care. A further baseline exercise would not be proportionate. When so declared by PCNs they will be deemed to be additional. However, some of the additional roles are restricted;

– The number of advanced practitioners will initially be limited to 1 WTE per PCN under or at 99,999 registered population; and 2 WTE for PCNs larger than that, until the HEE

advanced practitioner registration process has been established and implemented (expected by October 2021)

- Mental health practitioners will be limited to 1 per PCN for 2021/22. This entitlement will increase to 2 WTE in 2022/23 and 3 WTE by 2023/24, subject to a national review of implementation. For PCNs with more than 100,000 patients this doubles.

However, the existing limits on the number of pharmacy technicians and physiotherapists which can be reimbursed will be removed (provided the overall amount remains within the PCNs allocated additional roles reimbursement sum).

What employment terms should be used for PCN staff?

As is the case for practice-employed staff other than salaried GPs, there are no mandated contractual terms for staff employed under the PCN DES. However, when negotiating employment terms, practices should consider the levels of reimbursement available, which are linked to the Agenda for Change pay bands for each staff group.

PCN staff roles

Clinical pharmacists

What they can do²

Clinical pharmacists can carry out a wide range of activities, including:

- medication reviews, particularly in high-risk groups including:
 - the frail elderly
 - polypharmacy
 - renal impairment
 - hepatic impairment
 - substance misuse
 - patients on high-risk medicines
 - STOPP (screening tool for older people's potentially inappropriate prescriptions) / START (screening tool to alert doctors to right/appropriate treatments) identified patients
 - recurrent hospital admissions
- managing the repeat prescribing reauthorisation process by reviewing requests for repeat prescriptions and medicines reaching review dates
- improving prescribing practice through educational support for all prescribers in the practice
- leading on evidence-based changes in prescribing across the patient population, eg where a drug is withdrawn or indications change
- liaising with colleagues in community pharmacy to align support for medicines adherence, eg on Medicines Use Reviews and the New Medicine Service
- supporting improvements in clinical care through practice-based audit and implementing change
- offering prescribing advice to prescribers in the practice, eg temporary non-availability of drugs
- ensuring patient safety when they are transferred between care providers through reconciliation of prescribed medicine.

Job descriptions, sample job adverts and potential interview questions

To access template job descriptions, sample job adverts and interview questions you could use for clinical pharmacists, [visit the Primary Care Pharmacy Association website](#), scroll down and download the Guide for GPs Considering Employing Pharmacists, the GP Senior Pharmacist Job Description and the GP Clinical Pharmacist Job Description.

² [Practice based pharmacist job description, Pharmacists and GP surgeries](#), RPS (October 2016)

The Royal Pharmaceutical Society also offers guidance on the [practice-based pharmacist job description](#), role profile and purpose (scroll to the bottom of the page).

Benefits to patients

Patients often get to consult with pharmacists for two or three times longer than a doctor due to current GP workload intensity, eg 20–30 minutes, which they appreciate.

Medications are checked regularly and are appropriate for patients' conditions, and this improves wellbeing and quality of life if reviews have previously been too infrequent due to unmanageable GP and nurse workload. This reduces the likelihood of conditions worsening or leading to other complications and side effects that result in a future need for acute care.

All prescribers in the practice can learn from the clinical pharmacist and therefore use increasing medicines knowledge and expertise to improve patient treatment.

Benefits to practices

- GPs no longer carry out the activities that clinical pharmacists can carry out instead.
- Clinical pharmacists support the achievement of QOF indicators.
- Changes in prescribing practice can be implemented across the practice, eg where a drug is withdrawn or indications change
- Considerable savings can be made by improving prescribing processes across all prescribing staff
- Clinical pharmacists forge closer links with community pharmacy and improve patient advice / signposting
- All prescribers in the practice learn from the clinical pharmacist and therefore increase their own knowledge when consulting with and treating patients
- Patient access increases as patients consult with the clinical pharmacist rather than GP for medication needs and advice.

Benefits to the wider NHS

Closer monitoring and management of patient medicines improves their care, wellbeing, and their ability to self-care and manage their own conditions. This reduces avoidable urgent or emergency hospital attendances and the risks of medicine-related side effects, eg decreased renal or liver function or infrequently monitored dosages, are reduced. The demand on costly secondary and tertiary care services can be reduced due to improved management of patients following expansion of primary care capacity.

Clinical pharmacists can help reduce workload pressures for GPs and existing clinical colleagues across both primary and secondary care. Cost savings from improved prescribing practices will also have a positive impact in the practice and across the health system in terms of money saved and improved patient health and wellbeing.

Social prescribers

What they can do

Social prescribers can carry out a wide range of activities, including:

- identifying unmet needs – especially for the frail and vulnerable, those at risk of hospital admission, loss of independence or those coming toward the end of their lives
- spending time getting to know patients and their carers:
 - providing direct support
 - through regular contact by phone or home visits
 - open invitations to the surgery for a 'catch up and cuppa', and
 - regular 'getting to know you' events to meet with other people in similar situations.
- referring patients to appropriate VCS (voluntary, community and social enterprise) services
- continually building their knowledge of VCS groups and organisations that can help
- attending practice LTC (long-term condition) multi-disciplinary team meetings

- acting as a first port of call for nursing homes, initially handling issues such as prescription requests, visit requests and post-discharge coordination of services and medication.

Job descriptions, person specification and outcomes framework

NHS England has published a guide to [Social prescribing and community-based support](#). It contains an example job description and person specification, as well as information on an outcomes framework, the average cost of employing a social prescriber, an implementation checklist for local partners and commissioners.

Benefits to patients

- [People with LTCs and their carers benefit from access to additional, non-clinical support options via primary care](#)³
- Patients experience positive outcomes associated with their health and wellbeing, and
- Patients can become less socially isolated and more independent.

Benefits to practices

- Social prescribers can significantly reduce GP consultations ([by as much as 48%](#))
- One in five GPs regularly refer patients to social prescribing – 40% would refer if they had more information about available services
- GPs and their existing staff recognise the importance of social support as an alternative to medication
- Simple referral processes for GPs and other clinical staff are very helpful.

Benefits to the wider NHS

[Social prescribers are already having a positive impact on GP consultation rates, A&E attendances, hospital stays, medication use and social care](#).⁴

The [University of Westminster led an evidence review](#) looking at the impact of social prescribing on demand for NHS healthcare. The review found:

- an average of 28% fewer GP consultations and 24% fewer A&E attendances where social prescribing 'connector' services are working well
- [as much as a 33% reduction in A&E attendances and 58% reduction in unscheduled hospital admissions](#)
- that social prescribing generally improves people's health and wellbeing and contributes to building stronger communities
- social prescribing allows the provision of innovative community-based services that complement traditional medical interventions.

Workforce roles beginning from April 2020

Health and wellbeing coaches

What they can do:

- Coach and motivate patients through multiple sessions to identify their needs, set goals, and support them to implement their personalised health and care plan.

Provide personalised support to individuals, their families and carers to ensure that they are active participants in their own healthcare; empowering them to take more control in managing their own health and wellbeing, to live independently, and improve their health outcomes through:

- providing interventions such as self-management education and peer support; and
- supporting people to establish and attain goals set by the person based on what is important to them, building on goals that are important to the individual; and

³ [Rotherham social prescribing service](#), 10 High Impact Actions: Case Study 68, NHS England

⁴ [Social prescribing](#), NHS England

- working with the social prescribing service to connect them to community-based activities which support their health and wellbeing.
- Provide support to local community groups and work with other health, social care and voluntary sector providers to support the patients' health and well-being holistically.
- Ensure that fellow PCN staff are made aware of health coaching and social prescribing services and support colleagues to improve their skills and understanding of personalised care, behavioural approaches, and ensuring consistency in the follow up of people's goals where an MDT is involved.
- Raise awareness within the PCN of shared decision making and decision support tools and supporting people in shared decision-making conversations.
- Work with people with lower activation to understand their level of knowledge, skills and confidence (their "Activation" level) when engaging with their health and wellbeing.
- Explore and support access to a personal health budget, where appropriate, for their care and support.
- Utilise existing IT and MDT channels to screen patients, with an aim to identify those that would benefit from health coaching

Benefits to patients

- Interventions that 'coach' or actively support people to self-care
- It is person-centred, empowering and based around a person's own aspirations and goals
- Increased patient activation
- Increases in preventative behaviours and self-management
- Improved two-way communication and partnership working
- Improved health outcomes

Benefits to practices

- Patient activation is associated with fewer visits to general practice
- Support for people to self-manage their own health is increased
- Reduced demand for care due to improved patient wellbeing
- Increased efficiency due to quicker discharge from caseload and potential to cut waiting times
- Less waste from unnecessary tests and medication
- Long term sustained benefits in terms of cost reductions and service development
- Reported increase in job satisfaction amongst health and care

Benefits to the wider NHS

[An independent evaluation showed that, of over 5,000 referrals to Healthy Change \(Nottingham Public Health team\) in the first year:](#)

- The service successfully referred over 80% of clients to lifestyle change services
- Enabled over 75% of members to achieve one or more additional goals at end of the coaching period
- Was rated as good or better by over 85% of members
- Reduced "Did Not Attend" rates for specialist lifestyle services as well as supporting lifestyle change; and
- Improved self-care – coaching addresses lifestyle factors that are key determinants of health inequalities.

Care Co-ordinators

What they can do

- Proactively identify and work with a cohort of people to support their personalised care requirements, using the available decision support aids.
- Bring together all of a person's identified care and support needs, and explore their options to meet these into a single personalised care and support plan, in line with PCSP best practice.
- Help people to manage their needs, answering their queries and supporting them to make appointments.
- Support people to take up training and employment, and to access appropriate benefits where eligible.
- Raise awareness of shared decision making and decision support tools, and assist people to be more prepared to have a shared decision making conversation.
- Ensure that people have good quality information to help them make choices about their care, Support people to understand their level of knowledge, skills and confidence (their "Activation" level) when engaging with their health and wellbeing, including through use of the Patient Activation Measure.
- Assist people to access self-management education courses, peer support or interventions that support them in their health and wellbeing.
- Explore and assist people to access personal health budgets where appropriate.
- Provide coordination and navigation for people and their carers across health and care services, alongside working closely with social prescribing link workers, health and wellbeing coaches and other primary care roles.
- Support the coordination and delivery of MDTs within PCNs.

Benefits to patients

- The patient's go-to person if their needs change or if something goes wrong with service delivery
- The care coordinator ensures that there are no gaps in the patient's service provision
- Many elderly and disabled people with highly complex needs struggle to coordinate with all the relevant services directly on their own
- Improved patient education and understanding
- Better health outcomes
- Patients can eliminate unnecessary appointments, procedures and tests
- Patients feel more empowered and actively engaged in their treatment

Benefits to practices

- Ensuring seamless service provision significantly decreases the risk of the patient deteriorating and thereby reduces the overall cost of care and the likelihood that additional interventions will be needed in future
- By identifying high-risk patient populations before they incur costlier medical intervention, employers can begin to reduce both practice expenses and total NHS costs
- Employers can gain access to additional data that can reveal practice population health levels and risks Care coordinators glean information about patients' treatment histories, medication adherence, new symptoms and management of chronic conditions

Benefits to the wider NHS

- Ensuring seamless service provision significantly decreases the risk of the patient deteriorating and thereby reduces the overall cost of care and the likelihood that additional interventions will be needed in future
- By identifying high-risk patient populations before they incur costlier medical intervention, employers can begin to reduce both practice expenses and total NHS costs
- Employers can gain access to additional data that can reveal practice population health levels and risks
- Care coordinators glean information about patients' treatment histories, medication adherence, new symptoms and management of chronic conditions.

First contact physiotherapists

What they can do

- They will work as part of a multi-disciplinary team in a patient facing role, using their expert knowledge of Musculoskeletal (MSK) issues, to create stronger links for wider MSK services through clinical leadership, teaching and evaluation skills.
- They will assess, diagnose, triage and manage patients, taking responsibility for the management of a complex caseload etc
- They will receive patients who self-refer (where systems permit) or from a clinical professional within the network.
- First contact physiotherapists will progress and request investigations (such as x-rays and blood tests) and referrals to facilitate diagnosis and choice of treatment regime, understanding the limitations of investigations, interpret and act on results and feedback to aid diagnosis and the management plans of patients.
- They will develop integrated and tailored care programmes in partnership with patients and provide a range of first line treatment options, including self-management and referral to rehabilitation focused services and social prescribing provision. These programmes will facilitate behavioural change, optimise patients' physical activity and mobility, support fulfilment of personal goals and independence and reduce the need for pharmacological interventions.
- They will develop relationships and a collaborative working approach across the PCN supporting the integration of pathways in primary care.
- They will develop and make use of their full scope of practice, including skills relating to independent prescribing, injection therapy and investigation.
- They will provide learning opportunities for the whole multi-professional team within primary care, as determined by the PCN. They will also work across the multi-disciplinary team to develop and evaluate more effective and streamlined clinical pathways and services.
- They will liaise with secondary care MSK services, community care MSK services and local social and community interventions as required, to support the management of patients in primary care.
- Using their professional judgement, they will take responsibility for making and justifying decisions in unpredictable situations, including in the context of incomplete/contradictory information.
- They will manage complex interactions, including working with patients with psychosocial and mental health needs, referring to social prescribing when appropriate.
- Communicate effectively and appropriately, with patients and carers, complex and sensitive information regarding diagnosis, pathology, prognosis and treatment choices supporting personalised care.
- Implement all aspects of effective clinical governance for own practice, including undertaking regular audit and evaluation, supervision and training.
- They will 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.
- Encourage collaborative working across the health economy and be a key contributor to the primary care networks providing leadership and support on MSK clinical and service development across the network
- Support regional and national research and audit programmes to evaluate and improve the effectiveness of the FCP programme. This will include communicating outcomes and integrating findings into own and wider service practice and pathway development.
- First contact physiotherapists will develop integrated and tailored care programmes in partnership with patients through:
 - effective shared decision making with a range of first line management options (appropriate for the person's level of activation);
 - assessing levels of Patient Activation to confirm levels of knowledge, skills and confidence to self-manage and to evaluate and improve the effectiveness of self-management support interventions, particularly for those at low levels of activation; and

- agreeing appropriate support for self-management through referral to rehabilitation focused services and social prescribing provision. These programmes will facilitate behavioural change, optimise patient's physical activity and mobility, support fulfilment of personal goals and independence and reduce the need for pharmacological interventions

Benefits to patients

- Quick access to expert physiotherapy assessment, diagnosis, treatment and advice
- Prevention of short-term problems becoming long-term conditions
- Improved patient experience
- A shorter pathway, so patients have fewer appointments to attend
- Simple logistics, so patients are less likely to miss appointments or to suffer administrative errors
- Opportunities to gain lifestyle/physical activity advice
- Longer appointment times, meaning patients feel listened to, cared for and reassured.

Benefits to practices

- Release of GP time through reallocating appointments for patients with MSK problems
- Reduced prescription costs
- In-house physiotherapy expertise gained
- Increased clinical leadership and service development capacity
- Support in meeting practice targets
- Reduced pressure on GPs and other practice staff
- Making this part of the GP business model can optimise resources and reduce costs
- FCPs can often be funded by local CCGs whereby GP practices are paid per injection.

Benefits to the wider NHS

- Reduced number of physiotherapy referrals into secondary care
- Reduced demand and waiting times for orthopaedics, pain services, rheumatology and community physiotherapy and CMATS (Clinical Musculoskeletal Assessment and Treatment Services)
- Improved use of imaging
- Improved conversion rate to surgery when referrals are required
- Improved links with local voluntary sector and patient groups
- Continued support of individuals with conditions requiring physiotherapy is assured
- By providing these types of services, which decrease demand on costlier secondary care orthopaedic clinics, savings can be generated. This, in turn, can fund FCP roles.

Podiatrists

What they can do

- Provide treatments for patients of all ages whilst autonomously managing a changing caseload as part of the PCN's MDT team.
- Assess and diagnose lower limb conditions and foot pathologies, commence management plans, deliver foot health education to patients and colleagues.
- Liaise with PCN colleagues, community and secondary care staff, and named clinicians to arrange further investigations and onward referrals.
- Use and provide guidance on a range of equipment including surgical instruments, dressings, treatment tables, and orthotics.
- Provide treatment for high-risk patient groups such as the elderly and those with increased risk of amputation.
- Use therapeutic and surgical techniques to treat foot and lower leg issues (eg carrying out nail and soft tissue surgery using local anaesthetic).
- Prescribe, produce, and fit orthotics and other aids and appliances.
- Undertake continued professional development to understand the mechanics of the body in order to preserve, restore and develop movement for patients.
- Undertake a range of administrative tasks such as ensuring stock levels are maintained and securely stored, and equipment is kept in good working order.

Benefits to patients

- Access to screening, diagnostics and tailored care plans
- Increased access to the right care, closer to home
- Patients are kept active and mobile
- Support people to manage their condition so that they can recover faster and stay in work and/or return to work earlier
- Receive education and advice on inappropriate footwear, which can contribute to poor balance and an increased risk of certain conditions or risk of falling
- Prevent and correct deformity, relieve pain and treat infections.

Benefits to GPs /practices

- Work with other healthcare professionals such as dietitians, GPs, nurses and physiotherapists
- Relieve pressure on other primary care colleagues
- Help reduce patient attendances at the practice by intervening early and helping them stay well.

Benefits to the wider NHS

- The economic cost of sick leave and disability-related benefits relating to rheumatoid arthritis alone is £1.8bn
- Prevention of complications from long term conditions and reduction in the number of unnecessary referrals made to secondary care
- Podiatrists can make early interventions within the community to reduce A&E attendances and unnecessary hospital admissions by facilitating early detection and intervention of potentially life threatening conditions.

Dieticians

What they can do

- Provide specialist nutrition and diet advice to patients, their carers and healthcare professionals through treatment and education plans and prescriptions.
- Educate patients with diet-related disorders on how they can improve their health and prevent disease by adopting healthier eating and drinking habits.
- Make recommendations to PCN staff regarding changes to medications for the nutritional management of patients, based on interpretation of biochemical, physiological, and dietary requirements.
- 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.
- Work as part of a multidisciplinary team to gain patients' cooperation and understanding in following recommended dietary treatments.
- Develop, implement and evaluate a seamless nutrition support service that is aimed at continuously improving standards of patient care and wider MDT working.
- Work with clinicians, MDT 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.
- Ensure best-practice in clinical practice, caseload management, education, research and audit, to achieve corporate PCN and local population objectives.
- Undertake a range of administrative tasks such as ensuring stock levels are maintained and securely stored, and equipment is kept in good working order.

Benefits to patients

- Patients receive advice on eating habits to help the patient improve their health and wellbeing
- Dieticians work closely with patients and other staff to tailor individual eating plans
- Patients are better able to manage conditions including diabetes, heart disease, being overweight and obesity, cancer, food allergies and intolerances
- Initial consultation can run for around 45 minutes to an hour
- Improved outcomes.

Benefits to GPs /practices

- Help to upskill other primary health care professionals in nutrition
- Can work as part of a multidisciplinary general practice team
- Deliver more collaborative and coordinated nutrition care alongside their colleagues to benefit patient care
- Help to get patients better and keep them well.

Benefits to the wider NHS

- Deliver health promotion initiatives to their local community
- Can assist in reducing costly A&E attendances and avoidable hospital admissions by helping patients maintain their health and wellbeing through a healthy, balanced diet
- Teach and inform the public and health professionals about diet and nutrition
- Work to ensure nutrition is included as a priority in patient care

Occupational therapists

What they can do

- Assess, plan, implement and evaluate treatment plans, with an aim to increase patients' productivity and self-care.
- Work with patients through a shared-decision making approach to plan realistic, outcomes-focused goals.
- Undertake both verbal and non-verbal communication methods to address the needs of patients that have communication difficulties.
- Involve MDT colleagues, physiotherapists, social workers, alongside patients' families, teachers, carers and employers in treatment planning, to aid rehabilitation.
- 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.
- Periodically review, evaluate, and change rehabilitation programmes to rebuild lost skills and restore confidence.
- Where appropriate, advise on home, school, and workplace environmental alterations, such as adjustments for wheelchair access, technological needs, and ergonomic support.
- Teach coping strategies and support adaptation to manage long term conditions for physical and mental health.
- Advise on specialist equipment and organisations to help with daily activities.

Benefits to patients

- Improves the individual patient's independence
- Improves specific self-care skills
- Therapists provide compensatory techniques to improve an individual's ability to complete self-care tasks following a change in functional abilities
- Can improve strength and endurance for functional tasks
- Can work on functional cognition and visual deficits with the therapist
- Benefit from caregiver training from the therapists
- Patients receive expert advice in adaptive equipment and home modifications, eg through home evaluations.

Benefits to GPs /practices

- Help to upskill other primary health care professionals in nutrition
- Can work as part of a multidisciplinary general practice team
- Deliver more collaborative and coordinated selfcare and environmental adjustments advice alongside their colleagues to benefit patient care
- Help to better manage the patient's own selfcare, keep them well and reduce visits to the practice the patient may have otherwise needed to make.

Benefits to the wider NHS

- Deliver health promotion initiatives to their local community
- Can assist in reducing costly A&E attendances and avoidable hospital admissions by helping patients maintain their health and wellbeing through a healthy, balanced diet
- Teach and inform the public and health professionals about diet and nutrition
- Work to ensure nutrition is included

Physician associates

What they can do

Physician associates will provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems 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).

- Provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems 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)
- Review, analysis and action diagnostic test results
- Deliver integrated patient centred care through appropriate working with the wider primary care multi-disciplinary team and social care networks
- Undertake face-to-face, telephone and online consultations for emergency or routine problems, as determined by the PCN, including management of patient's with long-term conditions. Where required by the PCN, physician associates can offer specialised clinics following appropriate training including, but not limited to, family planning, baby checks, COPD, asthma, diabetes and anticoagulation
- Undertake home visits and participate in duty rotas
- Provide health/disease promotion and prevention advice to patients
- Utilise clinical guidelines and promote evidence-based practice and partake in clinical audits, significant event reviews and other research and analysis tasks
- Participate in CPD (continuing professional development) opportunities to keep up to date with evidence-based knowledge and competence in all aspects of their role, meeting clinical governance guidelines for CPD.

Benefits to patients

- Patients can currently spend two to three times longer consulting with PAs compared to GPs, e.g. 20–30 minutes
- As an additional member of the workforce, PAs should increase access to care
- Better access and longer consultations may decrease the number of visits a patient makes to the surgery or NHS services.

Benefits to practices

- Frees up GP time and reduces GP stress by consulting with patients with routine care needs
- Ensures a level of continuity and added value
- PAs can take part in audits and quality improvement
- Practice workload is supported by an extra generalist resource
- Easier access often results in better patient satisfaction

Benefits to the wider NHS

- Extra generalist staff resource will help alleviate workload pressures for doctors and other clinicians
- In an evolving healthcare system used by patients with a changing set of needs, innovation and adaptability in the face of the pressures currently experienced in all areas of the NHS is necessary
- Reduced GP workload should improve retention of the existing workforce and increase recruitment. This is the case for other clinicians too, e.g. GP nurses

Pharmacy technicians

What can they do

- Undertake patient facing and patient supporting roles to ensure effective medicines use, through shared decision-making conversations with patients
- Carry out medicine optimisation tasks including effective medicine administration, eg checking inhaler technique, supporting medication reviews and medicines reconciliation
- As determined by the PCN, support medication reviews and medicines reconciliation for new care home patients and synchronising medicines for patient transfers between care settings, linking with local community pharmacists, and referring to the pharmacist for structured medication reviews
- Take a central role in the clinical aspects of shared care protocols and liaising with specialist pharmacists for more complex patients.

Benefits to patients

- Help to increase patient action to support and advice on taking medicines and medicines optimisation
- Work in partnership with patients to ensure they use their medicines effectively
- Provide specialist expertise, where able to demonstrate competence, to address both the public health and social care needs of patients, including lifestyle advice and service information

Benefits to practices

- 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.
- Work with the PCN multi-disciplinary team to ensure efficient medicines optimisation, including implementing efficient ordering and return processes and reducing wastage
- Provide training and support on the legal, safe and secure handling of medicines, including the implementation of the Electronic Prescription Service (EPS).

Benefits to the wider NHS

- 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
- Help in tackling local health inequalities
- Support initiatives for antimicrobial stewardship to reduce inappropriate antibiotic prescribing

Advanced Clinical Practitioners

The term Advanced Clinical Practitioner (ACP) does not apply to a specific role, but is a catch-all term for practitioners across the NHS who have progressed to an advanced level. ACPs can be found practising across a range of fields, such as nursing, pharmacy, emergency medical services (paramedics) and adult and children's therapies

What can they do

- 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;
- manage undifferentiated undiagnosed condition and identify red flags and underlying serious pathology and take appropriate action;
- use complex decision making to inform the diagnosis, investigation, complete management of episodes of care within a broad scope of practice;
- actively take a personalised care approach and population centred care approach to enable shared decision making with the presenting person; and

- provide multi-professional clinical practice and CPD supervision to other roles within primary care, for example first contact practitioners and the personalised care roles.
- See patients in 'same day care' clinics, eg minor injury and illness, abdominal pains, chest pain, tiredness and headache
- Perform specialist health checks and reviews
- Support the delivery of 'anticipatory care plans' – a process designed to support patients living with a chronic long-term condition to help plan for an expected change at some time in the future
- Perform and interpret ECGs
- Undertake acute home visits on behalf of GPs, especially for local elderly or immobile populations
- Lead certain community services, eg monitoring blood pressure and diabetes risk for elderly patients living in sheltered housing to improve levels of cardiovascular and diabetes risk management – has led to a significant reduction in emergency calls for the monitored population.

Benefits to patients

- Ability to work autonomously can increase patient access to services
- Improved capacity for home visits can help manage chronic conditions and allow a greater level of proactive care outside of the practice.
- Better access and longer consultations may decrease the number of visits a patient makes to the surgery or NHS services.

Benefits to practices

- Frees up GP time, reduces GP stress by taking on home visits and often provides a much quicker response to patient need
- Practice workload is supported by an extra generalist resource increasing capacity to provide the most appropriate response first time to 999 calls and providing proactive care within the community
- Patient care improves due to the increase in access and timely interventions by skilled paramedic practitioners

Benefits to the wider NHS

- Role in the extended GP-led primary care team will relieve workload pressure and reduce impact on ambulance and secondary care
- Reduces avoidable patient trips to A&E and associated admissions (Encompass MCP vanguard serving 170,000 patients (across Whitstable, Faversham, Canterbury, Ash and Sandwich) and representing 122 GPs from 15 general practices – recently rolled out a paramedic practitioner scheme across its remit following a successful trial, which saw roughly 15% fewer hospital transfers, a more rapid response for patients and high levels of patient satisfaction
- EMIS Web allows paramedics to have GP records on their tablet, at the scene (home visits) – they can establish video links with the practice in the patient's home and have a three or four-way conversation between GP, paramedic, patient and carer.

Mental health practitioners

What can they do

- Undertake patient-centred interviews
- Identify areas where the person wishes to change how they feel, think or behave
- Carry out thorough risk assessments
- Provide a range of evidence-based psychological interventions including guided self-help based on cognitive behavioural therapy, counselling for depression, couple therapy for depression, brief dynamic interpersonal therapy, interpersonal psychotherapy for depression, online psychological treatment programmes and psychoeducational groups and workshops
- Liaise with other agencies and provide information about services such as employment and housing to patients

Benefits to patients

- Easier access to mental health services in a community setting, i.e. closer to home
- Improved mental health helps people to better manage their physical health
- Improved recovery – self-referrals tended to require fewer sessions, health outcomes and quality of life
- Improved equity of access for patients with both mental and physical health conditions.

Benefits to practices

- Improved access – therapists can see patients, via self or GP referrals, that would otherwise access their GP, thus balancing workload better and allowing GPs to focus on physical health
- Less medicines prescribed for mental health conditions if patients can access psychological therapies sooner
- Improved clinical reach, eg for PTSD, social anxiety disorder, OCD etc

Benefits to the wider NHS

- The system-wide benefits of improved mental health and emotional wellbeing are vast – [poor mental health is linked to deteriorating physical health, so increasing mental health care is essential in order to move to a more preventative health and care service](#)
- No patient waits longer than necessary for a course of treatment, doesn't present elsewhere in the system and does not deteriorate unchecked, which can ultimately require costlier crisis care.

PCNs in the wider NHS landscape

The move towards integration in England has gathered pace in recent years, with greater emphasis being placed on the need for health and care organisations to collaborate, rather than compete. Local health and care organisations are now working together as part of ICSs (Integrated care systems) to plan, provide, and manage services for their local areas.

As of 1st April 2021, every area in England is now covered by an ICS. ICSs bring together NHS, local authority and third sector bodies to take on collective responsibility for the resources and population health of a defined area on a larger scale than PCNs, with the aim of delivering better, more integrated care for patients in England.

ICSs have a specific focus on enhancing the role and scope of primary and community care services. Every ICS will have a critical role in ensuring that PCNs work in an integrated way with other community staff and use integrated MDTs across primary and community care.

PCNs are central to the provision of integrated, at-scale primary care, encompassing services beyond core general practice and working closely with acute, community and mental health trusts, as well as with pharmacy, voluntary and local authority services.

Recent developments

The UK Government has recently published a white paper on NHS structural reform - [Integration and Innovation: working together to improve health and social care for all](#) – which sets out a range of proposals that would see dramatic changes for the NHS in England.

The BMA supports the concept of integration of services, which we believe has the potential – if implemented with the full input of clinicians – to improve both patient care and doctors' working lives. There are however other areas which present some challenges and where we believe there is a case for lobbying for significant changes in the legislation.

The proposals raise for instance, a number of questions around how clinical representation and leadership should be embedded into any new NHS structure.

The White Paper which embeds the role of 'Place' within ICS structures, proposes to set out only headline specifications around governance arrangements in legislation, to enable local leaders greater flexibility over how to approach this.

ICSs will be required to set up a board which would be responsible for NHS services and provision, for the NHS spend and performance of the system. These boards will be expected to include, as a minimum, representatives from general practice, NHS trusts, and local authorities, as well as locally determined representation from other services such as community health (CHS) and mental health trusts.

The proposals also shift commissioning responsibility from CCGs to ICSs will have significant implications for the role of general practice in NHS decision making.

The proposed arrangements could create new opportunities for GPs to be involved in system decision making. However, the loss of a direct link between GP practices and commissioners could also have the opposite effect without a commitment to funding and promoting clinical leadership at every level. The BMA will therefore continue to lobby for clinicians to be at the heart of decision making in the NHS – including those working in general practice, secondary care, community care and public health.

The BMA will also lobby for clarity around what funding will be in place to support and develop clinical leadership. Discussion is needed around how this should work.

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