NHS
Barnsley
Clinical Commissioning Group

Public Primary Care Commissioning Committee
Thursday, 27 January 2022 at 9.00am via MS Teams

PUBLIC AGENDA

Item	Session	Committee Requested to	Enclosure Lead	Time
1	Housekeeping		Chair	9.00am 5mins
2	Apologies	Note	Chair	
3	Quoracy	Note	Chair	
4	Declarations of Interest relevant to the agenda	Assurance	**PCCC 22/01/04** Chair	9.05am
5	Minutes of the meeting held on 25 November 2021	Approve	**PCCC 22/01/05** Chair	9.05am 5mins
6	Matters Arising Report	Note	**PCCC 22/01/06** Chair	9.10am 5mins
Strategy, Planning, Needs Assessment and Co-ordination of Primary Care				
7	Primary Care Network Update • Temporary GP contract changes to support C19 Vaccinations	Information	**PCCC 22/01/07 Louise Dodson**	9.15am 5mins
8	Winter Access Fund • Primary Care Investments	Assurance	**PCCC 22/01/08 Louise Dodson**	9.20am 10mins
Quality and Finance				
9	Finance Update	Information	**PCCC 22/01/09** Ruth Simms	9.30am 10mins
10	CQC Update • CQC Monitoring Domain Indicators	Assurance/ Information	**PCCC 22/01/10 Terry Hague**	9.40am 5mins
Contract Management				
11	Contractual Issues Report	Approval/ Assurance	**PCCC 22/01/11** Terry Hague	9.45am 10mins
Governance, Risk, Assurance				
12	Risk and Governance Report • Assurance Framework • Risk Register • Work Plan Update	Assurance	**PCCC 21/11/12** Richard Walker	9.55am 10mins

Item	Session	Committee Requested to	Enclosure Lead	Time
Reflection on conduct of the meeting				
13	• Conduct of meetings • Any areas for additional assurance • Any training needs identified	Note	**Verbal** Chair	
Other				
14	Questions from the public relevant to the agenda	Note	**Verbal** Chair	10.05am 5mins
15	Items for escalating to the Governing Body	Note	**Verbal** Chair	10.10am 5mins
16	**Date and time of the next meeting:** Thursday, 24 March 2022 at 9.30am via MS Teams	Note	**Verbal** Chris Millington	**10.15am** **Close**

Exclusion of the Public:

The CCG Primary Care Commissioning Committee should consider the following resolution:

***"That representatives of the press and other members of the public be excluded from the remainder of this meeting due to the confidential nature of the business to be transacted* - publicity on which would be prejudicial to the public interest" Section 1 (2) Public Bodies (Admission to meetings) Act 1960**

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 January 2022

Declaration of Interests, Gifts, Hospitality and Sponsorship Report

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*		*Assurance*	X	*Information*	
2.	**PURPOSE**						
	To foresee any potential conflicts of interests relevant to the agenda.						
3.	**REPORT OF**						

	Name	Designation
Executive / Clinical Lead	Richard Walker	Head of Governance & Assurance
Author	Paige Dawson	Governance, Risk & Assurance Facilitator

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
N/A		

5. EXECUTIVE SUMMARY

Conflicts of interest are defined as a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold.

The table below details what interests must be declared:

Type	Description
Financial interests	Where individuals may directly benefit financially from the consequences of a commissioning decision e.g., being a partner in a practice that is commissioned to provide primary care services;
Non-financial professional interests	Where individuals may benefit professionally from the consequences of a commissioning decision e.g., having an unpaid advisory role in a provider organisation that has been commissioned to provide services by the CCG;
Non-financial personal interests	Where individuals may benefit personally (but not professionally or financially) from a commissioning decision e.g., if they suffer from a particular condition that requires individually funded treatment;
Indirect interests	Where there is a close association with an individual who has a financial interest, non-financial professional interest or a non-financial personal interest in a commissioning decision e.g., spouse, close relative (parent, grandparent, child, etc.) close friend or business partner.

Appendix 1 to this report details all Committee Members' current declared interests to update and to enable the Chair and Members to foresee any potential conflicts of interests relevant to the agenda. In some circumstances it could be reasonably considered that a conflict exists even when there is no actual conflict.

Members should also declare if they have received any Gifts, Hospitality or Sponsorship.

6. THE GOVERNING BODY / COMMITTEE IS ASKED TO:

- Note the contents of this report and declare if Members have any declarations of interest relevant to the agenda or have received any Gifts, Hospitality or Sponsorship.

7. APPENDICES / LINKS TO FURTHER INFORMATION

- Appendix A – Primary Care Commissioning Committee Members' Declaration of Interest Report

Agenda time allocation for report:	5 minutes

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care		7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
3.2 Maximising Elective Activity		9.1 Digital and Technology	
4.1 Mental Health		10.1 Compliance with statutory duties	✓
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)	✓	Duties as to reducing inequalities (s14T)	
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)	

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***NA***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4	**Improving quality (s14R, s14S)**	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

NHS Barnsley Clinical Commissioning Group

NHS Barnsley Clinical Commissioning Group Register of Interests

This register of interests includes all interests declared by members and employees of Barnsley Clinical Commissioning Group. In accordance with the Clinical Commissioning Group's Constitution the Clinical Commissioning Group's Accountable Officer will be informed of any conflict of interest that needs to be included in the register within not more than 28 days of any relevant event (e.g. appointment, change of circumstances) and the register will be updated as a minimum on an annual basis.

Register: Primary Care Commissioning Committee

Name	Current position (s) held in the CCG	Declared Interest
Nick Balac	Chairman	• Partner at St Georges Medical Practice (PMS) • Practice holds AQP Barnsley Clinical Commissioning Group Vasectomy contract • Member Royal College General Practitioners • Member of the British Medical Association • Member Medical Protection Society • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG • Two Partners at St Georges Medical Practice (PMS) are Partners on the Practice Contract at Kingswell Surgery (PMS). • Clinical Lead Primary Care SYB ICS (commissioning)
Nigel Bell	Lay Member for Governance	• Lay Member representing South Yorkshire & Bassetlaw organisations on the Integrated Assurance Committee of South Yorkshire & Bassetlaw Integrated Care System

Name	Current position (s) held in the CCG	Declared Interest
Chris Millington	Lay Member	• Partner Governor Barnsley Hospital NHS Foundation Trust (ceased July 18) • Partner Governor role with Barnsley Hospital NHS Foundation Trust (from 6 February 19) • Appointed Cancer Alliance Advisory Board
Mike Simms	Secondary Care Clinician	• Provider of Corporate and Private healthcare and delivering some NHS Contracts.
Chris Edwards	Governing Body Member	• Family member employed by Chesterfield Royal. • Family member employed by Attain. • Works as Accountable Officer for Rotherham CCG. • Works one day a week at the ICS as Capital and Estates and Maternity lead.
Mark Smith	GP Governing Body Member	• Senior Partner at Victoria Medical Centre also undertaking training and minor surgery roles. • Director of Janark Medical Ltd • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG
Madhavi Guntamukkala	Medical Director	• Senior GP in a Barnsley Practice (Apollo Court Medical Practice & The grove Medical Practice) Practices provide services under contract to the CCG • Spouse – Dr M Vemula is also partner GP at both practices • The practice is a member of Barnsley Healthcare Federation which may provide services for Barnsley CCG

Name	Current position (s) held in the CCG	Declared Interest
Richard Walker	Head of Governance & Assurance	• Daughter working for Health Education England.

Name	Current position (s) held in the CCG	Declared Interest
Julie Frampton	Head of Primary Care	• NIL
Victoria Lindon	Assistant Head of Primary Care Commissioning (NHSE and NHSEI)	• NIL
Nick Germain	NHS England & Improvement, Primary Care Manager	• NIL

NHS Barnsley Clinical Commissioning Group

Minutes of the PUBLIC Primary Care Commissioning Committee meeting held on Thursday, 25 November 2021 at 9.30am via MS Teams

PRESENT: (VOTING MEMBERS)

Chris Millington (Chair)	Lay Member for Patient & Public Engagement and Primary Care Commissioning
Nigel Bell	Lay Member for Governance
Mike Simms	Secondary Care Clinician
Chris Edwards	Chief Officer
Richard Walker	Head of Governance & Assurance

CLINICAL MEMBERS (NON-VOTING)

Dr Nick Balac	Chairman, Barnsley CCG
Dr Madhavi Guntamukkala	Governing Body Member (from agenda item 9)

IN ATTENDANCE:

Roxanna Naylor	Chief Finance Officer
Julie Frampton	Head of Primary Care
Katie Popple	Secretariat Team Leader/Executive Personal Assistant
Nick Germain	Primary Care Manager, NHSEI
Margaret Lindquist	Board Member, Healthwatch Barnsley
Carrie Abbott	Service Director, Public Health, BMBC
Ruth Simms	Finance Manager

APOLOGIES:

Dr Mark Smith	Governing Body Member

MEMBERS OF THE PUBLIC:

There were no members of the public present at the meeting.

Agenda Item	Note	Action	Deadline
PCCC 21/11/01	**HOUSEKEEPING**		
PCCC 21/11/02	**WELCOME AND APOLOGIES**		
	The Chair welcomed members to the meeting and apologies were noted as above.		
PCCC 21/11/03	**QUORACY**		
	The meeting was declared quorate.		
PCCC 21/11/04	**DECLARATIONS OF INTEREST RELEVANT TO THE AGENDA**		
	The Chair reported that agenda item 12, Contractual Issues report, two items were requesting Committee approval.		

	• To ratify the virtual decision to award the Brierley Medical Centre Contract to Barnsley Healthcare Federation and;
	• Approve the extension to the:
	  o Extended Access contract
	  o Out of Hours contract
	  o Covid Home Visiting contract
	
	The Chair informed the Committee that GP members had declared a non-financial professional interest in these items. They would be allowed to remain present for the discussion relating to the Contractual Issues Report in order to provide their clinical view should the Committee require it, but they would be asked to leave the meeting and not participate in the decision making.		

PCCC 21/11/05	**MINUTES OF THE LAST MEETING**		
	The minutes of the meeting held on 30 September 2021 were verified as a true and correct record of proceedings with the following amendments. <u>Minute Item 21/09/06 – Matters Arising Report</u> <u>GP Practice Premises Sale and Return</u> The Primary Care Manager, NHSEI commented that the final sentence of this item was not accurate and should read: "a prompt would be included in the sale and return of the GP premises procedure, highlighting the VAT implications of sale and leaseback of GP premises." The Chairman of the CCG requested that all GP Practices were made aware of the implications regarding VAT as this could affect practices in other ways as well as relating to the sale and leaseback of premises. **Action:** • **Minute item 21/09/06 of the matters arising report from the meeting held on 30 September to be amended to reflect the 'VAT implications of sale and leaseback of GP premises'.** • **VAT implications relating to Practice premises to be shared with all GP Practices.**	**AM** **JF/NG**	**Complete**
PCCC 21/11/06	**MATTERS ARISING REPORT**		
	Members noted the updates provided in the Matters Arising report. <u>PCCC 21/09/11 – Risk and Governance Report</u> Due to recruitment and retention issues currently being experienced it was agreed to keep the current risk score as it was.		

	PCCC 21/08/11 – GP Practice Sale and Return It was noted that the wording of the action/outcome relating to this item also needed amending to reflect that "a prompt would be included in the sale and return of the GP premises procedure, highlighting the VAT implications of sale and leaseback of GP premises". **Action:** • **Minute item of the meeting held on 30 September to be amended to reflect the above.**	**AM**	**Complete**
STRATEGY, PLANNING, NEEDS ASSESSMENT AND CO-ORDINATION OF PRIMARY CARE			
PCCC 21/11/07	**GP IT** The Primary Care Transformation Manager provided members with an update on the IT/Digital projects and schemes currently being delivered as part of the GP IT workstreams. The paper reflected some elements of the Governing Body Assurance Framework around GPIT and provided assurance to members of the work taking place in Primary Care to support Practices improve efficiency by providing alternative routes for patients into Primary Care. GPIT had adopted several devices, services and platforms that supported total triage, online and virtual consultations to ensure patient care could be accessed safely during the C19 pandemic and this was now being used as needed to support access to Primary Medical Services To ensure practices were cyber compliant, new software applications would be delivered into practices to enable Barnsley to use the same tools as other South Yorkshire CCGs who would transition into the ICS/ICB in 2022. The CCG was also working with other organisations across Barnsley on digital literacy to ensure people had access through alternative IT routes. The report provided assurance on the following general GP IT Workstream key deliverables:- • Compliance with mandatory core standards re: interoperability and cyber security • Delivery of O365 across Barnsley • Support the delivery of the Digital Primary Care First projects • Support the implementation and roll out of the GP IT Refresh programme, eConsultaion, Corporate Wi-Fi		

	• Support the wider use of digital technology as described within the Long-Term Plan • Support the resilience work at Hillder House with the servers and CCG corporate IT needs • Work closely with the SY&B ICS digital and IT workstreams • Lloyd George notes digitisation programme • Support the upgrade to utilise digital technology for telephony resilience across GP practices and Hillder House **The Committee:** • Noted the content of the report regarding GP IT and general digital projects work		
PCCC 21/11/08	**IMPROVING ACCESS PLAN** The Head of Primary Care informed members that in October NHS England produced a paper around planning to improve access for patients. There were several requests within the paper and each CCG was asked to work with their primary care teams to support general practice achieve the requirements. The Primary Care team had worked with SYB ICS teams and the Local Medical Council to develop a joint ICS-wide Improving Access Plan that addressed the asks within the paper and incorporated the aims and objectives of each CCG. The Plan had been submitted to NHS England Regional Team for final approval. Once the plan was approved, funding would be released to enable the work streams to be put in place. Members thanked the Head of Primary Care for the update provided.		
QUALITY AND FINANCE			
PCCC 21/11/09	**FINANCE UPDATE**		
	The Assistant Finance Manager presented the Finance Report that provided an update of the report. There were two sections to the report: . **<u>Forecast Position 2021/22 – H1 April – September 2021</u>** The forecast position as at Month 6 reflected a £240k underspend, the majority of which related to underutilisation on 2020/21 accruals. A full financial position for the full year covering April 2021 to March 2022 would be presented at the meeting in January 2022.		

	2021/22 Budget The report provided details of the primary care commissioning allocation for 2021/22 and a table that highlighted the budget requirements split by specific areas that had been approved by the Governing Body in November 2021. It was reported that total allocations for 2021/22 was £42,231k, £41,344k recurrent and £887k non-recurrent, with budget requirements being £43,215k. This was an overall shortfall of £984k for 2021/22 that would be funded from CCG programme costs. The Chief Finance Officer assured the Committee that the report reflected the position presented to the Governing Body in November and was part of the overall efficiency plan to ensure delivery of a financially balanced plan. **The Committee: -** • Noted the contents of the report		
21/11/10	**TELEPHONY** The Head of Primary Care presented a report that provided members with an update on the GP Telephony work. Since the establishment of the PCT, telephony had been provided to LIFT buildings using an onsite telephone system that allowed a total combination of 30 incoming and outbound calls at any one time. Anecdotal evidence had indicated that in busy periods patients were having difficulty contacting practices with the assumption that the telephone system required upgrading and modernising. A project plan had been developed to upgrade existing hardware and re-provide telephone lines utilising existing data connections that provided a modern cloud-based solution with increased functionality and flexibility to increase telephone capacity. Following a lengthy piece of work carried out by the Primary Care team, the new system would also remove all call charges and reduce line rental providing a cost reduction to the CCG from circa £7,000 to circa £2,700 per month. The cost of telephony for GP Practices outside LIFT buildings was covered within the practice global sum and practices sourced and paid for their own telephony. The next phase of the work was to work with these practices to support the migration to a modern, resilient telephony system.		

	The Committee: • Noted the content of the report regarding the transition of the telephony to Cloud-Based infrastructure and noted the cost reduction for the CCG.		
PCCC 21/11/11	**CQC REPORT** The Head of Primary Care presented the CQC report that provided members with an update on the current CQC position in relation to our GP Practices and for Barnsley Healthcare Federation i-Heart contracts. Following on from the transitional monitoring approach adopted by the Care Quality Commission during July 2021 due to the Covid-19 pandemic, further information had been received from the CQC informing of a revised monitoring approach built on what had worked well for both practices and the CQC . The report included a diagram outlining how the CQC were adapting their approach to monitoring and inspections. Members were informed that the majority of Barnsley Practices currently fell within the low monitoring stream with a monthly statement being added to the CQC website advising there was no evidence to further review those practices. The Primary Care team were working with the following practices who were currently being monitored through the CQC's medium-risk monitoring stream on domains that had 'required improvement'. The report provided assurance that positive feedback was being received from the CQC. • Lakeside Surgery • Hoyland Medical Practice • Woodland Drive Medical Centre • High Street Practice • The Kakoty Practice • Dodworth Medical Practice Each of these practices would be reinspected later this year and the outcome would be shared at a later Committee meeting when formal feedback from the CQC had been received. Following a query from the CCG's Chairman the Head of Primary Care agreed it would be helpful to include a report at the next PCCC meeting that provided a breakdown of the 5 CQC criteria definitions for clarity of terminology.		

	Action: • **A report detailing a breakdown of the 5 CQC criteria definitions to be presented at the January 2022 meeting.** **The Committee:** • Noted the CQC's inspection planning and approach • Noted the practices currently being monitored through the CQC's medium-risk monitoring stream	**JF**	**Complete**
CONTRACT MANAGEMENT			
PCCC 21/11/12	**CONTRACTUAL ISSUES REPORT**		
	As already reported under the Declarations of Interest, the Chair noted that GP Members of the Committee had a non-financial professional interest in this agenda item. He agreed to allow GP members to remain present for the discussion in order to provide their clinical view should the Committee require it, but they would be asked to leave the meeting and not participate in the decision making. The Primary Care Transformation Manager presented the Contractual Issues Report that provided members with an update on the current contractual issues in relation to primary care contracts. **<u>Brierley Medical Centre Procurement</u>** Following previous Committee approval for a 1-year extension to the APMS contract for BHF Brierley Medical Centre that would expire on 30 November 2021, the CCG had undertaken a competitive tender process in line with current requirements to ensure continuity of provision for this practice. Two organisations had submitted tenders that had been independently evaluated and a moderation panel had met to agree the consensus scores. Due to the timeline, the Committee had been asked to approve by virtual agreement the award of the Brierley Medical Centre contract to the recommended provider, Barnsley Healthcare Federation. The outcome had been brought to the meeting for ratification and noting the approval of the contract to be awarded.		

	Extended Access, OOH and Home Visiting Contracts The Extended Access, Out of Hours and Home Visiting contracts were all due to end on 31 March 2022 in line with the introduction of the new NHS Plan for national standardised specification for extended access as part of the Network Contract DES and associated national arrangements for the transfer of CCG extended access funding going live from April 2022. However, the NHS Plan for Improving Access for Patients and Supporting Practices published on 14 October 2021 announced the extended access transfer would be re-phased and had been postponed until October 2022. To support core general practice capacity and avoid disruption to existing service provision, the NHS Plan had instructed Commissioners to ensure necessary arrangements were made to extend existing services. Therefore, due to the uncertainties within the current climate and the postponement of the national enhanced access service specification, it was proposed to extend the commissioning of the extended access, out of hours and home visiting services to March 2023 with the inclusion of a break clause at 6 months in September 2022 in line with the current date of the proposed transfer of the service. **2021 GP Survey Analysis** The results of the GP Patient Survey published in August 2021 had been analysed and compared to national and CCG averages, with additional consideration given to individual GP practice results. Appendix A attached to the report included the outcome of the analysis that provided the Committee with assurances that: - • The Primary Care Team reviewed intelligence regarding GP practices and actioned appropriately. • There were effective systems and mechanisms to ensure that lessons were learned and shared within the CCG. • Barnsley CCG practices were on a par with both national and South Yorkshire and Bassetlaw practices in the feedback received regarding delivery of services. • Any trends and themes in the GP Patient Survey and, triangulating with other intelligence, were appropriately identified and actioned.		

	The GP Survey results also provided additional holistic data that included key performance indicators in respect of patient safety, quality and clinical effectiveness, governance and patient experience, workforce, and transformation activities. This information would be reviewed at the CCG's Quality Improvement Group and escalated to the Quality and Patient Safety Committee where appropriate. The Primary Care Team continued to work collaboratively and individually with Barnsley CCG practices to support improvements. **The GP members of the Committee left the meeting at this point.** **The Committee: -** • Ratified the virtual decision made to award the Brierley Medical Centre contract to the Barnsley Healthcare Federation. • Approved the extension of the following contracts via a Single Tender Waiver until 31 March 2023 with a break clause at 6 months in September 2022: o Extended Access which incorporated the Special Allocation Scheme o Out of Hours o Covid Home Visiting • Noted the analysis of the 2021 GP Survey and assurance provided.		
GOVERNANCE, RISK AND ASSURANCE			
PCCC 21/11/13	**<u>Risk and Governance Report</u>** The Head of Governance & Assurance presented the risk and Governance report that provided the Committee with: • Assurance regarding the delivery of the CCG's annual strategic objectives, and • Assurance that the current risks to the organisation were being effectively managed and monitored appropriately <u>Assurance Framework</u> The Assurance Framework continued to be reviewed and updated. Appendix 1 of the report provided the Committee with an extract from the GBAF of the two risks for which the Committee were the assurance provider.		

	Both risks had been scored as 'Amber' High Risk and related to: • Risk Ref 2.1 - the delivery of Primary Care priorities if identified threat(s) were not successfully managed and mitigated and; • Risk Ref 9.1 – the key deliverables of Digital Technology if identified threats(s) were not appropriately managed and mitigated. <u>Risk Register</u> There were currently five risks on the Corporate Risk Register allocated to the PCCC for which the Committee is responsible for managing. Of the five risks, there was one red (extreme) rated risk, one amber risk (high), one yellow risk (moderate) and two green (low) risks. Members were asked to review the risks detailed on Appendix 1 to ensure that the risks were being appropriately managed and scored. **The Committee: -** • Reviewed and agreed that the risks were being appropriately managed and scored.		
OTHER			
PCCC 21/11/14	**REFLECTION OF CONDUCT OF THE MEETING** The Committee agreed that the meeting had been conducted appropriately.		
PCCC 21/11/15	**QUESTIONS FROM MEMBERS OF THE PUBLIC RELEVANT TO THE AGENDA**		
	There were no questions received from the members of the public.		
PCCC 21/11/16	**ITEMS FOR ESCALATING TO THE GOVERNING BODY** There were no items for escalating to the Governing Body.		
PCCC 20/11/17	**DATE & TIME OF NEXT MEETING** Thursday, 27 January 2022 at 9.00am via MS Teams.		

PCCC 22/01/06

NHS Barnsley Clinical Commissioning Group

MATTERS ARISING REPORT TO THE PUBLIC PRIMARY CARE COMMISSIONING COMMITTEE

THURSDAY, 27 JANUARY 2022

1. MATTERS ARISING

The table below provides an update on actions arising from the meeting of the Primary Care Commissioning Committee held on **25 November 2021**

Minute ref	Issue	Action	Action/Outcome
21/11/05	**Minutes of the meeting held on 30 September 2021** <u>Minute Item 21/09/06 – GP Practice Premises Sale and Return</u> Matters arising report from the meeting held on 30 September to be amended to reflect the VAT implications of sale and leaseback of GP premises. GP Practices to be made aware of the VAT implications relating to Practices including the sale and leaseback of premises.	**AM** **JF/NH**	**Complete** As per guidance from the CCG Head of Finance, were a sale and leaseback of premises agreement to take place, the new owners have the right (option) to tax the rental, which would become a pressure for the CCG as we would have to refund the GP practice costs subject to any VAT recovery from them. If the practice were not VAT registered this would be the gross cost. The landlord can exercise this option at any time now or in the future which would then be a cost of the CCG. Therefore the agreed process for any future sale and leaseback applications would incorporate a caveat of approval for a clause be included in the lease contract, to confirm that the option to tax the rental will not be exercised whilst it is used as a Doctors premises and the cost reimbursed by the CCG. This ensures that there would not be any implications for GP practices in relation to VAT registration.

21/11/06	**Matters Arising Report of the meeting held on 30 September 2021** PCCC 21/08/11 – GP Practice Sale and Return Minute item of the meeting held on 30 September to be amended to reflect that "a prompt would be included in the sale and return of the GP premises procedure, highlighting the VAT implications of sale and leaseback of GP premises".	**AM**	**Complete**
21/11/11	**CQC Report** A report detailing a breakdown of the 5 CQC criteria definitions to be presented at the January 2022 meeting.	**JF**	27.01.22 – Update provided in CQC report. **Complete**

ITEMS FROM PREVIOUS MEETINGS CARRIED FORWARD TO FUTURE MEETINGS

Table 2 provides an update/status indicator on actions arising from earlier Board meetings held in public.

Minute ref	Issue	Action	Action/Outcome
PCCC 21/07/07	GP Patient Survey 2020 A thorough analysis of all the results would be carried out and a full report including an action plan would be presented at a future meeting of the Committee.	**JF**	Update – 25.11.21 On November agenda. **Complete**
PCCC 21/09/11	**Risk and Governance Report** Following recent discussions around the plan to recruit to additional roles, consideration to be given to the score for risk reference 14/10 Workforce Planning.	**JF**	Update – 25.11.21 Due to recruitment and retention issues currently being experienced it was agreed to keep the current risk score as it was. **Complete**
PCCC 21/08/11 **PCCC 21/08/11**	**PCCC 21/08/11 – GP Practice Sale and Return** It was noted that the wording of the action/outcome relating to this item needed amending to reflect that "a prompt would be included in the sale and return of the GP premises procedure, highlighting the VAT implications of sale and leaseback of GP premises". Barnsley Healthcare Federation (BHF) Contracts Review Update on the BHF Contracts review to be brought to the September meeting.	**NG**	Update 25.11.21 To ensure accurate information was provided to CCG colleagues, a prompt would be included in the sale and return of GP premises procedure, *highlighting the VAT implications of sale and leaseback of GP premises".* **Complete** 27.01.22 – SQP data set agreed with BHF and will be presented at the contract meeting in February. Update to be provided to PCCC in March when the successful implementation of the new system will be discussed.

			Update 30.09.21 **In Progress -** The PC team have worked up a minimum data set that supports the contractual requirements. We have not yet had the opportunity to discuss with BHF.

PCCC 22/01/07

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27th January 2022

PRIMARY CARE NETWORK UPDATE – TEMPORARY GP CONTRACT CHANGES TO SUPPORT C19 VACCINATIONS

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		*Approval*		*Assurance*		*Information*	x

2. PURPOSE

This paper outlines the temporary GP Contract changes to support COVID-19 Vaccinations.

3. REPORT OF

	Name	Designation
Executive Lead	Chris Edwards	Chief Executive
Author	Louise Dodson	Primary Care Transformation Manager

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
None		

5. EXECUTIVE SUMMARY

On the 7 December, NHSE wrote a letter detailing the actions they are taking to support GPs, primary care networks (PCNs) and their teams to progress the expansion of the vaccination programme alongside prioritisation of timely patient access to general practice services this winter. (Appendix A)

To support the ongoing response to COVID-19 and the increase in vaccination capacity, combined with the need to target proactively and support the most vulnerable patients during this period, changes were made to QOF and Impact and Investment Fund (IIF) for all practices and PCN's.

	Quality and Outcomes Framework Changes: • Practices should focus on the four vaccination and immunisation indicators, the two cervical screening indicators, the register indicators and the eight prescribing indicators • Forty-six QOF points for new indicators where there is no historic performance to use as the basis for income protection will be reallocated • The remaining indicators will be income protected using a methodology very similar to the one applied in 2020/21 Further guidance (Appendix B) was published on the 20th December updating the Primary Care Networks: Network Contract Directed Enhanced Service 2021/22 (Appendix C) and the Investment and Impact Fund 2021/22. (Appendix D) This variation to the 2021/22 Network Contract Directed Enhanced Service (DES) Specification implements the plans for temporary changes to the GP contract to support the COVID-19 vaccination programme outlined in the letter of 7 December 2021. The updated DES aims to support GPs and primary care networks (PCNs) to progress the expansion of the vaccination programme alongside prioritisation of timely patient access to general practice services this winter. The updated DES confirms: • three Investment and Impact Fund (IIF) flu immunisation indicators, and the appointment categorisation indicator (as the work is complete) are retained and operating as planned for 2021/22; • the remaining IIF indicators will be suspended and the allocated funding (worth £112.1m) repurposed: • £62.4m of the funding allocated to these suspended indicators will be allocated to PCNs via a PCN support payment, to be paid on a weighted patient basis, subject to a simple confirmation from the PCN that it will be reinvested into services or workforce Local Actions: • QOF Income Protection - Practices have been asked to return signed confirmation they will continue to provide care for patients in line with appropriate clinical guidelines and good medical practice. They have been asked to confirm capacity created will be used to participate in the covid-19 vaccination programme, to minimise health inequalities, and to prioritise care for those most vulnerable for chronic illness • IIF - PCN Payment Protection – The PCN Clinical Directors have been asked to confirm the payment will be reinvested into primary care services and workforce. The Primary Care Team has offered support to both Practices and the PCN during this period to ensure a smooth transition once the remaining QOF and IIF indicators resume in April 2022.
6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	Note the updated guidance and action taken.

7.	APPENDICES / LINKS TO FURTHER INFORMATION
	• Appendix A - 7th December 2021 Letter about temporary GP contract changes to support Covid-19 vaccination programme: https://www.england.nhs.uk/wp-content/uploads/2021/12/C1475_Letter-about-temporary-GP-contract-changes-to-support-COVID-19-vaccination-programme.pdf • Appendix B - Network Contract DES Guidance 2021/22 https://www.england.nhs.uk/publication/network-contract-des-guidance-2021-22/ • Appendix C - Network Contract Directed Enhanced Service Contract Specification 2021/22: https://www.england.nhs.uk/publication/network-contract-des-specification-2021-22/ • Appendix D - Investment and Impact Fund Implementation Guidance 2021/22: https://www.england.nhs.uk/publication/investment-and-impact-fund-2021-22-implementation-guidance/

Agenda time allocation for report:	5 minutes

PCCC 22/01/07

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	**x**	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
3.2 Maximising Elective Activity		9.1 Digital and Technology	
4.1 Mental Health		10.1 Compliance with statutory duties	
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act:

Management of conflicts of interest (s14O)	**See 3.2**	Duties as to reducing inequalities (s14T)	**See 3.5**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.3**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.4**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.4**	Public involvement and consultation (s14Z2)	**See 3.6**

2A. Links to delegated primary care commissioning functions

This report is relevant to the following responsibilities for primary care commissioning delegated to the CCG :

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts (inc breach notices etc)		Decisions in relation to the management of poorly performing GP Practices	
Planning the primary medical services provider landscape in Barnsley (inc closures, mergers, dispersals)		Decisions in relation to the Premises Costs Directions Functions	
Planning the Commissioning of Primary Medical Services in Barnsley		Co-ordinating a common approach to the commissioning of primary care services	x
Manage the delegated allocation for commissioning of primary medical care services in Barnsley			

3.	**Governance Considerations Checklist** *(these will be especially relevant where a proposal or policy is brought for decision or approval)*	
3.1	**Clinical Leadership**	
	Have GB GPs and / or other appropriate clinicians provided input and leadership?	***N***
3.2	**Management of Conflicts of Interest (s14O)**	
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***N***
3.3	**Discharging functions effectively, efficiently, & economically (s14Q)**	
	Have any financial implications been considered & discussed with the Finance Team?	***Y***
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***
3.4	**Improving quality (s14R, s14S)**	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***

3.10	**Environmental Sustainability**

Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

To:
- GP practices
- Primary care networks
- NHS England and NHS Improvement regions:
  - directors
  - directors of commissioning
- Clinical commissioning groups:
  - clinical leads
  - accountable officers

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

7 December 2021

Dear Colleagues

Temporary GP contract changes to support COVID-19 vaccination programme

1. In our letter of 3 December, NHS England and NHS Improvement set out plans for an acceleration of COVID-19 vaccination following the emergence of the Omicron variant. This letter sets out further details of the actions we are taking to support GPs, primary care networks (PCNs) and their teams to progress this expansion of the vaccination programme alongside prioritisation of timely patient access to general practice services this winter.

2. We recognise that balancing your resources this winter between the urgent needs of your patients, the management of long term conditions, and the vital task of vaccination and public health is a daily challenge. The measures in this letter seek to support your professional clinical judgement in balancing these considerations.

The Quality and Outcomes Framework (QOF)

3. The evidence-based care provided via QOF continues to be important in minimising health inequalities and securing the best outcomes for those with long term conditions. However, to support the ongoing response to COVID-19 and the increase in vaccination capacity, combined with the need to target proactively and support our most vulnerable patients during this period, we are making the following changes to QOF in 2021/22 – applying to all practices – which will be reflected in an amended statement of financial entitlement (SFE):

   a. Practices should focus on the four vaccination and immunisation indicators, the two cervical screening indicators, the register indicators and the eight prescribing

indicators (see Appendix 1). These will continue to operate on the basis of practice performance in 2021/22.

b. Forty-six QOF points for new indicators where there is no historic performance to use as the basis for income protection (the eight points associated with the new for 2021/22 cancer indicators, 20 points from the new for 2021/22 mental health indicators and 18 points from the non-diabetic hyperglycaemia indicator that was introduced for 2020/21) will be reallocated. These will increase the total points available for the eight prescribing indicators, reflecting the continued importance of effective prescribing in the management of long term conditions. We appreciate the work you will have undertaken in these domains to date and that you will continue to clinically prioritise care.

c. The remaining indicators will be income protected using a methodology very similar to the one applied in 2020/21: most income-protected indicators for 2021/22 will be paid based on achievement in 2018/19, while the income-protected indicators relating to diabetes and hypertension will be based on 2019/20 achievement, given some indicators in those domains were new for the 2019/20 year (see Appendix 2). Points will be subject to a list size and prevalence adjustment calculated in the usual way at year end. Practices are expected to continue to apply their clinical judgement and deliver as much patient care in these areas as they can, with a focus on the highest risk patients, but their income will not be dependent on recorded QOF achievement this year for the income-protected indicators.

d. The quality improvement (QI) domain will be paid to practices in full.

e. To be eligible for income protection, practices will need to agree with their commissioner a plan that will set out how QOF care will be delivered wherever possible, but with priority according to clinical risk and accounting for inequalities. We will be working with the Royal College of GPs (RCGP) and the British Medical Association (BMA) to provide some guidance to systems and practices.

4. All activity undertaken should continue to be coded. The Calculating Quality Report Service (CQRS) will continue to operate in 2021/22 and achievement data will be collected and reported for all indicators. Aspiration payments will continue as at present. Payment for QOF may be made later than usual for 2021/22, given that the proposed changes to the scheme are being made towards the end of the year.

5. QOF will recommence in full from April 2022.

Investment and Impact Fund (IIF)

6. The following changes will apply to IIF for 2021/22, implemented via a forthcoming Variation to the Network Contract Directed Enhanced Service (DES):

    a. The three flu immunisation indicators, and the appointment categorisation indicator (as the work is complete), will continue to operate on the basis of PCN performance in 2021/22 (see Appendix 3).

    b. The remaining indicators will be suspended and the funding allocated (worth £112.1m) repurposed (see Appendix 4).

    c. £62.4m of the funding allocated to these suspended indicators will instead be allocated to PCNs via a PCN support payment, to be paid on a weighted patient basis, subject to a simple confirmation from the PCN that it will be reinvested into services or workforce.

    d. £49.7m will be allocated to a new binary IIF indicator, paid on the basis of all practices within a PCN being signed up to phase 3 of the COVID-19 Vaccination Enhanced Service as at 31 December 2021, remaining signed up until 31 March 2022, and actively delivering the programme. Given the opt-in deadline of **10 December 2021**, practices not signed up to the phase 3 Enhanced Service would need to opt in by 10 December 2021, be assured to go live in early January, and continue to participate in the enhanced service until 31 March 2022 to be eligible for this indicator. Payment for this indicator will be made on a registered list size basis after the end of the financial year. Where, in exceptional circumstances, the commissioner agrees with one or more practices that they should not participate in the COVID-19 Vaccination Enhanced Service (as a result of wider access, performance or patient safety issues) then the PCN may still receive payment with those practices excluded from consideration. The payment will not apply if any practice in the PCN otherwise declines to participate in the programme.

7. As with QOF, CQRS will continue to operate in 2021/22 and achievement data will be collected and reported for all indicators. Recording of activity should continue. Payment for IIF may be made later than usual for 2021/22, given that the proposed changes to the scheme are being made towards the end of the year.

8. IIF will recommence in full from April 2022.

Wider measures

9. If participating in the vaccine programme, income protection for the Minor Surgery DES will apply from 1 December 2021 until 31 March 2022. Local commissioners

should make the monthly payments to practices for the Minor Surgery DES that they made for the corresponding period from 1 December 2018 to 31 March 2019. No contract enforcement will be taken where no activity is done under the Minor Surgery Additional Service from 1 December 2021 to 31 March 2022. Capacity released must be redeployed to vaccination.

10. From 1 December 2021 to 31 March 2022, where contractors consider it clinically appropriate and they are participating in the vaccine programme, routine health checks on request for those over 75 who have not had a consultation in the last 12 months, and for new patients may be deferred.

11. The Dispensary Services Quality Scheme will be amended to reduce the requirement for medication reviews from a minimum of 10% of dispensing patients to a minimum of 7.5% for 2021/22. Practices are asked to prioritise patients who they consider to be higher-risk or would benefit most from a review.

Additional telephony support

12. As a component of the NHS England and NHS Improvement Winter Access programme, NHSX have agreed a time-limited offer with Microsoft for general practice to utilise MS Teams telephony functionality. This solution will enable staff to use MS teams to make outbound only calls independently of the existing telephone solutions. This will free up the existing lines for incoming calls. Practices will keep their current telephony supplier and associated number in place to support the receiving of calls. This national offer is an additional component to the Microsoft Teams application currently provided and will increase telephone capacity at no additional cost to the practice. The additional outbound only call functionality will expire on 30 April 2023.

13. If you have already responded to the baselining questionnaire indicating interest, this functionality will be enabled for all Teams users in your practice. Further communications will follow from the NHSmail Team confirming the date of availability and providing links to the support site which contains details of how to access including training and support.

14. Contact the team on scwcsu.nhsei.winterpressures.advancedtelephony@nhs.net if you no longer wish to progress with this offer, or if you did not complete the original questionnaire, but wish to take up this offer.

Next steps

15. The sign-up window for the phase 3 GP COVID-19 Vaccination Enhanced Service has therefore been reopened. Practices who wish to sign up should liaise with their local commissioner as soon as possible to discuss next steps.

Yours sincerely,

Ed Waller
Director of Primary Care
NHS England and NHS Improvement

Dr Nikita Kanani MBE
Medical Director for Primary Care
NHS England and NHS Improvement

Appendix 1: QOF performance-based indicators 2021/22

Table 1: Performance-based public health indicators with unchanged points values 2021/22

Indicator ID	Indicator wording	Points	Payment thresholds	Points at the lower threshold
VI001	The percentage of babies who reached 8 months old in the preceding 12 months, who have received at least 3 doses of a diphtheria, tetanus and pertussis containing vaccine before the age of 8 months	18	90-95%	3
VI002	The percentage of children who reached 18 months old in the preceding 12 months, who have received at least 1 dose of MMR between the ages of 12 and 18 months	18	90-95%	7
VI003	The percentage of children who reached 5 years old in the preceding 12 months, who have received a reinforcing dose of DTaP/IPV and at least 2 doses of MMR between the ages of 1 and 5 years	18	87-95%	7
VI004	The percentage of patients who reached 80 years old in the preceding 12 months, who have received a shingles vaccine between the ages of 70 and 79 years	10	50-60%	-
CS005	The proportion of women eligible for screening aged 25-49 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 3 years and 6 months	7	45-80%	-
CS006	The proportion of women eligible for screening and aged 50-64 years at end of period reported whose notes record that an adequate cervical screening test has been performed in the previous 5 years and 6 months	4	45-80%	-
			Total	**75**

Table 2: Performance-based prescribing indicators with changed points values 2021/22

Indicator ID	Indicator wording	Original points	Updated points	Payment thresholds
AF007	In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy	12	25	40-70%
CHD005	The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken	7	15	56-96%
HF003	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB	6	12	60-92%
HF006	The percentage of patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, who are currently treated with a beta-blocker licensed for heart failure	6	12	60-92%
STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	4	8	57-97%
DM006	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)	3	6	57-97%
DM022	The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)	4	8	50-90%
DM023	The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin	2	4	50-90%
			Total	**90**

Table 3: Disease register indicators

Indicator ID	Indicator	Points
AF001	The contractor establishes and maintains a register of patients with atrial fibrillation	5
CHD001	The contractor establishes and maintains a register of patients with coronary heart disease	4
HF001	The contractor establishes and maintains a register of patients with heart failure	4
HYP001	The contractor establishes and maintains a register of patients with established hypertension	6
PAD001	The contractor establishes and maintains a register of patients with peripheral arterial disease	2
STIA001	The contractor establishes and maintains a register of patients with stroke or TIA	2
DM017	The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	6
AST005	The contractor establishes and maintains a register of patients with asthma aged 6 years or over, excluding patients with asthma who have been prescribed no asthma related drugs in the preceding 12 months	4
COPD009	The contractor establishes and maintains a register of: 1. Patients with a clinical diagnosis of COPD before 1 April 2021 and 2. Patients with a clinical diagnosis of COPD on or after 1 April 2021 whose diagnosis has been confirmed by a quality assured post bronchodilator spirometry FEV1/FVC ratio below 0.7 between 3 months before or 6 months after diagnosis (or if newly registered in the preceding 12 months a record of an FEV1/FVC ratio below 0.7 recorded within 6 months of registration); and 3. Patients with a clinical diagnosis of COPD on or after 1 April 2021 who are unable to undertake spirometry	8
DEM001	The contractor establishes and maintains a register of patients diagnosed with dementia	5
MH001	The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	4
CAN001	The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'	5
CKD005	The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)	6

Indicator ID	Indicator	Points
EP001	The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	1
LD004	The contractor establishes and maintains a register of patients with learning disabilities	4
OST004	The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis	3
RA001	The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis	1
PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age	3
OB002	The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥30 in the preceding 12 months	8
	Total	**81**

The points allocated to these indicators in Table 4 are reallocated to the prescribing indicators in Table 2.

Table 4: Indicators without historic performance

Indicator ID	Indicator wording	Points	Payment thresholds
MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months	4	50-90%
MH011	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of a lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or who have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight [BMI of ≥23 kg/m2 or ≥25 kg/m2 if ethnicity is recorded as White]) or preceding 24 months for all other patients	8	50-90%
MH012	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months	8	50-90%
CAN004	The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis	6	50-90%
CAN005	The percentage of patients with cancer, diagnosed within the preceding 12 months, who have had the opportunity for a discussion and been informed of the support available from primary care, within 3 months of diagnosis	2	70-90%
NDH001	The percentage of patients with non-diabetic hyperglycaemia who have had an HbA1c or fasting blood glucose performed in the preceding 12 months	18	50-90%
	Total points to be reallocated		**46**

Appendix 2: QOF income-protected indicators 2021/22

Table 5: Indicators to be paid based on performance in 2018/19 (with indicator dates amended as appropriate)

Indicator ID	Indicator description	Points
AF006	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)	12
CHD008	The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	12
CHD009	The percentage of patients aged 80 years or over with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5
HF005	The percentage of patients with a diagnosis of heart failure on or after 1 April 2021 which: 1. Has been confirmed by an echocardiogram or by specialist assessment between 3 months before or 6 months after entering on to the register; or 2. If newly registered in the preceding 12 months, with no record of the diagnosis originally being confirmed by echocardiogram or specialist assessment, a record of an echocardiogram or a specialist assessment within 6 months of the date of registration.	6
HF007	The percentage of patients with a diagnosis of heart failure on the register, who have had a review in the preceding 12 months, including an assessment of functional capacity and a review of medication to ensure medicines optimisation at maximal tolerated doses	7
STIA010	The percentage of patients aged 79 years or under with a history of stroke or TIA in whom the least blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	3
STIA011	The percentage of patients aged 80 years and over with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	2
AST006	The percentage of patients with a diagnosis of asthma on or from 1 April 2021 with either: 1. a record of spirometry and one other objective test (FeNO or reversibility or variability) between 3 months before or 6 months after diagnosis; or 2. If newly registered in the preceding 12 months with a diagnosis of asthma recorded on or after April 2021 but no record of objective tests being performed at the date of registration, with a record of spirometry and one other objective test (FeNO or reversibility or variability) recorded within 6 months of registration	15

Indicator ID	Indicator description	Points
AST007	The percentage of patients with asthma on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan	20
AST008	The percentage of patients with asthma on the register aged 19 or under, in whom there is a record of either personal smoking status or exposure to second-hand smoke in the preceding 12 months	6
COPD010	The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale	9
COPD008	The percentage of patients with COPD and Medical Research Council (MRC) dyspnoea scale ≥3 at any time in the preceding 12 months, with a subsequent record of an offer of referral to a pulmonary rehabilitation programme (excluding those who have previously attended a pulmonary rehabilitation programme)	2
DEM004	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months	39
DEP003	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	10
MH002	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate	6
MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	4
MH006	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	4
RA002	The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months	5
BP002	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years	15
SMOK002	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	25

Indicator ID	Indicator description	Points
SMOK004	The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months	12
SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months	25
	Total	**244**

Table 6: Indicators to be paid based on 2019/20 performance (with indicator dates amended as appropriate)

Indicator ID	Indicator description	Points
DM0012	The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months	4
DM014	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	11
DM019	The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less	10
DM020	The percentage of patients with diabetes, on the registers, without moderate or severe frailty in whom the last IFCCHbA1c is 58 mmol/mol or less in the preceding 12 months	17
DM021	The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months	10
HYP003	The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less	14
HYP007	The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less	5
	Total	**71**

Table 7: Indicators awarded in full for 2021/22

Indicator ID	Indicator description	Points
QIECD005	The contractor can demonstrate continuous quality improvement activity focused upon early cancer diagnosis as specified in the QOF guidance.	27
QIECD006	The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on early cancer diagnosis as specified in the QOF guidance. This would usually include participating in a minimum of two peer review meetings	10
QILD007	The contractor can demonstrate continuous quality improvement activity focused on care of patients with a learning disability as specified in the QOF guidance	27
QILD008	The contractor has participated in network activity to regularly share and discuss learning from quality improvement activity focused on the care of patients with a learning disability as specified in the QOF guidance. This would usually include participating in a minimum of two network peer review meetings	10
	Total	**74**

Appendix 3: Existing IIF indicators paid on a performance basis 2021/22

Indicator	Thresholds	Valuation
VI-01: Percentage of patients aged 65 years or over who received a seasonal influenza vaccination between 1 September and 31 March	80% (LT), 86% (UT)	£9.0m / 40 pts
VI-02: Percentage of at-risk patients aged 18 to 64 years who received a seasonal influenza vaccination between 1 September and 31 March	57% (LT), 90% (UT)	£19.8m / 88 pts
VI-03: Percentage of patients aged two or three years on 31 August of the relevant financial year who received a seasonal influenza vaccination between 1 September and 31 March	45% (LT), 82% (UT)	£3.2m / 14 pts
ACC-01: 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	n/a - Binary indicator	£6.1m / 27 pts

Appendix 4: Suspended IIF indicators 2021/22

Indicator	Thresholds	Valuation
HI-01: Percentage of patients on the Learning Disability register aged 14 years or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan	49% (LT), 80% (UT)	£8.1m / 36 pts
HI-02: Percentage of registered patients with a recording of ethnicity	81% (LT), 95% (UT)	£10.1m / 45 pts
CVD-01: Percentage of patients aged 18 years or over, not on the QOF hypertension register as of 30 September 2021, and who have (i) a last recorded blood pressure reading in the two years prior to 1 October 2021 >= 140/90mmHg or (ii) a blood pressure reading >= 140/90mmHg on or after 1 October 2021, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022	20% (LT), 25% (UT)	£12.0m / 53 pts
CVD-02: Percentage of registered patients on the QOF hypertension register	Increase 0.2pp (LT), Increase 0.3pp (UT)	£6.1m / 27 pts
PC-01: Percentage of registered patients referred to social prescribing	0.8% (LT), 1.2% (UT)	£4.5m / 20 pts
EHCH-01: Number of Patients recorded as living in a care home, as a percentage of care home beds eligible to receive the Network Contract DES Enhanced Health in Care Homes service	30% (LT), 85% (UT)	£4.1m / 18 pts
EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	80% (LT), 98% (UT)	£4.1m / 18 pts
EHCH-03: Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review	80% (LT), 98% (UT)	£4.1m / 18 pts
EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident	3 (LT), 4 (UT)	£2.9m / 13 pts
ACC-02: Number of online consultations on or after 1 October per 1000 registered patients	130 over 6 months (5 per 1000 per week) (single threshold)	£6.1m / 27 pts
ACC-03: By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions.	n/a Binary indicator	£12.6m / 56 pts

Indicator	Thresholds	Valuation
ACC-04: Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacist Consultation Service, with referral levels increasing by no later than 31 March 2022.	n/a Binary indicator	£12.6m / 56 pts
ACC-05: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups.	n/a Binary indicator	£12.6m / 56 pts
ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued on or after 1 October	53% (LT), 44% (UT)	£6.1m / 27 pts
ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO2e)	22.5kg (LT), 19.4kg (UT)	£6.1m / 27 pts

Classification: Official

Publication approval reference: PAR1220

Network Contract Directed Enhanced Service

Guidance for 2021/22 in England

20 December 2021

Contents

1. Introduction

1.1. The Network Contract Directed Enhanced Service (DES) was introduced during 2019 and will remain in place until at least 31 March 2024. For 2021/22, the Network Contract DES Directions come into force on 1 April 2021 and, following participation in the DES, the requirements on practices and Primary Care Networks (PCNs), as outlined in the Network Contract DES specification, will apply from that date.

1.2. This guidance provides supporting information for commissioners and practices. It does not take precedence over the Network Contract DES Specification.

1.3. The ongoing COVID-19 situation and COVID-19 vaccination programme is placing substantial pressures on general practice, and we are very grateful to all colleagues for the work they are doing to respond swiftly and professionally. NHS England and NHS Improvement has agreed a number of changes to the Network Contract DES for 2021/22 with the British Medical Associations (BMA) General Practitioners Committee (GPC) England, as set out in Supporting General Practice in 2021/22. The Network Contract DES and this guidance reflect those agreed changes.

1.4. This document has been updated since version 1 was agreed by NHS England and the British Medical Association's (BMA) General Practitioners Committee England (GPCE).

2. Participation in the Network Contract DES

2.1. Participation process

2.1.1 From April 2021 onwards, all Core Network Practices of Previously Approved PCNs will automatically participate in the 2021/22 and subsequent year's Network Contract DES, and any in-year variations unless a Core Network Practice chooses to opt out of participation. An opt-out and opt-in window will apply from the date of publication by NHS England and NHS Improvement of the Network Contract DES Specification or any Network Contact DES Variation. For the 2021/22 Network Contract DES, this opt-out and opt-in window will apply until 30 April 2021 and allows for:

a. Core Network Practices to opt-out of the 2021/22 Network Contract DES following automatic participation; or
b. Non-participating practices wishing to participate to opt-in to the 2021/22 Network Contract DES.

2.1.2 In the event of an in-year variation to the Network Contract DES, all Core Network Practices will automatically participate in the variation unless they choose to opt out, in which case they must do so within a 30 calendar day window from the date of publication by NHS England and NHS Improvement of the variation. Any variations to the Network Contract DES will be made nationally by NHS England and NHS Improvement; local variations to the Network Contract DES Specification, including to the requirements or financial entitlements, must not be made.

2.1.3 A New Practice may join a Previously Approved PCN at any time during the year.

Previously Approved PCNs with no changes to their Core Network Practice membership

2.1.4 Previously Approved PCNs without any changes to their Core Network Practice membership will automatically participate in the 2021/22 Network Contract DES. There is no need for the practices in these PCNs to submit a participation form to their commissioner. A written variation of the primary medical services contract of each Core Network Practice is required to ensure the relevant Network Contract DES Specification forms part of that contract and the commissioner will issue notification through the Calculating Quality Reporting Service (CQRS) for practices to accept. PCNs must ensure their Network Agreement has been updated as necessary.

Previously Approved with changes to their Core Network Practice membership

2.1.5 Where a Previously Approved PCN has one of the following scenarios which leads to a change in the Core Network Practice membership:

a. a Core Network Practice from another PCN joining; and/or
b. a non-participating practice joining; and/or
c. a New Practice joining; and/or
d. a Core Network Practice opting out of participating,

the Core Network Practices must follow the steps as set out in section 4.4 of the Network Contract DES Specification to seek approval of the change to the PCN's Core Network membership. PCNs must complete the Network Contract DES Participation and Notification Form included at Annex A of the Network Contract DES Specification to provide the required information and submit it to the commissioner by the 30 April 2021 or in the case of a Network Contract DES Variation, by the 30th calendar day following publication by NHS England and NHS Improvement of the variation. A single Participation Form can be submitted for a PCN.

2.1.6 Commissioners will consider all the information provided and confirm to the PCN as soon as possible (at the latest, within one month of receipt of the notification) whether or not the practices' participation in the Network Contract DES is confirmed.

2.1.7 PCNs are encouraged to submit the information to the commissioner as soon as possible to support payments, and prior to the next local payment deadline to avoid any disruption in payment. Commissioners should liaise with the PCN to confirm timescales. Where a local payment date has been missed, the commissioner will make the relevant payment in the next month. Where a Previously Approved PCN with changes requires payment adjustment, the commissioner will make these manually in the next month.

2.1.8 Commissioners are not required to wait for 100 per cent geographical coverage in order to approve Core Network Practice participation and PCN continuation or formation.

2.2. PCN unwilling to accept a practice as a Core Network Practice

2.2.1. Where a practice wishes to participate in the Network Contract DES but is unable to find a PCN to join, commissioners will have the ability as a last resort to allocate a practice to a PCN as a Core Network Practice. It is not anticipated that this will happen on a regular basis as it is expected that disagreements over joining a PCN should be managed through mediation, supported by the commissioner and the Local Medical Committee (LMC).

2.2.2. Where agreement cannot be reached through mediation, in order to ensure maximum population coverage through the Network Contract DES, a commissioner may allocate the practice to a PCN, with the full engagement of the LMC, in line with the process as set out in section 4.6 the Network Contract DES Specification.

3. Role of Commissioners and LMCs in reconfirming PCN establishment

3.1. Commissioners and LMCs will need to work together to ensure all practices who wish to join or continue their participation in the Network Contract DES are included within a PCN. Commissioners and LMCs will also need to work with PCNs to ensure that 100 per cent of registered patients are covered by network services, for example by commissioning a local contractual arrangement (see section 4). This may require discussion and mediation between the relevant PCN grouping and practice(s).

3.2. Commissioners will:

a. Liaise with the relevant Integrated Care System (ICS) to ensure each PCN Network Area continues to or does support delivery of services within the wider ICS strategy.
b. Engage with LMCs and bring practices together to resolve issues to ensure 100 per cent population coverage is maintained.
c. Engage with LMCs to aid a practice's participation in the Network Contract DES where the practice is unable to find a PCN.
d. Reconfirm or approve practice participation in the Network Contract DES as part of a PCN, ensuring that the participation requirements have been or continue to be met.
e. Have oversight of PCN footprints to ensure these make long term sense for service delivery and in the context of the GP contract framework.
f. Support PCN development via investment and development support outside of the Network Contract DES.

4. Establishing local agreements with a PCN for delivery of network services for patients of a practice not participating in the Network Contract DES

4.1. Key considerations

4.1.1. Commissioners are required to ensure that that any patients of a practice that is not participating in the Network Contract DES have access to network services.

4.1.2. In those instances where a practice has chosen not to sign up to the Network Contract DES and a commissioner is required to secure network services for the patients of that practice, a commissioner may contract with any other suitable provider for the delivery of network services, such as another PCN or a community services provider. Commissioners must, subject to procurement rules, initially seek to offer the provision of the network service to another Previously Approved PCN via a local agreement. If no Previously Approved PCN is suitable, the commissioner, subject to procurement rules, may offer the network service to any suitable provider and, for the avoidance of doubt, any other suitable provider would not include the practice that has opted out of the Network Contract DES. In commissioning any suitable provider, this must not be on terms better than those set out in the Network Contract DES (including any additional funding) nor divide the service into smaller components. Non-PCN providers commissioned to deliver network services will not be eligible for the Network Participation Payment.

4.1.3. The guidance below applies to those instances where a commissioner is contracting with a PCN through a local agreement to deliver network services to such patients.

4.1.4. Commissioners will need to work with PCNs to agree how any patients from a non-DES practice - a practice not signed up to the Network Contract DES - can be covered by a PCN. The local agreement would usually be with:

a. a single Core Network Practice (as a signatory on behalf of a PCN in a lead provider type of arrangement), or
b. with all the Core Network Practices in the PCN (as a multi-signatory agreement)[1].

4.1.5. These local agreements will be managed locally and the patient population of a non-DES practice, for whom a PCN is providing network services, will not be accounted for within the PCN ODS reference data.

4.1.6. There may be circumstances where more than one GP practice in an area is not participating in the Network Contract DES. Where a single PCN will be providing cover for multiple non-DES practices, this can be via either a single or multiple local agreement(s).

[1] Where the PCN has formed as a legal entity, the local agreement could be made directly with the PCN.

4.1.7. Having agreed which PCN or provider will provide the cover, commissioners will need to ensure the following services/activities[2] are provided to patients of the non-DES practice in accordance with the timescales for these services/activities:

a. a social prescribing service;
b. the extended hours access requirements as listed at section 8.1 of the Network Contract DES specification.
c. the Structured Medication Review requirements as listed at section 8.2 of the Network Contract DES Specification;
d. the Enhanced Health in Care Homes requirements as listed at section 8.3 of the Network Contract DES Specification; and
e. the Early Cancer Diagnosis requirements as listed at section 8.4 of the Network Contract DES Specification.

4.1.8. These requirements could be included in the local agreement by cross-referring to the relevant sections of the Network Contract DES Specification document. For some of the service requirements, co-operation between the provider of the local agreement and the non-DES practice(s) will be critical to delivery. Further information on the duty of co-operation on all practices is detailed below.

4.1.9. Other provisions that would be expected to be included in a local agreement are:

a. A provision requiring the PCN to provide to the commissioner any details of non-co-operation by a non-DES practice with the PCN who is providing network services via the local agreement to the non-DES practice's patients. This information will be used by the commissioner to consider whether to take any action under the non-DES practice's primary medical services contract;
b. Breach – how breaches by the PCN providing cover are dealt with by the commissioner; and
c. Boilerplate provisions – the usual contractual provisions about commencement, duration, extension, break-clause, termination, variation, dispute resolution, entire agreement, surviving provisions, governing law, etc.

4.1.10. Commissioners should make every effort to find suitable cover to provide network services for patients of a non-DES practice. Where a commissioner has not been able to secure cover to patients of a non-DES practice, this should be notified to the NHS England and NHS Improvement Regional Team.

4.1.11. In areas where the scale of non-participation in the Network Contract DES is significant, NHS England and NHS Improvement will consider the case for establishing a new APMS contract, in addition to existing GMS/PMS/APMS

[2] The list outlines the 2021/22 requirements. Commissioners and PCNs will need to review local agreements in future years to ensure they remain aligned to any changes to the Network Contract DES Specification.

contracts, in order to establish additional primary medical care capacity (covering both essential services and network services) in those areas.

4.2. Payments under a local agreement

4.2.1. For the purposes of the Network Contract DES, payments to a PCN for the provision of PCN services/activities are mostly calculated by reference to the sum of its Core Network Practices' registered lists as at 1 January each year. This sum will not therefore include patients from practices who are not participating in the Network Contract DES. Instead, the patients of practices not participating in the Network Contract DES would need to be accounted for under the local agreement put in place with the PCN that will be providing cover. These local agreements will not be supported by either the General Practice Extraction Service (GPES) or the Calculating Quality Reporting Service (CQRS) and commissioners will be required to manage these out-with of these systems.

4.2.2. In respect of payments under the local arrangement, the simplest approach would be for the commissioner to consider replicating or clearly referring to the relevant payment provisions in section 9 of the Network Contract DES Specification but calculated with reference, where appropriate, to the registered patient size of the non-DES practice. These could include payments that reflect:

a. Core PCN funding;
b. extended hours access; and
c. care homes premium.

4.2.3. The commissioner and PCN may need to consider on a case by case basis the extent to which the total number of patients that the PCN provides services to (i.e. including the non-DES practice patients) would require additional workforce capacity, in order to support delivery of network services and therefore what, if any, workforce related payments should be reflected in the local arrangements.

4.2.4. There may also need to be consideration of whether the Clinical Director of the PCN acts on behalf of the non-DES practice. If so, then consideration would need to be given to whether a payment in respect of this (calculated with respect to the patient list size of the non-DES practice) is appropriate.

4.2.5. Commissioners will have local discretion as to whether or not any additional funding can be made available, in part or in full to the PCN providing the cover for the non-DES practice.

4.2.6. The non-DES practice will not be entitled to the Network Participation Payment if not participating in the Network Contract DES.

4.3. Duty of co-operation

4.3.1. To support co-operation between all practices in delivering PCN related services to their patients, regardless of whether or not a practice is

participating in the Network Contract DES, the GMS and PMS Regulations require all practices to:

a. co-operate with Core Network Practices of PCNs who are delivering the Network Contract DES services/activities to the collective registered population and as required engage in wider PCN meetings with other PCN providers;
b. inform their patients, as required, of changes to PCN services/activities;
c. support wider co-operation with other non-GP provider members of the PCN;
d. as clinically required, support the delivery of PCN services/activities, be party to appropriate data sharing and data processing arrangements, that are compliant with data protection legislation; and
e. share non-clinical data with members of the PCN to support delivery of PCN business and analysis, following a process that is compliant with data protection legislation.

4.3.2. Alongside the above, a practice's compliance with the GMC Good Medical Practice to act in the best interests of patients and not put them at risk of harm, should provide assurance that non-DES practices will co-operate with the delivery of PCN services/activities. In the event a non-DES practice does not co-operate, the commissioner will need to be made aware of, and address, the matter appropriately in line with normal contract management arrangements.

5. PCN Organisational Requirements

5.1 Membership of a Primary Care Network, network area and crossing commissioner boundaries

5.1.1. Under the Network Agreement, PCN membership is divided into two categories – Core Network Practices and other PCN members. Core Network Practices are the practices participating in the Network Contract DES[3]. Any other organisations party to the Network Agreement are known as PCN members and may include other providers, such as a GP Federation, community or secondary care trust, community pharmacy, community or voluntary sector provider, and GP practices who are not participating in the Network Contract DES or who are not Core Network Practices of the PCN.

5.1.2. The Core Network Practice membership of a PCN must cover a Network Area that aligns with a footprint that would best support delivery of services to patients in the context of the relevant ICS. The Network Area must also:

a. cover a boundary that makes sense to:
   i. the Core Network Practices of the PCN;
   ii. other community-based providers which configure their teams accordingly; and

[3] Practices eligible to participate in the Network Contract DES must hold a primary medical services contract, have a registered list of patients and offer in-hours (essential services) primary medical services.

iii. the local community;

b. cover a geographically contiguous area;

c. not cross Clinical Commissioning Group (CCG) or ICS boundaries except where:

i. a Core Network Practice's boundary or branch surgery crosses the relevant boundaries; or

ii. the Core Network Practices are situated in different CCGs.

5.1.3. From contractual perspective, a primary medical services provider who holds either:

a. a single eligible primary medical services contract will only be able to hold one Network Contract DES and be a Core Network Practice of a single PCN, this applies regardless of whether or not the single primary medical care provider has multiple sites spanning large areas and/or commissioner boundaries; or

b. multiple eligible primary medical care contracts will be able to have each of those contracts varied to include the Network Contract DES and each practice will be a Core Network Practice of the relevant PCN(s).

5.1.4. A practice not participating in the Network Contract DES could be a PCN member (like any other non-practice provider, i.e. not a Core Network Practice) and therefore be party to a PCN's Network Agreement.

5.1.5. A practice may be a member of more than one PCN, for example where a practice provides services from a branch surgery and sub-contracts the delivery of PCN services and/or activities for that branch surgery to a different PCN, or where a practice is the nominated payee for two PCNs. In these examples, the practice would be a Core Network Practice of one PCN and a PCN member (i.e. non-Core Network Practice) of another PCN. Similarly, within the PCN ODS reference data, GPES and CQRS, practices will only be a Core Network Practice of one PCN.

5.1.6. A practice with one or more branch surgeries in different PCNs acknowledges that its list of patients will be associated with the PCN of which the practice is a Core Network Practice. For PCNs/practices intending to have a different PCN provide PCN services/ activities to a branch surgery, see section 6 for information about sub-contracting arrangements.

5.2 PCN organisational or Core Network Practice membership changes

5.2.1. As outlined in section 2 above, a PCN may seek approval of a change to its Core Network Practice membership as part of the participation process following publication of the 2021/22 Network Contract DES Specification or an in-year variation. This change will be signed off as part of the process for practices confirming participation in the Network Contract DES, as outlined in section 2 of this guidance (and section 4.8 of the Network Contract DES Specification).

5.2.2. Changes to Core Network Practice membership of a PCN can only take place outside of this window in exceptional circumstances as set out in

sections 6.6 to 6.9 of the Network Contract DES Specification and with the approval of the commissioner.

5.2.3. Commissioners should maintain accurate records of all PCN Core Network Practice membership approvals and rejections and will be required to demonstrate if requested, the rationale for their decision.

5.2.4. Where a PCN wishes to change its Clinical Director or nominated payee, it must follow the process as set out in sections 6.2 and 6.3 respectively of the Network Contract DES Specification.

5.3 PCN Organisational Data Service (ODS) information and Change Instruction Notice Form

5.3.1. Where changes to PCN membership or nominated payee have been approved by the commissioner, the commissioner must complete and submit the ODS Change Instruction Notice Form[4]. This form must be completed and submitted at the earliest opportunity and by no later than the last working day on or before the 14th day of each month, in order for the change to be actioned by the end of that month in the payment systems. In so doing, commissioners should have due regard to local payment arrangements and the timings implications of this when submitting an ODS Change Instruction Notice. Where the ODS Change Instruction Notice Form is not submitted by the monthly deadline, commissioners may be required to follow a manual exception process (i.e. manual payment reconciliation) to ensure the correct payments are made – see section 10.3 below).

5.3.2. The PCN ODS reference data provides the following information:

Category	Detailed information included
Organisational data for the PCN	ODS code PCN name PCN address Start and end dates of PCN Status (active or inactive)
Core Network Practice(s) to PCN	IsPartnerTo relationship: ODS for Practice and PCN Start and end dates of relationship Relationship Status (active or inactive)
PCN to commissioner mapping	IsCommissionedBy relationship: ODS for PCN and commissioner Start and end dates of relationship Relationship Status (active or inactive)
Nominated payee (NP)	IsNominatedPayeeFor relationship: ODS Code for Nominated Payee and PCN NP Name NP address Start and end dates of relationship Relationship Status (active or inactive) NP Role (whether NP is a practice or not)

[4] The PCN ODS Change Instruction Notice is available here.

	Note: A Nominated Payee can be payee for more than one PCN. This means some payee records will have multiple 'IsNomiantedPayeeFor' relationships to different PCNs. A PCN can only have one Nominated Payee.

5.3.3. Each PCN will have a single commissioning relationship, regardless of whether the Core Network Practices of a PCN cross commissioner boundaries. In the event a PCN crosses commissioner boundaries, then the relevant commissioners must agree who will be the 'lead' commissioner for the PCN. The agreed 'lead' will be identified as such within both the PCN ODS reference data and subsequently within the relevant GP IT systems for payment processing. The identified lead commissioner will make payments to the relevant Nominated Payee in relation to the Network Contract DES. The lead commissioner and any other relevant commissioner must reconcile any funding allocation discrepancies between themselves and not via national GP payment systems.

5.3.4. Only a PCN's 'lead' commissioner will be able to instruct changes to the ODS reference data and by someone from within the primary care commissioning team.

5.3.5. The NHS Digital ODS Team is not able to distinguish between a delegated or non-delegated CCG. Where a Regional Team submits an ODS Change Instruction Notice, the assumption will be that this is due to the CCG not having delegated authority and/or that this has been agreed locally between the Regional Team and CCG. As such, it is the responsibility of the commissioners (Regional Team and/or CCG) to ensure that they have the authority to submit the ODS Change Instruction Notice, as it will have implications for payment system calculations and processing. Where a submission is made by a Regional Team, it will also need to be done by someone from within the primary care commissioning team.

5.4 Network Agreement

5.4.1. The Network Agreement sets out the collective rights and obligations of a PCN's Core Network Practices and is required to enable PCN claims of the financial entitlements under the Network Contract DES. It also sets out how the Core Network Practices will collaborate with non-GP providers which make up the wider PCN.

5.4.2. PCNs will continue to be required to use the national mandatory Network Agreement and its Schedules to support the Network Contract DES. The mandatory sections of the Network Agreement cannot be amended, except in those instances where the Network Agreement states that wording in a specific clause may be replaced with wording to reflect agreement which the PCN has reached.

5.4.3. Core Network Practices are required to ensure that PCN arrangements and agreements reached in the Network Agreement are updated to take account of any changes to the Network Contract DES specification. This would include how new services will be delivered, and for any other changes such as when new workforce is recruited.

5.4.4. Where PCNs decide to seek advice related to the Network Agreement, these costs will not be covered under the Network Contract DES nor by commissioners at a local level.

5.5 Recording agreements reached with local providers

5.5.1. In 2020/21, each PCN was required to agree with local community services providers, mental health providers and community pharmacy providers how they would work together. The collaboration agreements reached with these local providers must be documented in Schedule 7 of the PCN's Network Agreement.

5.5.2. As set out in the Network Contract DES Specification, PCNs must update Schedule 7 of their Network Agreement to set out:

a. the specifics of how the appropriate service requirements (those which require joint working with community services providers, community mental health providers and community pharmacy) under the Network Contract DES or other services deemed appropriate will be delivered through integrated working arrangements between PCNs and other providers; and
b. how providers will collaborate, including agreed communication channels, agreed representatives, and how any joint decisions will be taken.

5.5.3. Commissioners should use reasonable endeavours to facilitate the agreement of arrangements, or any subsequent amendment to the arrangements, between the local community services provider(s) and the PCN.

5.6 Clinical Director

5.6.1. The Clinical Director should be a practicing clinician from one of the PCN's Core Network Practices, working regularly within the PCN (regardless of whether the clinician is directly employed, self-employed or engaged via a sub-contracting arrangement) and be able to undertake the responsibilities of the role, representing the PCN's collective interests. It is most likely to be a GP, but this is not a requirement and can be any clinician including one of the PCN additional roles. The post should be held by an individual (or individuals if they are job-sharing the role) from within the PCN and should not be a shared role between PCNs. The Clinical Director should not be employed by a commissioner and provided to the PCN.

5.6.2. PCNs may wish to consider rotating the Clinical Director role within a reasonable term.

5.6.3. A national outline of the key requirements is included in section 5.3 of the Network Contract DES Specification. The Clinical Director has overall responsibility for their key requirements and may, where appropriate, engage others within the PCN to aid in their delivery.

Appointment of Clinical Director

5.6.4. It will be the responsibility of the PCN to agree who their Clinical Director will be. The selection process will be for the PCN to determine but may include:

a. Election - nomination and voting;
b. Mutual agreement between the members;
c. Selection – via application and interview for example; or
d. Rotation within a fixed term (this could equally apply against the above processes).

Managing Conflicts of interest

5.6.5. PCNs and Clinical Directors will be responsible for managing any conflicts of interest, taking account of what is within the best interests of the PCN and their collective patients. They will need to consider how best to manage inappropriate behaviour which negatively impacts on PCN member relationships or delivery of care to patients.

5.7 Data and analytics

5.7.1. Each PCN is required to have in place appropriate data sharing and, where appropriate, data processing arrangements between members of the PCN and any sub-contractors as required. These arrangements must be in place prior to the start of the activity to which they relate. The Data Sharing Agreements and Data Processing Agreement non-mandatory templates are available for PCNs to use.

5.7.2. Where functionality is available, clinical data sharing for service delivery should be read/write access, so that a GP from any practice, and where required other PCN staff, can refer, order tests, and prescribe electronically and maintain a contemporaneous record for every patient.

5.7.3. PCNs should be routinely monitoring, sharing, and aggregating relevant data across the Core Network Practices. This is to allow for benchmarking of activity and the identification of:

a. opportunities for improvement;
b. variation in access and service delivery; and
c. capacity and demand across the PCN population in order to review and manage appropriately.

5.7.4. The Calculating Quality and Reporting Service (CQRS) includes functionality to enable practice-level data for PCN Core Network Practices to be summed to PCN-level. PCN Core Network Practices and the lead commissioner will be able to review both PCN and practice-level data.

5.7.5. With regards to cross-boundary PCNs identified through the PCN ODS mapping data, reporting within CQRS will not enable PCN related data to be available to multiple commissioners. The commissioners will therefore need to work together and the ‘lead CCG’ – identified by the PCN ODS reference data - will be required to share all relevant PCN level data with the ‘non-lead CCG’ to support monitoring and payment information linked to the Network

Contract DES. Providing the data is not patient identifiable – which for the purposes of the Network Contract DES it will not be – General Data Protection Regulation (GDPR) does not require a data sharing agreement to be in place between controllers.

5.8 Network Dashboard

5.8.1. The Network Dashboard was introduced during 2020/21 and will evolve each year, in line with feedback from users and the availability of new information to populate it. To access the Dashboard, please either register on the Insights Platform, or login in using your existing Insights Platform account, and then select the NHS ViewPoint product. A user guide is available to help navigate the dashboard.

5.8.2. The dashboard includes key metrics to allow every PCN to see the benefits it is achieving for its local community and patients and is intended to support local quality improvement. It will enable effective benchmarking between practices within PCNs, and between comparable PCNs, and will be accessible, on request, to all commissioners, providers and arms-length bodies working in health and social care.

5.8.3. These indicators will be displayed alongside contextual information for each PCN – for example the size, density and relative level of deprivation of their population.

6. Sub-contracting of network services

6.1 Core Network Practice with sites in different PCNs

6.1.1. When a Core Network Practice of a PCN (PCN 1) is looking to sub-contract services/activities to a different PCN (PCN 2) for a proportion of their registered population (for example where it holds a single contract but delivers services from multiple sites, such as a branch surgery), PCN 1 should give careful consideration to how the patients - to whom PCN 2 will provide PCN services/activities - will be identified. This is particularly important where those patients are under a single registered list under a single primary medical services contract.

6.1.2. Identification of patients for whom PCN 2 will provide PCN services/activities may, for example, be the patients who usually access care at a GP practice site within PCN 1. The GP practice should also take care not to do anything that could mean that a cohort of registered patients were treated differently e.g. a GP practice should not tell specific patients that they can only access PCN services/activities from sites in PCN 2. This is important as the practice needs to ensure that it does not breach any of the practice's obligations to patients set out in its core primary medical services contract.

6.1.3. There are two main options for the sub-contracting of PCN services/activities:

1) **Option 1: Sub-contracting via the Network Agreement**

a. In this scenario, the practice will be a Core Network Practice of a PCN (PCN 1) and will be signed up to PCN 1's Network Agreement in the usual way. That Network Agreement will note that it has been agreed that another PCN (PCN 2) will provide PCN services/activities to certain patients of the relevant practice. It would be helpful for PCN 1's Network Agreement to set out the reasoning for this. The relevant practice will also sign the Network Agreement of PCN 2 as an "other member" (i.e. not as a Core Network Practice). The details of the sub-contracting arrangement - the financial/service delivery/workforce arrangements - would be set out in an additional schedule of PCN 2's Network Agreement.

b. Careful consideration would need to be given to the role that the relevant practice has in PCN 2. The Network Agreement for PCN 2 would need to be clear on:
   i. setting out what requirements, if any, the relevant practice should be expected to deliver to facilitate the delivery of PCN services/activities to its patients. This might include agreed arrangements for communicating with patients and data sharing, for example;
   ii. defining which matters of PCN 2 the relevant practice may have an interest/vote in; and
   iii. whether there is any PCN 2 related information e.g. financial accounts, that it should not be party to.

2) **Option 2: Entering into a separate specific sub-contract**

a. In this scenario, the relevant practice could enter into a separate sub-contract with one or more of the Core Network Practices of PCN 2 for the delivery of PCN services/activities. Both PCNs will need to reflect the sub-contracting arrangement in both Network Agreements. In this scenario, it would not be necessary for the relevant practice to sign the Network Agreement of PCN 2.

6.1.4. PCNs will need to carefully consider the pros and cons of each approach, bearing in mind the additional complexity that either of the sub-contracting arrangements may bring and ensure that the agreed position is set out in clear and unambiguous wording. In all cases, the sub-contracting arrangements should include the ability to review/update the sub-contracting arrangements in light of any changes to the Network Contract DES Specification.

6.1.5. In entering into any sub-contracting arrangement, GP practices should at all times ensure they are complying with the sub-contracting requirements within their individual primary medical services contracts. Where a PCN wishes to sub-contract delivery of network services to a GP federation, this is permitted if the arrangement complies with the sub-contracting requirements in each GP practice's primary medical services contract.

6.2 Sub-contracting of clinical and non-clinical services or matters

6.2.1. Following an amendment to GMS and PMS Regulations[5], a sub-contractor to a practice or practices may be allowed to onward sub-contract a clinical matter that relates to the Network Contract DES. If, for example, practices have sub-contracted provision of clinical services to a GP federation, the sub-contract could now allow the GP federation to sub-contract the clinical services to another organisation with the prior written approval of the commissioner. The commissioner's approval will not unreasonably be withheld or delayed.

6.2.2. A sub-contractor to a practice or practice(s) will be allowed to onward sub-contract a non-clinical matter that relates to the Network Contract DES where the prior written approval of the commissioner is given. The commissioner's approval will not unreasonably be withheld or delayed.

7. Additional Roles Reimbursement Scheme

7.1 Workforce planning and ongoing reporting

7.1.1. Expanding the workforce is the top priority for primary care, and commissioners must support their PCNs to undertake recruitment under the Additional Roles Reimbursement Scheme to deliver this priority.

7.1.2. PCNs are required to plan their future workforce requirements in order to support claims under their Additional Roles Reimbursement Sum each year. As set out in the Network Contract DES Specification, each PCN is required to complete and return to the commissioner by 31 August 2021 the workforce planning template[6], providing details of any updated recruitment plans for 2021/22 and by 31 October 2021 any updated indicative intentions through to 2023/24. The commissioner will confirm the plan with each PCN's Clinical Director and, once each plan is agreed, will share with NHS England and NHS Improvement Regional Teams by 30 September 2021 for 2021/22 plans, and by 30 November 2021 for indicative future plans.

7.1.3. The PCN may change these plans at any stage provided that such change is shared with the commissioner as this aids management of the redistribution of Additional Roles Reimbursement Scheme funding across all PCNs, as described in section 7.5 of the Network Contract DES Specification.

7.1.4. PCNs working with their commissioners and their ICS are encouraged to have ongoing dialogue in relation to workforce strategies, to ensure these are consistent with broader ICS workforce strategies.

7.1.5. The commissioner must complete and return the six-monthly workforce report to england.primarycareworkforce@nhs.net. There are plans to develop an online template for future returns, and further details will be made available to commissioners in due course.

---

[5] The NHS (GMS Contracts and PMS Agreements) (Amendment) (No2) Regulations 2020: https://www.legislation.gov.uk/uksi/2020/911/schedule/1/made?view=plain

[6] This template will be available at https://www.england.nhs.uk/gp/investment/gp-contract/

7.1.6. PCN Core Network Practices must record, on a monthly basis, within the National Workforce Reporting Service (NWRS) information on any staff employed or engaged through the Additional Roles Reimbursement Scheme.

System Support for PCNs

7.1.7. CCGs and systems are expected to explore different ways of supporting PCNs. These should include, but not be limited to:

a. the immediate offer of support from their own staff to help with co-ordinating and running recruitment exercises;
b. the offer of collective/batch recruitment across PCNs. Where groups of PCNs wish to advertise vacancies collectively, CCGs or ICSs should support this;
c. brokering arrangements to support full-time direct employment of staff by community partners, or to support rotational working across acute, community and (in time) mental health trusts, as well as community pharmacy; and
d. ensuring that NHS workforce plans for the local system are as helpful as possible in meeting PCN intentions.

7.2 Additional Roles Reimbursement Sum

7.2.1. Each PCN will be allocated an Additional Roles Reimbursement sum each year, based upon the PCN's Contractor Weighted Population share of the total Additional Roles Reimbursement Scheme funding. To ensure consistency and fairness in allocations, the basis for weighting is the same as for global sum (i.e. Carr-Hill Formula). PCNs will be able to claim up to this maximum sum each year, in line with the rules set out in the Network Contract DES Specification.

7.2.2. Each PCN's Additional Roles Reimbursement Sum will use the Contractor Weighted Population[7] as at 1 January of the financial year preceding and be calculated as follows:

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

7.2.3. The Additional Roles Reimbursement Sum for any given year would be calculated as follows:

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

7.3 Ready reckoner

7.3.1. A ready reckoner is available to support PCNs to calculate their indicative Additional Roles Reimbursement Sum based on their PCN Contractor

[7] 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.

Weighted Population. Table 1[8] sets out the indicative Additional Roles Reimbursement Sum allocations for different PCN sizes from 2021/22 to 2023/24. Calculations are based on a national population of 60,616,648[9] (figures for both national population and PCN size will, on average, grow proportionally to each other).

7.3.2. For 2021/22 the Additional Roles Reimbursement Sum will be calculated using £12.314 multiplied by the PCN Contractor Weighted Population as at 1 January 2021. The 2021/22 figures in Table 1 are calculated using £12.314 per PCN Contractor Weighted Population. The figures for years 2022/23 to 2023/24 are calculated using the formula in section 7.2 and the 2021/22 national population of 60,616,648.

Table 1: Indicative Additional Roles Reimbursement Scheme Sum per PCN Contractor Weighted Population

Table 1	2021/22	2022/23	2023/24
Total National Workforce funding	**£746,458,000**	**£1,026,747,000**	**£1,412,011,000**
PCN Size (weighted)			
15,000	184,700	254,100	349,400
20,000	246,300	338,800	465,900
25,000	307,900	423,500	582,400
30,000	369,400	508,200	698,800
40,000	492,600	677,500	931,800
50,000	615,700	846,900	1,164,700
80,000	985,100	1,355,100	1,863,500
100,000	1,231,400	1,693,800	2,329,400
150,000	1,847,100	2,540,800	3,494,100

7.4 Entitlements not taken up under the Additional Roles Reimbursement Scheme

7.4.1. The Additional Roles Reimbursement Sum funding is only available to fund additional PCN workforce in line with the rules of the scheme.

7.4.2. NHS England expects the funding under the Additional Roles Reimbursement Scheme to be used in full, on the terms set out in the Network Contract DES Specification and in this guidance, in each year of the scheme.

7.4.3. As set out in the Network Contract DES Specification, each PCN is required to complete a workforce plan which commissioners will use to inform their estimation of likely unclaimed Additional Roles Reimbursement Scheme

[8] For illustrative purposes, both national population and PCN size have been fixed in table 1 to give an indicative view of the funding current PCN population sizes will attract in future as they grow, on average, in line with the growth in the national population. The figures in table 1 do not include any subsequent uplifts that may be agreed to the Agenda for Change pay rates on which the maximum reimbursable sum is based. Figures are therefore subject to change to take this into account in future.

[9] The total England weighted population is equal to the total England registered population.

funding. Following this, commissioners will be required to follow the process for redistributing any unclaimed Additional Roles funding in line with the requirements and process as set out in the Network Contract DES Specification.

7.4.4. Any unused funding in a given financial year cannot be carried forward into subsequent years, and a PCN's entitlement to that funding in that year will therefore be lost.

7.5 Principle of additionality and baselines

7.5.1. To receive the associated funding through the Additional Roles Reimbursement Scheme, a PCN must show that the staff delivering health services for whom reimbursement is being claimed are additional and comply with the "principle of additionality" as set out in sections 7.2 of the Network Contract DES Specification. The additionality rule serves both to protect pre-existing local investment in primary care (e.g. by commissioners), as well as to expand capacity. It is not possible for Core Network Practices or commissioners to stop funding staff identified in the baseline exercise on the grounds that these could instead be funded through PCN reimbursement.

7.5.2. 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. The two baselines established during 2019 are as follows (further detail on how the baselines were established is available in the 2019/20 Additional Roles Reimbursement Scheme Guidance):

a. A PCN baseline declared by the Core Network Practices of the PCN and agreed with the commissioner. It is comprised of the actual whole time equivalent (WTE) staff across these six reimbursable roles and funded by general practice as at 31 March 2019. The PCN baseline will be fixed until 31 March 2024.

b. A Clinical Commissioning Group (CCG) baseline declared by the CCG. It is comprised of the WTE patient facing or first contact time of staff across the six reimbursable roles deployed to support general practice or primary medical care services - either in a specific practice or in the wider community - funded[10] by the CCG as at 31 March 2019 (regardless of whether funded due to direct CCG employment or through a contract). Any admin, travel, triage or other time directly related to patient care is included in the WTE. The commissioner is required to maintain funding for these baseline posts and will be subject to audit. CCGs will be obliged to continue to fund baseline posts and will be subject to audit. All CGGs have been fully funded for GP contract costs in their primary medical services allocations. CCG baseline posts will have no bearing on PCN additionality claims.

[10] The six reimbursable roles funded include those directly employed by the CCG.

7.5.3. These baselines will be monitored at a national level in line with the *NHS Long Term Plan* commitment that resources for primary medical and community services will increase in real terms by 2023/24 and rise as a share of the overall NHS budget.

7.5.4. The purpose of the baseline is to provide a fixed reference point against which additionality claims should be assessed. Thus, changes to baseline numbers will not be permitted. However, in the rare circumstances that it becomes apparent at a later date that the baseline was incorrect, the PCN Clinical Director and CCG Accountable Officer should agree and sign a new declaration confirming that the revised baseline reflects a true position. The changes to the baseline should be reflected, where appropriate, in the next quarterly NWRS and CCG six-monthly returns.

7.5.5. The PCN and CCG baselines are fixed for five years. PCN reimbursement claims under the Additional Roles Reimbursement Scheme will be assessed against the PCN baseline only.

7.5.6. Practices are required to maintain the declared PCN baseline in order to meet the additionality rules under the Network Contract DES Additional Roles Reimbursement Scheme. Reimbursement claims under the Scheme will be assessed against the PCN baseline only. It should generally be assessed for individual workforce groups, rather than the total number of staff in the PCN baseline in all six reimbursable roles. However, with agreement from the commissioner, a PCN will be able to substitute between clinical pharmacists, first contact physiotherapists, physician associates and paramedics within the practice-funded PCN baseline posts as outlined in section 7.2.4 of the Network Contract DES Specification.

7.5.7. For the purposes of the Additional Roles Reimbursement Scheme claims, WTE is defined as 37.5 hours in line with Agenda for Change (AfC) Terms and Conditions, although this may vary for non-AfC posts. Where AfC does not apply, PCNs should calculate the relevant WTE according to the normal full-time hours for that role in the employing organisation with reimbursement being made on a pro-rata basis accordingly.

7.5.8. A PCN baseline will not be established for health and wellbeing coaches, care coordinators, dietitians, podiatrists, occupational therapists, nursing associates, trainee nursing associates, mental health practitioners (MHPs) or advanced practitioners. While the PCN baseline will not include these roles, the additionality principles will still apply. A PCN claiming reimbursement in respect of these roles does so on the basis that it is for additional staff engaged or employed since 31 March 2019, and that the reimbursement is not being used to subsidise practice-funded roles that existed as at 31 March 2019.

7.5.9. Local agreements for the provision of MHPs (Adult and/or Child and Young Person MHPs) to a PCN must be additional over and above any:

a. MHPs already employed by the secondary care provider of community mental health services to work as a member of, whether full-time or part-time, including on a rotational basis, a general practice or PCN's core multi-disciplinary team as at 31 January 2021; and

b. Improving Access to Psychological Therapies (IAPT) Practitioner already employed by the by the secondary care provider of community mental health services and working co-located within the relevant general practice as at 1 January 2021.

7.5.10. As set out in section 7.6.1 below, any clinical pharmacists who transferred to the PCN by either 31 March 2020 or transfer between 1 April 2021 to 30 September 2021, are exempt from the PCN baseline providing the post was included in the PCN baseline established on 31 March 2019. Similarly, as set out in section 7.6.2 any pharmacists (clinical pharmacists and pharmacy technicians) employed under the *Medicines Optimisation in Care Homes (MOCH) Scheme* who were included in the PCN baseline established on 31 March 2019 and who transferred by 31 March 2021 or will transfer between 1 April 2021 and 30 September 201 are exempt from the additionality rules.

7.5.11. Baseline posts occupied by fixed term appointed staff can be considered to be 'filled' only if they are part of a long-term arrangement, which must be in place for a minimum of six months or more. Equally, PCNs will only be eligible to claim reimbursement for additional posts to be occupied by staff on fixed-term contracts, if these are for a minimum period of six months or more, unless the purpose is to provide temporary cover (e.g. sickness or parental leave) for an individual employed through the Additional Roles Reimbursement Scheme. In these circumstances, PCNs will be able to claim up to the maximum reimbursement amount per WTE as set out in the Network Contract DES Specification for actual salary plus employer on-costs (NI and pension), pro-rata for the period of the contract of employment and relevant WTE.

7.5.12. The Additional Roles Reimbursement Scheme cannot distinguish between staff with different job descriptions e.g. a MSK physiotherapist is the same as a non-MSK physiotherapist for the purposes of the baseline and additionality, so long as both roles have an element of patient-facing or first contact care time in specific practices or in the wider neighbourhood or community.

Changes to PCN baselines and staffing levels

7.5.13. It is expected that PCN staffing levels will change from time to time. PCNs will be required to notify commissioners at the earliest opportunity of any changes to staffing levels, which may affect the PCN's reimbursement entitlement. The mandatory online claim portal includes a section to notify commissioners of any changes.

7.5.14. The PCN should notify the commissioner that a member of staff who is in the PCN baseline or for which the PCN is claiming reimbursement will cease or has ceased to work for the PCN or (for PCN baseline roles) a Core Network Practice. Where possible, the PCN should notify the commissioner in advance of the member of staff's last day of employment (or the last day of the sub-contract where applicable) but no later than the last day of the calendar month in which the member of staff ceased to be employed/engaged.

7.5.15. Where a vacancy arises in a Core Network Practices' PCN baseline WTE, the PCN must apply an equivalent WTE reduction in their workforce funding

under the Network Contract DES Additional Roles Reimbursement Scheme. This reduction will be applied from three months (a three-month grace period) after the date at which the vacancy arose and which resulted in the PCN baseline reduction. For example, if one WTE post becomes vacant in a PCN's baseline and is not recruited to within three months, the PCN must deduct one WTE from its reimbursement claim until such time as the PCN baseline vacancy is filled, in order to maintain the principle of reimbursement for additional workforce. Sections 7.2.3 and 10 of the Network Contract DES Specification provide further information.

7.6 Transfer of clinical pharmacists and pharmacy technicians

Transfer of clinical pharmacists from the Clinical Pharmacist in General Practice Scheme

7.6.1. Any clinical pharmacists who were in post as at 31 March 2019 under the *Clinical Pharmacist in General Practice Scheme* were required to transfer to the PCN by 31 March 2020 in order to be eligible for funding through the Additional Roles Reimbursement Scheme and to be exempt from the PCN baseline. A further opportunity is available between 1 April 2021 and 30 September 2021 for any clinical pharmacists still employed under this scheme on 31 March 2021 to transfer and be eligible for funding through the Additional Roles Reimbursement Scheme. Practices are responsible for fully funding any clinical pharmacist posts which have not transferred after the tapering of the *Clinical Pharmacist in General Practice Scheme* funding.

Transfer of pharmacists from the Medicines Optimisation in Care Homes Scheme

7.6.2. For all pharmacists (clinical pharmacists and pharmacy technicians) employed under the *Medicines Optimisation in Care Homes (MOCH) Scheme*, transfer to the PCN must have taken place by no later than 31 March 2021. A further opportunity is available between 1 April 2021 and 30 September 2021 for any MOCH pharmacists still employed under this scheme on 31 March 2021 to transfer and be eligible for funding through the Additional Roles Reimbursement Scheme.

7.6.3. Where MOCH pharmacists do not transfer, commissioners are required to align the priorities of the CCG commissioned MOCH team to that of the Enhanced Health in Care Homes service requirements outlined in section 8.3 the Network Contract DES Specification.

7.7 Additional Roles Reimbursement Scheme claims process

7.7.1. Commissioners should ensure that any staff for which reimbursement is being claimed meet the requirements set out in section 10 of the Network Contract DES Specification.

7.7.2. PCNs must use the mandatory online claim portal for all workforce reimbursement claims under the Additional Roles Reimbursement Scheme, in accordance with sections 10.1, 10.2 and 10.5 of the Network Contract DES Specification. Commissioners may ask PCNs for further evidence to support new workforce reimbursement claims, which may include:

a. A signed contract of employment (can remove personal information where appropriate) clearly setting out the salary.
b. A contract/agreement with a provider for the provision of services.
c. A copy of a Network Agreement – if used as the basis for sub-contracting for services/staff.

7.7.3. In the event the practice(s) within the PCN decide to engage the services of staff reimbursable under the Additional Roles Reimbursement Scheme via a sub-contracting arrangement, the PCN will need to agree with the sub-contractor the relevant costs of the service while bearing in mind the scheme rules. The rules are that reimbursement can only be claimed for 100 per cent, or 50 per cent for mental health practitioners, of **actual salary plus employer on-costs (NI and pension)** up to the maximum amount for the relevant role, as outlined in the Network Contract DES Specification and within the PCNs overall Additional Roles Reimbursement Sum.

7.7.4. For social prescribing link workers engaged via a sub-contract to an organisation outside the PCN, and not directly employed, the reimbursement claim may include a contribution towards the additional costs charged by a sub-contractor for the delivery of social prescribing services. See section 10.1.14 below for details.

7.7.5. Commissioners should ensure that local processes are as straightforward as possible, with clear deadlines for submission of claims, and claims should be processed in a timely manner.

7.7.6. Reimbursement claims will be subject to validation and any suspicion that deliberate attempts have been made to subvert the additionality principles or to claim costs above and beyond those allowable, will result in a referral for investigation as potential fraud. PCNs may be asked as part of the validation process to re-confirm the position regarding the number of filled baseline posts at the point a reimbursement claim is made. They may also be asked to provide copies of sub-contracting or Service Level Agreements where they are claiming for staff employed or supplied by a third party.

7.7.7. Reimbursement will apply up to the Additional Roles Reimbursement Scheme cap and applies to actual salary plus employer on-costs (NI and pension) only, not to additional hours or recruitment and retention premia agreed in addition.

7.7.8. Commissioners may claim back reimbursement monies where it becomes apparent that a PCN was not eligible to claim reimbursement under the Network Contract DES e.g. because it failed to declare a vacant baseline post.

8. Additional Roles Reimbursement Scheme Workforce

8.1. Additional Roles

8.1.1. A PCN may employ or engage any one or more of the reimbursable roles in accordance with the details set out in section 7 and section 10 of the Network

Contract DES Specification. Annex B of the Network Contract DES Specification sets out the minimum role requirements for each of the reimbursable roles from April 2021 and the associated requirements placed on PCNs.

8.1.2. This section provides additional information to support that included in the Network Contract DES and supporting materials available.

8.2. Role descriptions and terms and conditions

8.2.1. Employers of staff recruited under the Additional Roles Reimbursement Scheme will determine what terms and conditions, including salary, they offer new staff and may consider using Agenda for Change bands as a guideline. In doing so, they should take a fair approach with regards to remuneration relative to other staff already working within and across the PCN GP member practices.

8.2.2. Employers will decide the job descriptions of their own staff, ensuring they incorporate the minimum role requirements outlined Annex B of the Network Contract DES Specification and bearing in mind the abilities for the roles to support delivery of network services.

8.2.3. Decisions to amend terms and conditions of employment for existing staff is a matter for the employer following due process.

8.3. Clinical pharmacists

8.3.1. A minimum of 0.5 WTE should apply to the clinical pharmacists employed via the Network Contract DES. This is to ensure the clinical pharmacist is able to access timely national training and can deliver continuity of care whilst working across multiple providers within the PCN.

8.3.2. Clinical pharmacists being employed through the Network Contract DES funding will either be enrolled in or have qualified from an accredited training pathway that equips the pharmacist to be able to practise and prescribe safely and effectively in a primary care setting currently, the Clinical Pharmacist training pathway[11,12]) and in order to deliver the key responsibilities of the role. NHS England and NHS Improvement will be arranging a funding mechanism to allow all clinical pharmacists to access and complete an approved training pathway that equips the pharmacist to achieve this.

8.3.3. Upon completing the training pathway, the clinical pharmacist receives a ‘Statement of Assessment and Progression’ which details the learning undertaken and confirms the assessments they have passed. This documentation is available in both hardcopy and electronic format. In addition to this, evidence of training need for any current or future employer can be

[11] CPPE Clinical Pharmacists in General Practice Training Pathway https://www.cppe.ac.uk/career/clinical-pharmacists-in-general-practice-education#navTop

[12] CPPE Medicines Optimisation in Care Homes Training Pathway https://www.cppe.ac.uk/career/moch/moch-training-pathway#navTop

access through the protected section of the website of the learning provider, which captures the learning of the Clinical Pharmacists participating in their training.

8.3.4. This training requirement can be met with pre-existing qualifications / experience on the basis that it meets the learning objectives of the current approved training pathway funded by NHS England and NHS Improvement. The training will be modular and clinical pharmacists are only required to undertake the training they need to complete the portfolio requirements. This accreditation of prior learning should be undertaken by the supervising senior clinical pharmacist and Clinical Director for the PCN.

Supervision of Clinical Pharmacist

8.3.5. All clinical pharmacists will be part of a professional clinical network and will always be clinically supervised by a senior clinical pharmacist and GP clinical supervisor. The following supervision must be in place for senior clinical pharmacists and clinical pharmacists:

a. Each clinical pharmacist will receive a minimum of one supervision session per month by a senior clinical pharmacist[13];
b. The senior clinical pharmacist will receive a minimum of one supervision session every three months by a GP clinical supervisor; and
c. All clinical pharmacists will have access to an assigned GP clinical supervisor for support and development.

8.3.6. The ratio of senior to junior clinical pharmacists should be up to one to five, and in all cases appropriate peer support and supervision must be in place.

8.3.7. Flexible and innovative approaches to the formation of clinical networks can be adopted and promoted to enhance collaboration/integration across healthcare interfaces.

8.4. MOCH pharmacists

8.4.1. Where any MOCH pharmacists remain, PCNs will be expected to make operational use of the pharmacist's experience in relation to Care Homes as outlined in section 9.3 below and section 8.3 of the Network Contract DES Specification. This will include:

a. supporting care homes with local policies and procedures, training, vaccinations and provide support for any challenges the home may have, including:
b. ordering and storage of medicines to reduce waste
c. supporting care planning and comprehensive geriatric assessments (CGA) structured medication reviews
d. link-in to community services, acute trusts and mental health services
e. supporting weekly care home rounds, working with the MDT

[13] This does not need to be a senior clinical pharmacist within the PCN but could be part of a wider local network, including from secondary care or another PCN.

f. working with the wider MDT (including external organisations) to support the delivery of Enhanced Health in Care Homes.

8.5. Further guidance and supporting information

8.5.1. Supporting guidance providing further information to help PCNs employ or engage Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Co-ordinators is available at:

a. Social prescribing link workers - https://www.england.nhs.uk/publication/social-prescribing-link-workers/
b. Health and Wellbeing Coaches - https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/
c. Personalised Care Institute - https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

8.5.2. PCNs employing or engaging one of the Allied Health Professionals must consider the qualifications, experience and capabilities when determining which job description is utilised for the role and considering the minimum role requirements set out in Annex B of the Network Contract DES Specification. Further information:

a. on capabilities is available at (while this document refers to the MSK framework, the capabilities have been written for all AHPs): https://www.csp.org.uk/system/files/musculoskeletal_framework2.pdf;
b. https://www.england.nhs.uk/ahp/ahps-in-primary-care-networks/.

8.5.3. Each AHP employed or engaged by a PCN must have access to appropriate clinical supervision and an appropriate named individual for general advice and support daily.

8.5.4. A number of supporting materials are available in the Primary Care Networks Development Support section of the FutureNHS Collaboration Platform.

8.5.5. During 2021/22, all Additional Roles will be made available for inclusion on Smartcards, to support accurate recording of Health Care Professional type in GP records. Further information will be provided in due course as to how these roles can be applied to Smartcards, for both new and existing employees.

9. Service requirements

9.1. Extended hours access

9.1.1. Section 8.1 of the Network Contract DES Specification sets out the requirements for delivery of extended hours access.

9.1.2. Where a practice has signed up to the Network Contract DES, they become contractually obliged to offer extended access to its registered patients via the PCN (which can be delivered by the practice or sub-contracted). Therefore, all patients should have access to extended hours services

through the PCN, but it will be for the PCN to determine how that offer is made available to all its registered patients.

9.1.3. The additional clinical appointments provided by a PCN are to be held at times that take account of patient's expressed preferences and are outside the hours that the PCN Core Network Practices' are required to provide as part of their primary medical services contracts. This means that if a Core Network Practice was required under a General Medical Services (GMS) contract to provide core services at its premises until 6:30pm, the additional clinical appointments could be provided after 6:30pm. If, however, another Core Network Practice in the PCN provided core services at its premises until 8pm, then:

a. 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
b. a proportion of the additional clinical appointments must be provided after 8pm.

9.1.4. Core Network Practices within a PCN are collectively responsible for the delivery of extended hours access. In the event the commissioner is not satisfied that a PCN is delivering extended hours access in accordance with the Network Contract DES, then the commissioner may take action as set out in section 9 of the Network Contract DES Specification. If a commissioner determines to withhold payment[14], the amount withheld will be an appropriate proportion of the extended hours access payment and the Core PCN funding payment.

9.1.5. PCNs have the flexibility, once providing extended access, to sub-contract those services to other providers in accordance with any sub-contracting provisions of the GP practices' primary medical services contracts.

9.1.6. The delivery of extended hours access through the Network Contract DES will be in addition to any CCG commissioned extended access services.

Delivery models for PCN extended hours access appointments

9.1.7. It will be up to the PCN to determine the delivery model for the extended hours access appointments as part of the Network Agreement, but PCNs will need to ensure this service is offered to the entire PCN population. The exact model of delivery in each PCN may vary and could include:

a. All practices in the PCN continuing to offer extended hours to its own registered list.
b. One practice undertaking the majority of the extended hours provision for the PCN's population, with other practices participating less frequently (but those practices' registered patients still having access to extended hours services at other sites).

[14] Payment withheld in this context would be an appropriate proportion of the payments in relation to both extended hours access and Core PCN funding payments.

c. One practice offering extended hours to its own registered list and the other practices sub-contracting delivery for their respective patients.
d. The PCN subcontracting as a whole to another provider for its collective population.

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

Funding for the extended hours access in the Network Contract DES

9.1.9. The full year funding under the Network Contract DES equates to £1.44 per registered patient per annum. On top of this payment of £1.44 per registered patient per annum through the Network Contract DES, practices will receive within their global sum payments around £0.50p per patient to cover the expansion in delivery to 100 per cent of patients. Taken together, the two amounts would total a payment of approximately £1.94 (£1.44 plus £0.50p) per registered patient per year.

9.1.10. This funding is in addition to funding the practice may already receive from the CCG for delivering their commissioned extended access services.

9.2. Structured Medication Reviews (SMRs) and Medicines Optimisation

9.2.1. Further guidance related to the implementation and delivery of requirements relating to this service have been published[15]. The Network Contract DES Specification sets out that PCNs must have due regard to that separate guidance in delivery of the service requirements.

Recording of SMRs on GP IT systems

9.2.2. The relevant SMR codes must be used to record the occurrence of a SMR and follow up appointments. The relevant SMR codes are available in the supporting Business Rules[16].

Additional metrics and outcomes

9.2.3. PCN rates of prescription of high-carbon inhalers and medicines of low priority will be displayed in the Network Dashboard. Metrics on prescribing quality for anti-microbials and drugs that potentially cause dependency, as well as a wider patient outcome measurement, are being considered and will be informed by future developments, such as the implementation of Public Health England's (PHE) report into prescribed medicines[17]. Once

[15] https://www.england.nhs.uk/publication/structured-medication-reviews-and-medicines-optimisation-2021-22/
[16] Network Contract DES related Business Rules are published by NHS Digital under the relevant years 'Enhanced Services, Vaccinations and Immunisations and Core Contract components' page.
[17] https://www.gov.uk/government/publications/prescribed-medicines-review-report

finalised, measures of prescribing quality will be displayed on the new Network Dashboard. In the meantime, the Network Dashboard will link to existing data on prescribing rates of relevant drugs hosted by the NHS Business Services Authority (NHS BSA) and Open Prescribing. Further detail will be contained in the standalone guidance document.

9.3. Enhanced Health in Care Homes

Relationship of DES to Enhanced Health in Care Homes Framework

9.3.1. The Network Contract DES and requirements for relevant providers of community physical and mental health services within the NHS Standard Contract establish a consistent, national, model for the Enhanced Health in Care Homes (EHCH) service. Commissioners, PCNs and other providers should consider these requirements as a minimum standard. The Enhanced Health in Care Homes requirements remain of vital importance during the COVID-19 pandemic, to support the organisation and delivery of a coordinated service to care home residents, many of whom will be at very high risk of a severe negative impact (directly or indirectly) from COVID-19. Good practice is described in the EHCH Framework which will support implementation of a mature EHCH service.

Definition of Care Home

9.3.2. 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. Whether each home is included in the scope of the service will be determined by its registration with CQC. The CQC website contains a spreadsheet which can be filtered to show CQC registered care homes. This spreadsheet can be found here and is titled *CQC care directory – with filters* followed by the date of the latest update. Column C can be filtered to show CQC registered care homes. All care homes in this directory are in the scope of the EHCH service.

9.3.3. The EHCH service requirements apply equally to people who self-fund their care and to people whose care is funded by the NHS or their local authority. It is equally applicable to care homes for people with learning disabilities and/or mental health needs and should not be interpreted as only pertaining to care homes for older people. However, secure mental health units are not in scope.

Alignment of Care Homes to PCNs

9.3.4. Commissioners hold overall responsibility for ensuring that each care home is aligned to a single PCN, and this is an ongoing obligation. Commissioners must keep this alignment up to date. In instances after 31 July 2020 where there are changes in circumstance after the initial alignment decision was 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 have aligned a PCN to that home within three months of becoming aware of the alignment not being in place.

9.3.5. PCNs and commissioners are expected to take into account the following factors when considering which homes align with which PCNs:
   a. Where the home is located in relation to PCNs and their constituent practices
   b. The existing GP registration of people living in the home
   c. What contracts are already held between commissioner and practices to provide support to the home, or directly between the home and practices
   d. Existing relationships between care homes and practices.

9.3.6. PCNs that have care homes allocated to them must provide the EHCH service to those care homes.

Delivery plan with local partners

9.3.7. The plan for delivery of the EHCH service should include:
   a. An agreement between the PCN, relevant providers of community services and mental health, the care home, the commissioner and other local partners on the operating model for the home round and MDT.
   b. Clear roles and responsibilities for delivery of each EHCH requirement, including the ongoing provision of care described in the personalised care and support plan.
   c. Agreed risks to the successful delivery of the EHCH service, with clear mitigating actions, owners and timescales for resolution.

Supporting re-registration of patients

9.3.8. In supporting patients to re-register with a practice in the aligned PCN, care homes, PCNs and commissioners must clearly communicate the benefits offered under the EHCH service, and ensure that the patient understands that they will not receive the service if they choose not to re-register. In instances where patients do not have the capacity to understand or make choices on re-registration, this discussion must take place with the person who has power of attorney over their affairs.

Further guidance

9.3.9. Guidance for implementation of the following service requirements - and other aspects of a mature EHCH service - can be found in the EHCH Framework:
   a. establishment and operation of a MDT;
   b. establishment of information sharing protocols; and
   c. delivery of a weekly home round.

9.4. Early Cancer Diagnosis

9.4.1. Primary care has a vital role to play in system-wide improvement efforts to increase the proportion of cancers diagnosed early, supporting the NHS Long Term Plan ambition to diagnose 75% of cancers at stages 1 and 2 by 2028. The ECD service requirements for PCNs seek to improve referral practice and screening uptake through network level activity and are aligned with the Supporting Early Cancer Diagnosis QOF QI Module which will run in 2021/22. Further guidance related to the implementation and delivery of

requirements relating to the PCN service, including guidance on the appropriate management of suspected cancer referrals during the COVID-19 pandemic, is available here.

9.5. Social prescribing service

9.5.1. A PCN must provide a social prescribing service to their collective patients.

9.5.2. This service can be provided by either directly employing Social Prescribing Link Workers or by sub-contracting the provision of the service to another provider. Regardless of which option a PCN chooses to deliver, the PCN should be employing or engaging at least some Social Prescribing Link Worker resource in accordance with section B3 of Annex B of the Network Contract DES Specification.

9.6. Cardiovascular Disease (CVD) Prevention and Diagnosis

9.6.1. CVD is the leading cause of death worldwide and is strongly associated with health inequalities (the most deprived quintile of the population is four times more likely to die from CVD than the least deprived). Hypertension is the most prevalent risk factor, and the focus of this service in 2021/22. From April 2022, this will be expanded to incorporate detection and management of atrial fibrillation (AF) and addressing cholesterol in the context of CVD risk, including detection and management of familial hypercholesterolaemia (FH).

9.6.2. Further guidance related to the implementation and delivery of requirements relating to this PCN service is available here.

9.7. Tackling Neighbourhood Health Inequalities (TNHI)

9.7.1. From October 2021, PCNs must improve delivery of annual learning disability health checks and action plans for patients over 14, improve recording of patients with a severe mental illness and delivery of comprehensive physical health checks, record the ethnicity of all PCN registered patients (where provided) and appoint a health inequalities lead for the PCN.

9.7.2. PCNs must meet further milestones in February 2022 to identify a population experiencing inequality in health provision and/or outcomes, agree with the commissioner an approach to engagement and tackling the unmet needs of the population, and from 1 March 2022 begin ongoing delivery of its planned intervention.

9.7.3. Further resources, including case studies and toolkits, are available on the FutureNHS Equality and Health Inequality network.

2. Financial entitlements, nominated payee and payment information

10.1. Financial entitlements

10.1.1. Financial entitlements under the Network Contract DES reflect a blended payment as set out in section 10 of the Network Contract DES Specification.

10.1.2. Table 2 provides a summary of the Network Contract DES financial entitlements payable to the PCNs nominated payee. All Network Contract DES payments are inclusive of VAT, where VAT is applicable.

Table 2: Summary of Network Contract DES financial entitlements

Payment details and allocation	Amount	Allocations	Payment timings
Core PCN funding	£1.50 per registered patient[18] per year (equating to £0.125 per patient per month).	CCG core programme allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Clinical Director contribution	£0.736 per registered patient[17] per year (equating to £0.061 per patient per month).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Staff reimbursements	Actual salary plus employer on-costs (NI and pension) to the maximum per WTE[19] amounts[20] as outlined in Network Contract DES Specification. For the London Region PCNs, inner and outer maximum reimbursable rates apply in accordance with the Network Contract DES Specification.	PMC allocations	Monthly in arrears by the last day of the month following the month in which the payment relates and taking into account local payment arrangements. Payment claimable following start of employment.
Extended hours access	£1.44 per registered patient[17] (equating to £0.120 per patient per month).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Care home premium	£120 per bed per year (equating to £10 per bed per month).	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
Investment and Impact Fund (IIF)	Amount payable dependant on achievement.	PMC allocations	See paragraph 10.1.3 below

[18] Based on the patient numbers as at 1 January immediately preceding the financial year. For example, the 1 January 2021 patient figures are used for the 2021/22 financial year.

[19] WTE is usually 37.5 hours in line with Agenda for Change (AfC) Terms and Conditions, although this may vary for non-AfC posts. Where AfC does not apply, PCNs should calculate the relevant WTE according to the normal full-time hours for that role in the employing organisation with reimbursement being made on a pro-rata basis accordingly.

[20] The annual maximum amounts for 2021/22 as outlined in the Network Contract DES are to be pro-rated on the proportion of the year that an individual is in post.

Payment details and allocation	Amount	Allocations	Payment timings
Leadership and management payment	£0.707 multiplied by PCN Adjusted Population[21] (equating to £0.118 per adjusted patient per month) where PCN Adjusted Population is based on the CCG primary medical care allocation.	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements.
PCN Support Payment	£1.029 multiplied by PCN Contractor Weighted Population (equating to £0.257 multiplied by the PCN Contractor Weighted Population per month) as at 1 January 2021.	PMC allocations	Monthly by the last day of the month in which the payment applies and taking into account local payment arrangements, with the exception of the December payment which may be made as soon as practicable and no later than the end of January

10.1.3. The details on how the IIF operates and associated payments can be found in Section 10.6 and Annexes C and D of the Network Contract DES Specification and the separate IIF guidance[22]. This information has now been updated to reflect the IIF changes from December 2021.

10.1.4. Payments due to the PCN nominated payee for Core PCN Funding, Clinical Director, Extended Hours Access and Care Home Premium will be payable in 12 equal monthly instalments and made by the commissioner no later than the last day of the month in which the payments apply and taking into account local payment arrangements. For a Previously Approved PCN with membership changes and a new proposed PCN, these payments will be made no later than the end of the month in which participation of all Core Network Practices of that PCN has been confirmed, taking into account local payment arrangements. Where an ODS Change Instruction Notice needs to be submitted, this must be by the last working day on or before the 14th day of any month and where it is submitted after this time, the change and payment will not take effect until the end of the following month.

10.1.5. Where the PCN is a Previously Approved PCN and the first payment is paid after April 2021, the first payment will be backdated to include payments due from 1 April 2021. Where the PCN is a new proposed PCN after 1 April 2021, the PCN will only be entitled to receive payments for the months for which it delivers the requirements of the Network Contract DES. Refer to section 10.3 for further information on how payment calculations for 2021/22 will be managed.

10.1.6. Apart from the PCN Core Funding payment (i.e. the £1.50 per head payment), all other Network Contract DES payments and the Network

[21] The PCN Adjusted Population as at 1 September 2021.
[22] https://www.england.nhs.uk/publication/investment-and-impact-fund-2021-22-implementation-guidance/

Participation Payment will be payable from CCG Primary Care Medical allocations. The Core PCN Funding payment is payable from CCG core allocations[23] and is set out in the NHS Operational Planning and Contracting Guidance 2020/21[24].

10.1.7. Additional Role Reimbursement Scheme payments will be made monthly in arrears following the start of employment or commencement of service provision. The nominated payee will be required to submit the relevant monthly claims using the online claim portal. Commissioners will make the relevant payments to the nominated payee no later than the last day of the month following the month to which the payment relates and taking into account local payment arrangements.

10.1.8. The Leadership and Management payment will be payable from October 2021 in 6 equal monthly instalments and made by the commissioner no later than the last day of the month in which the payment applies and taking into account local payment arrangements. For a Previously Approved PCN with membership changes or a new proposed PCN, these payments will be made no later than the end of the month in which participation of all Core Network Practices of that PCN has been confirmed, taking into account local payment arrangements. Where an ODS Change Instruction Notice needs to be submitted, this must be by the last working day on or before the 14th day of any month and where it is submitted after this time, the change and payment will not take effect until the end of the following month.

10.1.9. Where the PCN is a Previously Approved PCN and the first Leadership and Management payment is paid after October 2021, it will be backdated to include payments due from 1 October 2021. Where the PCN is a new proposed PCN after 1 October 2021, the PCN will only be entitled to receive Leadership and Management payments for the months for which it delivers the requirements of the Network Contract DES. Refer to section 10.3 for further information on how payment calculations for 2021/22 will be managed.

10.1.10. The PCN Support Payment will be payable from December 2021 in 4 equal monthly instalments and made by the commissioner no later than the last day of the month in which the payment applies and taking into account local payment arrangements, with the exception of the December payment which may be made as soon as practicable and no later than the end of January For a Previously Approved PCN with membership changes or a new proposed PCN, these payments will be made no later than the end of the month in which participation of all Core Network Practices of that PCN has been confirmed, taking into account local payment arrangements. Where an ODS Change Instruction Notice needs to be submitted, this must be by the last working day on or before the 14th day of any month and where it is submitted after this time, the change and payment will not take effect until

[23] Details available at the following link: https://www.england.nhs.uk/publication/ccg-allocations-2019-20-to-2023-24-core-services/

[24] https://www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21/

the end of the following month.

10.1.11. Where the PCN is a Previously Approved PCN and the first PCN Support Payment is paid after December 2021, it will be backdated to include payments due from 1 December 2021. Where the PCN is a new proposed PCN after 1 December 2021, the PCN will only be entitled to receive PCN Support Payment payments for the months for which it delivers the requirements of the Network Contract DES. Refer to section 10.3 for further information on how payment calculations for 2021/22 will be managed.

Network Participation Payment

10.1.12. In addition to the payments made to the PCN's nominated payee under the terms of the Network Contract DES, practices participating in the Network Contract DES will be entitled to the Network Participation Payment (NPP) - as set out in the General Medical Services Statement of Financial Entitlements and Network Contract DES Specification. This payment is £1.761 per weighted patient per year, equating to £0.147 per patient per month. The numbers of weighted patients are based on the Contractor Weighted Population taken as at quarter 4 immediately preceding the financial year (i.e. at 1 January in the preceding financial year). For example, the 2021/22 contractor weighted population figure will be that for quarter 4 in the 2020/21 financial year i.e. at 1 January 2021.

10.1.13. The NPP will be paid monthly in arrears on or before the last day of the month following the month in which the payment relates (i.e. payment for April will be made on or before the end of May). Where a practice is a Core Network Practice of a Previously Approved PCN and the first payment is paid after April 2021, the first payment will be backdated to include payments due from 1 April 2021. Where a practice is a Core Network Practice of a new proposed PCN after 1 April 2021, the practice will only be entitled to receive the NPP for the months for which it is actively participating in the Network Contract DES. Refer to section 10.3 below for further information on how payment calculations for 2021/22 will be managed.

Sub-contracted social prescribing service

10.1.14. For Social Prescribing Services sub-contracted by a PCN to another provider, PCN may claim a contribution towards additional costs charged by the sub-contracted provider. A PCN may claim a contribution of up to £200 per month (£2,400 per year) for each WTE that the sub-contracted provider has apportioned to the PCN related activity. The overall contribution claimed cannot exceed £200 per month, the total amount claimed must not exceed the maximum reimbursable amount for a social prescribing link worker and must be within the PCN's Additional Roles Reimbursement Sum. PCNs may wish to ensure that any sub-contracting agreement explicitly states the relevant costs (or WTE equivalent) as a copy may be requested by commissioners as evidence to support a reimbursement claim.

10.2. Network Contract DES nominated payee

10.2.1. The following paragraphs in the Network Contract DES Specification set out the factual points regarding who can hold the Network Contract DES and be the nominated payee:

a. Paragraph 2.2.10 – "the "**Nominated Payee**" refers to a practice or organisation (which must hold a primary medical services contract) that receives payment of the applicable financial entitlement set out in this Network Contract DES Specification."
b. Paragraph 10.1.1 – "A practice participating in the Network Contract DES acknowledges that payments made under the Network Contract DES are dependent on the Core Network Practices of a PCN working together to deliver the requirements of this Network Contract DES."
c. Paragraph 10.1.6 – "The commissioner must ensure that payments due to a PCN set out in this Network Contract DES are made into the bank account of the Nominated Payee. The PCN must inform the commissioner of the relevant payment details of its Nominated Payee. The PCN will include in the Network Agreement the details of arrangements with the Nominated Payee and may indicate the basis on which the Nominated Payee receives the payments on behalf of the other practices, e.g. as an agent or trustee."

10.2.2. The nominated payee must be party to the PCN's Network Agreement. This is because the Network Agreement forms the legal agreement between the constitute members of the PCN. It will set out how the PCN has agreed to use the DES funding to support delivery and how the PCN has agreed the funding will be apportioned between the members within the PCN.

10.2.3. Unlike the requirements over who can hold the Network Contract DES, the nominated payee does not have to hold a registered list and be delivering an essential primary medical services contract. The nominated payee must, however, hold a primary medical services contract and be party to the Network Agreement.

10.2.4. An APMS provider (including a provider who holds a hybrid NHS Standard Contract that is delivering primary medical care services under a Schedule 2L arrangement) can therefore be a nominated payee, even if they do not hold the Network Contract DES. As such, it is possible that a GP Federation holding an APMS contract for extended access or improved access (or another reason), could be nominated as the payee if all the Core Network Practices of the PCN agree. It also means that the same GP Federation could be nominated to be the payee for more than one PCN.

10.2.5. There are a few considerations that PCNs and commissioners should be mindful of in nominating a non-GP Practice APMS provider (i.e. a provider who does not hold the APMS contract for delivery of essential primary medical care services). See section 10.3.11 below.

10.3. Network Contract DES Payments

Manual payment arrangements

10.3.1. The Care Home Premium, Additional Roles Reimbursement Scheme, PCN Support Payment and Leadership & Management payments will continue to

be processed manually by commissioners and not be calculated automatically via CQRS. These PCN payments are to be made to the nominated payee in accordance with section 10 of the Network Contract DES Specification and using the relevant national subjective and other finance system codes outlined in section 10.3.10 below, as follows:

a. where the nominated payee is a GP practice setup Primary Care Support England (PCSE) Online, the commissioner will be required to process payments via a manual variation to NHAIS; OR
b. where the nominated payee is a non-GP practice APMS provider the commissioner will be required to make local payment arrangements.

10.3.2. For new proposed PCNs approved after 1 April 2021, the PCN will only be entitled to receive the monthly payments for the months it delivers the service requirements of the Network Contract DES. Similarly, the NPP will only be payable to a Core Network Practice of a new proposed PCN for the months they deliver the requirements of the Network Contract DES.

10.3.3. The PCN's nominated payee will be required to sign up and submit the monthly claims via Tradeshift https://www.sbs.nhs.uk/supplier-einvoicing. NHS England are working in partnership with NHS SBS to eliminate paper invoices and deliver e-invoicing via Tradeshift. Tradeshift allows registered users to easily upload their own invoices direct to the web-based portal at www.tradeshift.com offering immediate access to submit and track invoices. If you have any queries please email SBS-W.e-invoicingqueries@nhs.net or, for more information, visit http://tradeshift.com/supplier/nhs-sbs.

Automated payment arrangements through CQRS

10.3.4. Four payment calculations – the Core PCN Funding, Clinical Director, Extended Hours Access and NPP are **automated** via the CQRS. Apart from the NPP, these PCN payments are to be processed as follows:

a. For GP practice nominated payees – the payment file will be processed directly from CQRS to PCSE Online.
b. For non-GP practice APMS provider nominated payees - commissioners will be required to make manual payments, using the payment calculation information supplied by CQRS – details to be confirmed on how this will be provided. The payments are to be made to the nominated payee, using the relevant national subjective and other finance system codes (see 10.3.10 below) using local payment arrangements.

10.3.5. The NPP will be processed directly from CQRS to PCSE Online as with any other practice related payments. Practices will need to ensure that they validate the payment in CQRS before it proceeds for validation by the commissioner.

10.3.6. CQRS will calculate these four payments using the PCN ODS reference data towards the end of each month. Commissioners should ensure that any changes to the PCN ODS reference data are submitted using the PCN

ODS Change Instruction Notice[25] by the last working day on or before the 14th day of each month, so as to ensure the changes take effect prior to the CQRS payment calculation date. In the event a PCN ODS Change Instruction Notice is completed after the 14th day of a month, then changes will not take effect until the subsequent month and the commissioner may be required to follow a manual exception process (i.e. manual payment reconciliation) to ensure the correct payment are made.

10.3.7. Commissioners will need to ensure the NPP and PCN payments within CQRS are all validate through the two approval steps.

Additional payment information

10.3.8. A PCN is required to use the national mandatory online claim portal for all workforce claims. This claim form is to be completed and submitted on a monthly basis in accordance with the instructions from the commissioner. Commissioners are to inform PCNs as soon as possible where claim forms should be returned to. As of 1 April 2021, the portal will be the only way to claim reimbursement under the Additional Roles Reimbursement Scheme.

Any nominated payee

10.3.9. Work is being undertaken to support the introduction of 'any nominated payee'. This is to allow for a non-GP provider to be a PCN's nominated payee and/or for a separate bank account to be link to the PCN ODS code. Further information will be made available in due course.

National subjective and finance system codes for Network Contract DES

10.3.10. Table 3 sets out the relevant subject and finance system codes that commissioners will be required to use to support all payments under the 2021/22 Network Contract DES.

Table 3: National subjective and finance system codes for Network Contract DES payments

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
Network Participation Payment	PARTIA	A	C&M-APMS *PCN DES Participation*	521610XO
	PARTIG	G	C&M-GMS *PCN DES Participation*	521610XW
	PARTIP	P	C&M-PMS *PCN DES Participation*	521610YD
Core PCN funding	PCNSUA	A	C&M-APMS *PCN DES PCN support*	521610ZE
	PCNSUG	G	C&M-GMS *PCN DES PCN*	521610ZI

[25] The PCN ODS Change Instruction Notice is available here.

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
			Support	
	PCNSUP	P	C&M-PMS *PCN DES PCN Support*	521610ZL
Clinical Director contribution (population-based payments)	CLINDA	A	C&M-APMS PCN DES Clinical Director	521610YE
	CLINDG	G	C&M-GMS PCN DES Clinical Director	521610YI
	CLINDP	P	C&M-PMS PCN DES Clinical Director	521610YN
Staff reimbursements	CPHARA	A	C&M-APMS *PCN DES Clin Pharmacist*	521610UD
	CPHARG	G	C&M-GMS *PCN DES Clin Pharmacist*	521610UE
	CPHARP	P	C&M-PMS *PCN DES Clin Pharmacist*	521610UO
	SPRESA	A	C&M-APMS *PCN DES Soc Prescribing*	521610VD
	SPRESG	G	C&M-GMS *PCN DES Soc Prescribing*	521610VE
	SPRESP	P	C&M-PMS *PCN DES Soc Prescribing*	521610VI
	PHYSIA	A	C&M-APMS *PCN DES Physiotherapist*	521610VO
	PHYSIG	G	C&M-GMS *PCN DES Physiotherapist*	521610WD
	PHYSIP	P	C&M-PMS *PCN DES Physiotherapist*	521610WE
	PASSOA	A	C&M-APMS *PCN DES Physician Assoc*	521610WI
	PASSOG	G	C&M-GMS *PCN DES Physician Assoc*	521610WO
	PASSOP	P	C&M-PMS *PCN DES Physician Assoc*	521610XA
	DIETIA	A	*C&M-APMS PCN DES Dieticians*	5216108A
	DIETIG	G	*C&M-GMS PCN DES Dieticians*	
	DIETIP	P	*C&M-PMS PCN DES Dieticians*	
	PHARTA	A	*C&M-APMS PCN DES Pharmacy technicians*	5216108B
	PHARTG	G	*C&M-GMS PCN DES Pharmacy technicians*	
	PHARTP	P	*C&M-PMS PCN DES Pharmacy technicians*	
	PODIAA	A	*C&M-APMS PCN DES Podiatrist*	5216108C
	PODIAG	G	*C&M-GMS PCN DES Podiatrist*	
	PODIAP	P	*C&M-PMS PCN DES Podiatrist*	
	OCCTHA	A	*C&M-APMS PCN DES Occupational Therapists*	5216108D
	OCCTHG	G	*C&M-GMS PCN DES Occupational Therapists*	
	OCCTHP	P	*C&M-PMS PCN DES Occupational Therapists*	
	HWELLA	A	*C&M-APMS PCN DES Health and Wellbeing Coach*	5216108E

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
	HWELLG	G	*C&M-GMS PCN DES Health and Wellbeing Coach*	
	HWELLP	P	*C&M-PMS PCN DES Health and Wellbeing Coach*	
	CARECA	A	*C&M-APMS PCN DES Care Coordinator*	5216108F
	CARECG	G	*C&M-GMS PCN DES Care Coordinator*	
	CARECP	P	*C&M-PMS PCN DES Care Coordinator*	
	HOMRRA	A	*C&M-APMS PCN DES Home/RR paramedic*	521610XD
	HOMRRG	G	*C&M-GMS PCN DES Home/RR paramedic*	521610XE
	HOMRRP	P	*C&M-PMS PCN DES Home/RR paramedic*	521610XI
	NURSAA	A	*C&M-APMS PCN DES Nursing Associate*	5216108L
	NURSAG	G	*C&M-GMS PCN DES Nursing Associate*	
	NURSAP	P	*C&M-PMS PCN DES Nursing Associate*	
	TNURSA	A	*C&M-APMS PCN DES Trainee Nursing Associate*	5216108M
	TNURSG	G	*C&M-GMS PCN DES Trainee Nursing Associate*	
	TNURSP	P	*C&M-PMS PCN DES Trainee Nursing Associate*	
	CPHAPA	A	*C&M-APMS PCN DES Clinical Pharmacist Advanced Practitioner*	5216107S
	CPHAPG	G	*C&M-GMS PCN DES Clinical Pharmacist Advanced Practitioner*	
	CPHAPP	P	*C&M-PMS PCN DES Clinical Pharmacist Advanced Practitioner*	
	PHYAPA	A	*C&M-APMS PCN DES Physiotherapist Advanced Practitioner*	5216107T
	PHYAPG	G	*C&M-GMS PCN DES Physiotherapist Advanced Practitioner*	
	PHYAPP	P	*C&M-PMS PCN DES Physiotherapist Advanced Practitioner*	
	DIEAPA	A	*C&M-APMS PCN DES Dietician Advanced Practitioner*	5216107U
	DIEAPG	G	*C&M-GMS PCN DES Dietician Advanced Practitioner*	
	DIEAPP	P	*C&M-PMS PCN DES Dietician Advanced Practitioner*	
	PODAPA	A	*C&M-APMS PCN DES Podiatrist Advanced Practitioner*	5216107V
	PODAPG	G	*C&M-GMS PCN DES Podiatrist Advanced Practitioner*	

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
	PODAPP	P	*C&M-PMS PCN DES Podiatrist Advanced Practitioner*	
	OCTAPA	A	*C&M-APMS PCN DES Occupational Therapist Advanced Practitioner*	5216107W
	OCTAPG	G	*C&M-GMS PCN DES Occupational Therapist Advanced Practitioner*	
	OCTAPP	P	*C&M-PMS PCN DES Occupational Therapist Advanced Practitioner*	
	PARAPA	A	*C&M-APMS PCN DES Paramedic Advanced Practitioner*	5216107X
	PARAPG	G	*C&M-GMS PCN DES Paramedic Advanced Practitioner*	
	PARAPP	P	*C&M-PMS PCN DES Paramedic Advanced Practitioner*	
	ADMHPA	A	*C&M-APMS PCN DES Adult Mental Health Practitioner*	5216107Y
	ADMHPG	G	*C&M-GMS PCN DES Adult Mental Health Practitioner*	
	ADMHPP	P	*C&M-PMS PCN DES Adult Mental Health Practitioner*	
	CYPMHA	A	*C&M-APMS PCN DES CYP Mental Health Practitioner*	5216107Z
	CYPMHG	G	*C&M-GMS PCN DES CYP Mental Health Practitioner*	
	CYPMHP	P	*C&M-PMS PCN DES CYP Mental Health Practitioner*	
Care home premium	CHOMPA	A	*C&M-APMS PCN DES Care Home Premium*	5216108G
	CHOMPG	G	*C&M-GMS PCN DES Care Home Premium*	
	CHOMPP	P	*C&M-PMS PCN DES Care Home Premium*	
Extended hours access	EXTHDA	A	*C&M-APMS Extended Hours Access DES (APMS)*	521610UN
	EXTHDG	G	*C&M-GMS Extended Hours Access DES (GMS)*	521610V8
	EXTHDP	P	*C&M-PMS Extended Hours Access DES (PMS)*	521610VW
IIF Aspiration Payment	IIFASA	A	*C&M-APMS IIF Aspiration*	5216108H
	IIFASG	G	*C&M-GMS IIF Aspiration*	
	IIFASP	P	*C&M-PMS IIF Aspiration*	
IIF Achievement Payment	IIFACA	A	*C&M-APMS IIF Achievement*	5216108I
	IIFACG	G	*C&M-GMS IIF Achievement*	
	IIFACP	P	*C&M-PMS IIF Achievement*	
Leadership and management payment	LEADPA	A	*APMS PCN DES Leadership Payment*	52161418
	LEADPG	G	*GMS PCN DES Leadership Payment*	52161419
	LEADPP	P	*PMS PCN DES Leadership Payment*	52161420
PCN Support Payment	SUPPPA	A	*C&M-APMS PCN Support Payment (APMS)*	5216108K

Payments	Paycode	APMS/ GMS/ PMS	Paycode Description	Subjective code
	SUPPPG	G	*C&M-GMS PCN Support Payment (GMS)*	
	SUPPPP	P	*C&M-PMS PCN Support Payment (PMS)*	

Payment considerations

10.3.11. The following sets out a number of considerations for commissioners and networks with regards to who is nominated the payee and how payments will be processed:

a. The nominated payee must be party to the Network Agreement (this could mean party to more than one Network Agreement if it is a GP Federation).
b. As outlined above non-GP Practice APMS providers are not currently setup within NHAIS (also known as Exeter) and as such, this system (and its subsequent replacement) cannot be used to process the payments. In 2021/22, commissioners will therefore need to put in place local payment arrangements to make payments to a non-GP Practice APMS provider.
c. APMS contracts are time limited. In the event a non-GP practice APMS provider acting as a nominated payee no longer holds an APMS contract, then the nominated payee will need to be changed to be a provider who holds a primary medical services contract. In this circumstance, the PCN would also need to update their Network Agreement accordingly.
d. There are VAT considerations for the PCN if the APMS provider (e.g. GP Federation) charges any commission for their services in being the nominated payee. These charges would not be reimbursed by commissioners and would remain a liability for the PCN to manage. Further information on VAT is available in the Network Contract DES and VAT Information Note.

3. Frequently Asked Questions

11.1. A set of Frequently Asked Questions for the Network Contract DES has been published by NHS England and NHS Improvement and will be updated periodically throughout the year.

NHS England and NHS Improvement
www.england.nhs.uk

Classification: Official

Publication approval reference: PAR1218

Network Contract Directed Enhanced Service

Contract specification 2021/22 – PCN Requirements and Entitlements

20 December 2021

Contents

Please be aware that all aspects of this service specification outline the requirements for this programme. As such, commissioners and practices should ensure they have read and understood all sections of this document as part of the implementation of this programme.

Practices are advised that to ensure they receive payment, particular attention should be paid to the payment and validation terms. Practices will need to ensure they understand and use the designated clinical codes as required to ensure payment.

1. Introduction

1.1. The Network Contract Directed Enhanced Service (the "**Network Contract DES**") was first introduced in the Directed Enhanced Services Directions 2019[1].

1.2. The Network Contract DES placed obligations on practices and commissioners and granted various entitlements to practices with effect from 1 July 2019.

1.3. An objective of the Network Contract DES in 2019 was for primary medical services contractors to establish and develop Primary Care Networks ("**PCNs**").

1.4. The Network Contract DES forms part of a long-term, larger package of general practice contract reform originally set out in *Investment and Evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan* and subsequent updates.

1.5. It is intended that there will be a Network Contract DES each financial year until at least 31 March 2024 with the requirements of the Network Contract DES evolving over time.

1.6. This document sets out:

1.6.1. how commissioners must offer to primary medical services contractors the opportunity to participate in the Network Contract DES;

1.6.2. the eligibility requirements and process for primary medical services contractors to participate in the Network Contract DES; and

1.6.3. in relation to the Network Contract DES, the rights and obligations of:

a. primary medical services contractors that participate;

b. the PCNs of which they are members; and

c. commissioners,

for the financial year from 1 April 2021 to 31 March 2022.

1.7. This document has been updated since version 1 was agreed by NHS England and the British Medical Association's (BMA) General Practitioners Committee England (GPCE).

2. Commonly used terms

2.1. This document is referred to as the "**Network Contract DES Specification**".

2.2. In this Network Contract DES Specification:

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

2.2.1. the "**Network Contract DES**" refers to the Network Contract DES for the financial year commencing 1 April 2021 and ending on 31 March 2022 unless expressly stated otherwise;

2.2.2. the "**Network Contract DES Variation**" refers to an in-year variation to the Network Contract DES during the period 1 April 2021 to 31 March 2022 issued on a national basis by NHS England and NHS Improvement;

2.2.3. the "**subsequent year's Network Contract DES**" refers to the Network Contract DES commencing on the 1 April 2022;

2.2.4. a "**practice**" refers to a primary medical services contractor;

2.2.5. a "**New Practice**" refers to a practice that is newly formed following the taking effect of a new primary medical services contract;

2.2.6. the "**commissioner**" refers to the organisation with responsibility for contract managing a practice and this will be either NHS England or a clinical commissioning group ("**CCG**") where the latter carries out contract management of primary medical services contracts under delegated arrangements with NHS England;

2.2.7. the "**Network Agreement**" refers to the agreement entered into by practices (and potentially other organisations) that are members of a PCN and which incorporates the provisions that are required to be included in a network agreement[2] in accordance with section 5.1.2.d;

2.2.8. a "**Core Network Practice**" of a PCN has the same meaning as in a PCN's Network Agreement and refers to the practices that are members of a PCN who are responsible for delivering the requirements of the Network Contract DES in relation to that PCN;

2.2.9. an "**Previously Approved PCN**" refers to a PCN that was approved in the period commencing 1 July 2019 and ending on 31 March 2021;

2.2.10. the "**Nominated Payee**" refers to a practice or organisation (which must hold a primary medical services contract) that receives payment of the applicable financial entitlement set out in this Network Contract DES Specification;

2.2.11. the "**Network Area**" refers to the area of a PCN as described in section 5.1.3;

2.2.12. a "**list of patients**" refers to the registered list of patients in respect of a practice that is maintained by NHS England and NHS Improvement in accordance with that practice's primary medical services contract;

---

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

2.2.13. the "**PCN's Patients**" refers collectively to the persons on a PCN's Core Network Practices' lists of patients;

2.2.14. the "**practice list size**" refers to the number of persons on the list of patients of the practice;

2.2.15. the "**PCN list size**" refers to the number of PCN Patients, which is the sum of all practice list sizes of the Core Network Practices of the PCN;

2.2.16. the **"Contractor Weighted Population"** refers to a practice's Contractor Registered Population (as calculated in accordance with the SFE regardless of whether the SFE applies to that practice and as calculated at the relevant date set out in the relevant section of this Network Contract DES Specification) adjusted by the Global Sum Allocation Formula set out in Part 1 of Annex B of the SFE;

2.2.17. the **"PCN Contractor Weighted Population"** refers to the PCN's Core Network Practices' collective Contractor Weighted Population;

2.2.18. the **"CCG Extended Access Service"** refers to the CCG commissioned extended access services in 2021/22

2.2.19. the **"PCN Adjusted Population"** is a weighted population figure that is different to the PCN Contractor Weighted Population figure as it is derived from the CCG primary medical care allocation formula. Such a figure is periodically calculated and indicated to a PCN by NHS England and NHS Improvement; and

2.2.20. the **"SFE"** is the General Medical Services Statement of Financial Entitlements Directions 2021, as amended from time to time.

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

3.1.1. Where this Network Contract DES Specification sets out a requirement or obligation of a PCN, each Core Network Practice of a PCN is responsible for ensuring the requirement or obligation is carried out on behalf of that PCN.

3.1.2. A practice participating in the Network Contract DES must enter into a variation of its primary medical services contract to incorporate the provisions of this Network Contract DES Specification.

3.1.3. The provisions of this Network Contract DES Specification therefore become part of the practice's primary medical services contract.

3.1.4. Where a practice chooses not to participate in the Network Contract DES, this will not impact on the continuation of primary medical services under its primary medical services contract.

4. Eligibility for and participation in the Network Contract DES

4.1. Eligibility

4.1.1. A practice must satisfy each eligibility criteria below to be eligible to participate in the Network Contract DES:

a. the practice must hold a primary medical services contract;

b. the practice has a registered list of patients which means that persons are recorded in the registration system approved by NHS England as being registered with the practice; and

c. the practice's primary medical services contract must require the practice to offer in-hours (essential services) primary medical services.

4.2. Participation requirements

4.2.1. A Core Network Practice and the commissioner acknowledge that the Network Contract DES Specification 2020/21 contained a provision pursuant to which the Core Network Practices will automatically participate in the following year's Network Contract DES (which means the Network Contract DES commencing on 1 April 2021), unless the Core Network Practice chose to opt-out. A Core Network Practice that participates in this Network Contract DES (which means the Network Contract DES commencing on 1 April 2021) will automatically participate in the subsequent year's Network Contract DES, unless and until the Core Network Practice opts out. For the avoidance of doubt, this means that a Core Network Practice will be required to deliver the services in accordance with the subsequent Network Contract DES until the opt-out date.

4.2.2. Where a practice wishes to participate in the Network Contract DES or any Network Contract DES Variations, one of the situations below will apply. The practice, and where applicable the PCN, must identify the relevant situation and act in accordance with the appropriate sections:

a. If the practice is automatically participating in a Previously Approved PCN and there have been no changes to the PCN's Core Network Practices, the practices in the PCN must act in accordance with section 4.3;

b. If the practice is automatically participating, or wishes to participate, in a Previously Approved PCN and there will be changes to the identity of the PCN's Core Network Practices due to:

   i. a Core Network Practice from another PCN joining; and/or

   ii. a non-participating practice joining; and/or

   iii. a New Practice joining; and/or

   iv. a Core Network Practice opting out of participating;

   then the PCN's Core Network Practices, joining practices and leaving practices must collectively act in accordance with section 4.4;

c. If the practice is either a New Practice or an existing practice and wishes to be a Core Network Practice of a newly proposed PCN, the practice must act in accordance with section 4.5; or

d. If the practice cannot identify a Previously Approved PCN or a newly proposed PCN that is willing to allow the practice to be a Core Network Practice under its Network Agreement, the practice must act in accordance with section 4.6.

4.2.3. A commissioner must ensure that any patients of a practice that is not participating in the Network Contract DES are covered by a PCN or alternative provider (for example through commissioning a local contractual arrangement). For the avoidance of doubt, subject to procurement rules, commissioners may not commission such a local contractual arrangement with any practice choosing not to participate in the Network Contract DES. Further information on commissioning PCN services for patients of non-participating practices is available in the Network Contract DES Guidance.

4.2.4. Subject to sections 4.2.5 and 4.2.6, this Network Contract DES Specification will cease to have effect on:

a. 31 March 2022; or

b. where a Core Network Practice ceases to participate in the Network Contract pursuant to any provision of this Network Contract DES Specification, the date it is determined that the Core Network Practice ceases to participate in the Network Contract DES,

and the practice agrees that from the relevant date the practice's primary medical services contract will be deemed to have been varied to remove this incorporation of the Network Contract DES Specification.

4.2.5. Where NHS England and NHS Improvement issues a Network Contract DES Variation, a Core Network Practice will automatically participate in that variation unless the Core Network Practice follows the opt-out process which

starts with notifying the commissioner of its intention to opt out of the Network Contract DES in accordance with section 4.9.5. Each practice that automatically participates must, as soon as practicable, enter into a written variation of its primary medical services contract with the commissioner to incorporate the Network Contract DES Variation and ensure the PCN's Network Agreement reflects the arrangements for delivery of the Network Contract DES Variation.

4.2.6. Unless expressly stated otherwise or by necessary implication, no term of this Network Contract DES Specification shall survive beyond 31 March 2022 or, if earlier, the date it is determined that a Core Network Practice ceases to participate in the Network Contract DES (as relevant).

4.3. Automatic participation in a Previously Approved PCN with no change in Core Network Practice membership

4.3.1. The Previously Approved PCN's Core Network Practices will automatically participate in the Network Contract DES and each practice must as soon as practicable:

a. enter into a written variation of its primary medical services contract with the commissioner that incorporates the provisions of this Network Contract DES Specification;

b. if the practice has been provided with access to the Calculating Quality Reporting Service ("**CQRS**"), indicate via CQRS that it is participating in the Network Contract DES; and

c. ensure the PCN's Network Agreement reflects the arrangements for delivery of the Network Contract DES.

4.4. Participation in a Previously Approved PCN with changes in Core Network Practices

4.4.1. This section applies to Previously Approved PCNs with changes in their Core Network Practices due to any one or more of the following situations:

a. a Core Network Practice from another PCN joining; and/or

b. a non-participating practice joining; and/or

c. a New Practice joining; and/or

d. a Core Network Practice opting out of participating.

and all practices acknowledge that as a result of any change to the Core Network Practices the participation in the Network Contract DES will be in accordance with this section 4.4.

4.4.2. The Previously Approved PCN's Core Network Practices will automatically participate in the Network Contract DES subject to sections 4.4.6, 4.4.8 and 4.4.9.

4.4.3. A Core Network Practice joining from another PCN will automatically participate in the Network Contract DES subject to sections 4.4.6, 4.4.8 and 4.4.9.

4.4.4. A New Practice may participate in the Network Contract DES at any time during the financial year and join a Previously Approved PCN subject to sections 4.4.6, 4.4.7, 4.4.8 and 4.4.9.

4.4.5. Where a Core Network Practice leaves a PCN during the opt-out period, the opting out practice must act in accordance with section 4.4.6 and 4.9. Sections 4.4.8 and 4.4.9 will apply to the remaining Core Network Practices in the PCN to enable the commissioner to determine the extent to which the PCN with its amended membership meets the criteria for a PCN and therefore whether the participation in the Network Contract DES of the remaining Core Network is confirmed.

4.4.6. All practices whether remaining, joining or leaving the PCN must complete a single form at Annex A and promptly submit it to the commissioner on or before 30 April 2021 and on or before the 30th calendar day following the date the Network Contract DES Variation is published. The form must be submitted by the method the commissioner has indicated and should be used to provide the information and include notification of:

a. the membership change that has occurred;

b. the reasons for the change pursuant to 4.4.1.

4.4.7. Where a New Practice wants to join a Previously Approved PCN outside of the periods pursuant to section 4.4.6, the PCN's Core Network Practices and the New Practice must complete a single form at Annex A and promptly submit it to the commissioner, by the method the commissioner had indicated and include notification of:

a. the membership change that has occurred;

b. the reasons for the change pursuant to 4.4.1.

4.4.8. Where the commissioner is satisfied that it has all required and necessary information, the commissioner will consider all information received including the extent to which the Previously Approved PCN meets the criteria for a PCN set out in section 5.1.2 and, as soon as practicable and in any event within one month of receipt of the notification, notify the practice(s) whether its participation in the Network Contract DES is confirmed.

4.4.9. Where the commissioner notifies the practice(s) that its participation, or continued participation, in the Network Contract DES:

a. is not confirmed, section 4.7 applies;

b. is confirmed, section 4.8 applies.

4.4.10. Where the commissioner consents to a change in the details of the Previously Approved PCN, the commissioner must:

a. complete the PCN ODS Change Instruction Notice[3], to indicate any changes to a PCN's membership and/or Nominated Payee and submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month; and

b. consider the list of care homes for which the PCN will have responsibility pursuant to section 8.3.1.a and any required adjustment to care home allocations across PCNs within the area.

4.4.11. The practices in the PCN must:

a. update the PCN's Network Agreement accordingly to reflect the list of Core Network Practices;

b. confirm that all practices agree that payments under the Network Contract DES are made to the PCN's Nominated Payee; and

c. confirm that the PCN's Core Network Practices will have in place patient record sharing arrangements (as clinically required) and data sharing arrangements of the PCN, in line with data protection legislation and patient opt-out preferences, prior to the start of any service delivery under the Network Contract DES.

4.5. New Practice or existing practice forming a new PCN

4.5.1. Where this section applies, the practice(s) must promptly provide the following information to the commissioner on or before 30 April 2021 and on or before the 30th day following the date the Network Contract DES Variation is published, using the form at Annex A:

a. the names and ODS codes[4] of the proposed PCN's Core Network Practices[5];

[3] The PCN ODS Change Instruction Notice is available here.
[4] https://digital.nhs.uk/services/organisation-data-service
[5] This may be a single super practice.

b. the number of the PCN's Patients as at 1 January 2021[6];

c. a map clearly marking the geographical area covered by the Network Area of the proposed PCN;

d. an initial Network Agreement – this requires completion of the proposed Core Network Practices' details in the front end of the Network Agreement and in Schedule 1, details of the Network Area, the Clinical Director and Nominated Payee (additional information in Schedule 1 relating to PCN meetings and decision-making may also be submitted but it is recognised that this may not have been fully agreed at the point of submission to the commissioner);

e. the Nominated Payee[7] and details of the relevant bank account that will receive funding on behalf of the PCN; and

f. the identity of the accountable Clinical Director,

the form must be submitted by the method the commissioner had indicated should be used to provide the information.

4.5.2. The practice must promptly provide to the commissioner any further information the commissioner requests in relation to the proposed PCN.

4.5.3. Where the commissioner is satisfied that it has all required and necessary information, the commissioner will consider all information received including the extent to which the proposed PCN meets the criteria for a PCN set out in section 5.1.2 and, as soon as practicable and in any event within one month of receipt of the notification, notify the practice whether its participation in the Network Contract DES is confirmed and whether the proposed PCN is approved.

4.5.4. Where the commissioner approves the PCN, the commissioner must:

a. complete the PCN ODS Change Instruction Notice[8] to indicate the details of the PCN and submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month;

b. indicate to the PCN and its Core Network Practices when they are required to commence delivery of the Network Contract DES and the date

[6] This can be obtained by aggregating the number of persons on the lists of patients for all Core Network Practices as recorded in the registration system approved by NHS England.

[7] Payment nomination would only apply where there is more than one primary medical care contractor in the PCN.

[8] The PCN ODS Change Instruction Notice is available here.

payments will be made, taking into account local payment arrangements; and

c. consider the list of care homes for which the PCN will have responsibility pursuant to section 8.3.1.a and any required adjustment to care home allocations across PCNs within the area.

4.5.5. Where the commissioner notifies a practice that its participation in the Network Contract DES:

a. is not confirmed, section 4.7 applies;

b. is confirmed, section 4.8 applies.

4.6. Previously Approved PCNs or proposed PCN unwilling to accept a practice

4.6.1. Where this section applies to an existing practice, the practice must notify the commissioner by 30 April 2021 and on or before the 30th calendar day following the date the Network Contract DES Variation is published, that no Previously Approved PCN or proposed PCN is willing to enable the practice to be a Core Network Practice of the PCN. As a New Practice may be formed at any point between 1 April 2021 and 31 March 2022, the situation above may arise outside these periods in which case the New Practice can notify the commissioner of this situation at any point during the year.

4.6.2. The commissioner may require a PCN to include the practice as a Core Network Practice of that PCN. Where the commissioner is minded to require a PCN to do so, the commissioner must engage with the relevant LMC and, when making its determination, have regards to the views of the LMC. The commissioner acknowledges that the Core Network Practices of the PCN may already have submitted information and had their participation in the Network Contract DES confirmed at the point the commissioner is minded to require the PCN to include the practice as a Core Network Practice. If the commissioner requires a PCN to include the practice, the commissioner will consider this a change to the details of the PCN and consider any consequences of inclusion on the PCN and its Core Network Practices.

4.6.3. Where the commissioner requires a PCN to include the practice as a Core Network Practice of that PCN:

a. the commissioner must inform that PCN on or before the 30th day following its determination that the PCN is required to include the practice as a Core Network Practice; and

b. each practice in the PCN to which the practice has been allocated will, as soon as practicable, and in any event within 30 days, after the

commissioner informs them of its decision, take the necessary steps to enable the practice to become a Core Network Practice of the PCN including, but not limited, to varying the Network Agreement to include the practice.

4.6.4. As soon as practicable after the PCN has taken the necessary steps pursuant to section 4.6.3.b, the practice joining the PCN must provide the following information to the commissioner:

a. confirmation that the practice has signed an updated version of the PCN's Network Agreement;

b. confirmation that the practice is listed as a Core Network Practice in the PCN's Network Agreement;

c. confirmation that the practice agrees that payments under the Network Contract DES are made to the PCN's Nominated Payee;

d. confirmation that the practice will have in place patient record sharing arrangements (as clinically required) and data sharing arrangements of the PCN, in line with data protection legislation and patient opt-out preferences[9], prior to the start of any service delivery under the Network Contract DES.

4.6.5. Where the commissioner is satisfied that it has all relevant and necessary information, the commissioner will as soon as practicable but in any event within five working days, taking into account the information that has been provided and the fact that the commissioner has required the PCN to include the practice in the PCN, notify the practice whether its participation in the Network Contract DES is confirmed.

4.6.6. Where, as a result of the commissioner's decision, there is a change in the details of the PCN, the commissioner must complete the PCN ODS Change Instruction Notice[10]. The commissioner must submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month.

4.6.7. Where the commissioner notifies a practice that its participation in the Network Contract DES:

a. is not confirmed, section 4.7 applies;

b. is confirmed, section 4.8 applies.

---

[9] https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/how-we-look-after-your-health-and-care-information/your-information-choices/opting-out-of-sharing-your-confidential-patient-information

[10] The PCN ODS Change Instruction Notice is available here.

4.7. Participation not confirmed

4.7.1. Where the commissioner notifies a practice that its participation in the Network Contract DES is not confirmed:

a. the commissioner will explain to the practice the reasons for its decision;

b. the commissioner, the practice, and the relevant PCN if applicable must make every reasonable effort to communicate and co-operate with each other, and with the local LMC if relevant, with a view to enabling the commissioner to confirm the practice's participation in the Network Contract DES as soon as practicable;

c. if no agreement is reached after a reasonable timescale, the commissioner or the practice may refer the matter to the local NHS England team.

4.7.2. Where a local LMC is involved in the matter, the commissioner must work with the local LMC to support PCN development, addressing where appropriate issues that arise and seeking to maintain 100 per cent geographical coverage of PCNs.

4.7.3. If the commissioner notifies the practice that its participation in the Network Contract DES is confirmed, section 4.8 applies.

4.8. Confirmation of participation

4.8.1. Where a commissioner has confirmed a practice's participation in the Network Contract DES, the practice must, as soon as practicable:

a. enter into a written variation of its primary medical services contract with the commissioner that incorporates the provisions of this Network Contract DES Specification;

b. if the practice has been provided with access to CQRS, indicate via CQRS that it is participating in the Network Contract DES; and

c. ensure the PCN's Network Agreement reflects the arrangements for delivery of the Network Contract DES.

4.9. Opting out of participation or ending participation in year

4.9.1. There are three types of opt outs:

a. opt out of this Network Contract DES in accordance with section 4.9.4;

b. opt out of the Network Contract DES in-year following the issue of a Network Contract DES Variation by NHS England and NHS Improvement in which case section 4.9.5 applies; and

c. opt out of the subsequent Network Contract DES (which means the Network Contract DES commencing on 1 April 2022) in accordance with section 4.9.6.

The circumstances in which each of the above can take place and the associated process are set out in sections 4.9.4, 4.9.5 and 4.9.6.

4.9.2. Where sections 4.9.1.a, 4.9.1.b or 4.9.1.c apply, the remaining Core Network Practices in the PCN will promptly discuss with the Commissioner (and including the LMC, if relevant), the proposed date of opt out and the consequences of the opt out including:

a. whether the PCN with its amended membership meets the criteria for a PCN;

b. the likely consequences for the registered patients of the practice when that practice is no longer a Core Network Practice of the PCN;

c. changes to the Network Area;

d. any impact on the list of care homes for which the PCN will have responsibility pursuant to section 8.3.1.a and any required adjustment to care home allocations across PCNs;

e. the effect on the financial entitlements of the PCN,

and the commissioner will determine the outcome of such matters.

4.9.3. With effect from the date agreed or, if not agreed, determined by the commissioner:

a. the opting out practice will no longer participate in the Network Contract DES;

b. in accordance with section 4.2.4.b the opting out practice's primary medical services contract will be deemed to have been varied to remove the incorporation of this Network Contract DES Specification;

c. the opting out practice will no longer be a Core Network Practice of the PCN; and

d. where the PCN remains approved, it must remove the opting out practice from the Network Agreement before any changes to the PCN, such as the Network Area, financial entitlements, etc will take effect.

4.9.4. **Opting out of this Network Contract DES**

a. A Core Network Practice participating in the Network Contract DES may end its participation in this Network Contract DES by first notifying the commissioner prior to 30 April 2021 of its intention to opt out in accordance with section 4.4. Sections 4.4.8 and 4.4.9 will apply to the

remaining Core Network Practices in the PCN to enable the commissioner to determine the extent to which the PCN with its amended membership meets the criteria for a PCN and therefore whether the participation in the Network Contract DES of the remaining Core Network is confirmed. As part of its consideration of the PCN, the commissioner will include the matters set out in section 4.9.2. Once the matters set out in section 4.9.2 are determined, section 4.9.3 will apply.

b. If a Core Network Practice does not notify the commissioner as set out in section 4.9.4, the Core Network Practice will continue to participate in this Network Contract DES. There is no option for the Core Network Practice to continue with a previous year's Network Contract DES Specification.

4.9.5. **Opting out of an in-year Network Contract DES Variation**

a. Where NHS England and NHS Improvement issues a Network Contract DES Variation, a Core Network Practice will automatically participate in that variation unless the Core Network Practice first notifies the commissioner of its intention to opt out of the Network Contract DES within 30 calendar days of the date of publication by NHS England and NHS Improvement of the Network Contract DES Variation.

b. If a Core Network Practice does not notify the commissioner in accordance with section 4.9.5.a, the Core Network Practice will automatically participate in the Network Contract DES Variation and the second sentence of section 4.2.5 will apply.

c. Where a Core Network Practice notifies the commissioner of its intention to opt out in accordance with section 4.9.5.a, section 4.9.2 will apply. Once the matters set out in section 4.9.2 are determined, section 4.9.3 will apply.

4.9.6. **Opting out of the subsequent Network Contract DES**

a. A Core Network Practice of a PCN may choose not to participate in the subsequent Network Contract DES (which means the Network Contract DES commencing on 1 April 2022) in which case that Core Network Practice must notify the commissioner of its intention to opt out and follow the process set out in the subsequent Network Contract DES Specification.

4.9.7. **Ending participation in-year**

a. There may be other situations, other than the opt out situations set out in section 4.9.1 in which a Core Network Practice's participation in the Network Contract DES, or its involvement in a PCN, may end:

   i. expiry or termination of the Core Network Practice's primary medical services contract, in which case section 6.6 applies;

   ii. there has been an irreparable breakdown in relationship or an expulsion, in which case section 6.7 applies;

   iii. the commissioner consents to a merger or split of the Core Network Practice, in which case section 6.8 applies;

   iv. the commissioner determines that the Core Network Practice's participation in the Network Contract DES should cease in accordance with section 9.

b. Where a practice's participation in the Network Contract DES ends prior to 31 March 2022 as a result of any of the provisions of this Network Contract DES, then section 4.2.4.b applies.

5. PCN Organisational Requirements

5.1. Definition and criteria for a PCN

5.1.1. A PCN can be broadly defined as a practice or practices (and possibly other providers[11]) serving an identified Network Area with a minimum population of 30,000 people.

5.1.2. The criteria for a PCN is:

a. that the PCN has an identified Network Area that complies with the requirements set out in section 5.1.3;

b. that the PCN list size as at 1 January 2021 is between 30,000 and 50,000 except that:

   i. in exceptional circumstances, a commissioner may waive the 30,000 minimum PCN list size requirement where a PCN serves a natural community which has a low population density across a large rural and remote area; and

   ii. a commissioner may waive the 50,000 maximum PCN list size requirement where it is satisfied that it is appropriate to do so. In such

[11] Examples of other providers - community (including community pharmacy, dentistry, optometry), voluntary, secondary care providers, social care - and GP providers who are not participating in the Network Contract DES.

circumstances, the commissioner may require the Core Network Practices of the PCN to organise the PCN operationally into smaller neighbourhood teams that cover population sizes between 30,000 to 50,000 and the Core Network Practices will comply with such requirement. For the avoidance of doubt, the PCN will still be required to have one Nominated Payee.

iii. that there is more than one Core Network Practice in the PCN except that there may only be one Core Network Practice if the commissioner is satisfied that this is appropriate having regard to all relevant factors. Where a PCN has only one Core Network Practice, the PCN must work with other providers as set out in section 5.7.1 to achieve the optimal benefits of PCN working.

c. that the PCN has a Nominated Payee which must hold a primary medical services contract;

d. that the PCN has in place a Network Agreement signed by all PCNs members, that incorporates the mandatory provisions set out in the national template network agreement[12][13].

e. that the PCN has at all times an accountable Clinical Director;

f. that the PCN has in place appropriate arrangements for patient record sharing in line with data protection legislation honouring patient opt-out preferences[14][15].

5.1.3. The Network Area must:

a. satisfy the commissioner that the Network Area is sustainable for the future, taking account of how services are delivered by wider members of the PCN beyond the practices and with a view to the evolution of PCNs;

b. align with a footprint which would best support delivery of services to patients in the context of the relevant Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) strategy;

---

[12] Where PCNs decide to seek advice related to the Network Agreement, these costs will not be covered under the Network Contract DES nor by commissioners at a local level.

[13] The Network Agreement template has been agreed between NHS England and GPC. The Network Agreement template can be found at https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-network-agreement/

[14] https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/how-we-look-after-your-health-and-care-information/your-information-choices/opting-out-of-sharing-your-confidential-patient-information

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

c. cover a boundary that makes sense to:

   i. the Core Network Practices of the PCN;

   ii. other community-based providers which configure their teams accordingly; and

   iii. the local community;

d. cover a geographically contiguous area;

e. not cross CCG, STP or ICS boundaries except where:

   i. a Core Network Practice's boundary or branch surgery crosses the relevant boundaries; or

   ii. the Core Network Practices are situated in different CCGs.

5.1.4. Where a practice has one or more branch surgeries in different PCNs, the practice must ensure that it will be a Core Network Practice of only one PCN and a non-core member of the other PCN(s) within which the relevant branch surgeries are situated. The practice acknowledges that its list of patients will be associated with the PCN of which the practice is a Core Network Practice.

5.1.5. Where a PCN's Core Network Practices are situated within different CCG areas, the relevant commissioners must agree which commissioner will be the 'lead' for the PCN and identified as such within the PCN ODS reference data and subsequently within the relevant GP IT systems for payment processing. The identified lead commissioner will make payments to the relevant Nominated Payee in relation to the Network Contract DES. The lead commissioner and any other relevant commissioner must reconcile any funding allocation discrepancies between themselves and not via national GP payment systems.

5.2. General PCN organisational requirements

5.2.1. A PCN must ensure it remains compliant with the criteria of a PCN set out in section 5.1.2 at all times. A PCN must ensure its Network Agreement reflects the requirements of this Network Contract DES Specification.

5.2.2. Where a PCN is not compliant with the criteria of a PCN then, subject to any relevant processes set out in the Network Contract DES Specification, the commissioner may revoke the relevant Core Network Practice's participation in the Network Contact DES and section 4.2.4.b will apply.

5.2.3. Where required by data protection legislation, a PCN must ensure each member of the PCN has in place appropriate data sharing arrangements and,

if required, data processor arrangements[16], that are compliant with data protection legislation to support the delivery of all service requirements set out in this Network Contract DES prior to the provision of these services to patients.

5.2.4. A Previously Approved PCN must ensure that there is no interruption in provision of services in the transition from the previous year's Network Contract DES to this Network Contract DES. For the avoidance of doubt, this requires a Previously Approved PCN to provide all services under this Network Contract DES Specification from 1 April 2021.

5.2.5. The PCN acknowledges that where there are changes to the PCN's membership, confirmation of the Core Network Practices' participation in this Network Contract DES may not be received until after 1 April 2021. The PCN acknowledges that it must act in accordance with section 5.2.4 but the PCN acknowledges that section 10 sets out backdating of certain elements of the financial entitlements.

5.2.6. Except for a Network Contract DES Variation, a commissioner and a PCN must not vary this Network Contract DES Specification. For the avoidance of doubt, except as may be set out in a Network Contract DES Variation, a commissioner must not increase or reduce the requirements of the financial entitlements set out in this Network Contract DES Specification.

5.2.7. Where a commissioner commissions local services from the PCN that are supplemental to the Network Contract DES (referred to in this Network Contract DES Specification as "**Supplementary Network Services**")[17], the arrangements for such local Supplementary Network Services must not be included in a varied version of this Network Contract DES Specification and should instead be contained in a separate contractual arrangement.

5.3. PCN Clinical Director

5.3.1. A PCN must have in place a Clinical Director who:

a. is accountable to the PCN members;

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

[17] Supplementary Network Services would be services commissioned locally, under separate arrangements and with additional resource, building on the foundation of the Network Contract DES. Further information regarding commissioning local services can be found in the Network Contract DES Guidance.

b. provides leadership for the PCN's strategic plans, working with PCN members to improve the quality and effectiveness of its delivery of the Network Contract DES;

c. is a direct and integral component of the overall Network Contract DES;

d. is a practicing clinician from within the PCN's Core Network Practices;

e. is able to undertake the responsibilities of the role and represent the PCN's collective interests;

f. works collaboratively with Clinical Directors from other PCNs within the ICS/STP area, playing a critical role in shaping and supporting their ICS/STP, helping to ensure full engagement of primary care in developing and implementing local system plans;

5.3.2. A PCN must ensure its Clinical Director has overall responsibility for the following key requirements[18]:

a. strategic and clinical leadership for the PCN, developing and implementing strategic plans, leading and supporting quality improvement and performance across Core Network Practices (including professional leadership of the Quality and Outcomes Framework Quality Improvement activity across the PCN). The Clinical Director is not solely responsible for the operational delivery of services - this is a collective responsibility of the PCN;

b. strategic leadership for workforce development, through assessment of clinical skill-mix and development of a PCN workforce strategy;

c. completing the workforce planning template and agree, on behalf of the PCN, the estimate as referred to in section 7.5;

d. supporting PCN implementation of agreed service changes and pathways and work closely with Core Network Practices and the commissioner and other PCNs to develop, support and deliver local improvement programmes aligned to national priorities;

e. developing local initiatives that enable delivery of the PCN's agenda, working with commissioners and other networks to reflect local needs and ensuring initiatives are coordinated;

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

f. developing relationships and work closely with other Clinical Directors, clinical leaders of other primary care, health and social care providers, local commissioners and LMCs;

g. facilitating participation by practices that are members of the PCN in research studies and act as a link between the PCN and local primary care research networks and research institutions; and

h. representing the PCN at CCG-level clinical meetings and the ICS, contributing to the strategy and wider work of the ICS.

5.3.3. A PCN must manage any conflicts of interest. A PCN must ensure that its Clinical Director takes a lead role in developing the PCN's conflict of interest arrangements, taking account of what is in the best interests of the PCN and its patients.

5.3.4. A PCN's appointment of a Clinical Director must follow a selection process either via appointment, election or both, details of which must be included in Schedule 1 of the Network Agreement.

5.4. Data, analytics and monitoring

5.4.1. A PCN must share non-clinical data between its members in certain circumstances. The data to be shared is the data required to:

a. support understanding and analysis of the population's needs;

b. support service delivery in line with local commissioner objectives; and

c. support compliance with the requirements of this Network Contract DES specification.

5.4.2. A PCN must determine appropriate timeframes for sharing of this data.

5.4.3. Where the functionality is available, a PCN should ensure that clinical data sharing for service delivery uses read/write access, so that relevant workforce from any practice can refer, order tests and prescribe electronically, and maintain a contemporaneous record for every patient.

5.4.4. A PCN must:

a. benchmark and identify opportunities for improvement;

b. identify variation in access, service delivery or gaps in population groups with highest needs; and

c. review capacity and demand management across the PCN, including sharing appointment data for the PCN to action (this could be achieved through using the GP workload tool or other similar tools), and the PCN

must monitor, share and aggregate relevant data[19] across the Core Network Practices to enable it to carry out these requirements.

5.4.5. A commissioner and the wider system may support PCNs in the analysis of data.

5.4.6. Core Network Practices of a PCN must use the relevant SNOMED codes and other agreed approaches of capturing activity to support data collections for the indicators related to the Network Contract DES and other PCN activity, some of which will be included in the Network Dashboard[20].

5.4.7. The relevant SNOMED codes, as published in the supporting Business Rules[21] on the NHS Digital website, should be used within Core Network Practices' clinical systems to record activity as required under the Network Contract DES. Only those codes included in the supporting Business Rules will be acceptable to allow CQRS calculations. A PCN's Core Network Practices will therefore need to ensure that they use the relevant codes and if necessary, re-code patients. Further information is available in the Network Contract DES Guidance.

5.4.8. To support contract monitoring and PCN quality improvement efforts, a PCN's Core Network Practices agree to collection of data related to the Network Contract DES via the General Practice Extraction Service ("GPES") (or any subsequent replacement system), and to manually input data into CQRS where required. The commissioner will monitor services and calculate payments under the Network Contract DES using CQRS and/or PCSE Online.

5.5. Patient engagement

5.5.1. A PCN must act in accordance with the requirements relating to patient engagement under the PCN's Core Network Practice's primary medical services contracts by:

a. engaging, liaising and communicating with the PCN's Patients in the most appropriate way;

---

[19] Data sources include workload data, population data, appointment data, cost data, outcome data and patient experience data (e.g. friends and family test, GP patient survey).

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

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

b. informing and/or involving them in developing new services and changes related to service delivery; and

c. engaging with a range of communities, including 'seldom heard' groups.

5.5.2. A PCN must provide reasonable support and assistance to the commissioner in the performance of its duties[22] to engage patients in the provision of and/or reconfiguration of services where applicable to the PCN's Patients.

5.6. Sub-contracting arrangements

5.6.1. Where a PCN (or any one or more of its members which are practices) is considering sub-contracting arrangements related to the provision of services under the Network Contract DES, the PCN must have due regard to the requirements set out in the statutory regulations or directions that underpin each Core Network Practices' primary medical services contracts in relation to sub-contracting, which will also apply to any arrangements to sub-contract services under the Network Contract DES.

5.6.2. A PCN acknowledges that its members that are practices may be required under their primary medical services contract to notify the commissioner, in writing, of their intention to sub-contract as soon as reasonably practicable and before the date on which the sub-contracting arrangement is intended to begin.

5.6.3. A PCN (and its members that are practices) must make available on request from the commissioner any information relating to sub-contracting arrangements and reporting information relating to either the delivery of network services or the engagement of PCN staff, for which reimbursement is being claimed under the Network Contract DES.

5.6.4. Notwithstanding any provision to the contrary of a PCN Core Network Practices' primary medical services contract, a Core Network Practice may sub-contract any of its rights or duties under the Network Contract DES in relation to non-clinical matters provided that the Core Network Practice obtains prior written approval from the commissioner (such approval to not be unreasonably withheld or delayed).

5.6.5. Where a Core Network Practice of a PCN has sub-contracted a non-clinical matter that relates to the Network Contract DES, the sub-contract may allow the sub-contractor to sub-contract the non-clinical matter provided that the Core Network Practice obtains prior written approval from the commissioner (and such approval will not be unreasonably withheld or delayed).

---

[22] Section 14Z2 of the 2006 NHS Act.

5.7. Collaboration with non-GP providers

5.7.1. A PCN must agree with local community services providers, mental health providers and community pharmacy providers how they will work together.

5.7.2. A PCN must ensure that compliance with this requirement is evidenced through setting out in Schedule 7 of the Network Agreement:

a. the specifics of how, where required by this Network Contract DES Specification or otherwise deemed appropriate, the service requirements will be delivered through integrated working arrangements between the PCN and other providers; and

b. how providers will work together, including agreed communication channels, agreed representatives, and how any joint decisions will be taken.

5.7.3. A PCN must detail the arrangements with its local community services provider(s) in Schedule 7 of the Network Agreement. The commissioner will use reasonable endeavours to facilitate the agreement of arrangements between the local community services provider(s) and the PCN.

5.7.4. A PCN must detail its arrangements with community mental health providers, and community pharmacy (via the community pharmacy nominated Pharmacy PCN Lead) in Schedule 7 of the Network Agreement.

6. Changes to a PCN

6.1. Circumstances in which PCN changes can take place

6.1.1. A PCN acknowledges that:

a. it was approved; and

b. its Core Network Practices' participation in the Network Contract DES was confirmed,

on the basis of the information provided to the commissioner.

6.1.2. A PCN must ensure the information held by the commissioner in relation to its Previously Approved PCN is at all times accurate and up to date.

6.1.3. Where a PCN is minded to change that information, it must act in accordance with the appropriate section of this Network Contract DES Specification.

6.2. Clinical Director change

6.2.1. Where a PCN wishes to change the identity of its clinical director, it is required to notify the commissioner of the identity of the new clinical director as soon as reasonably practicable following the change.

6.3. Nominated Payee change

6.3.1. A PCN must obtain the prior written consent of the commissioner to any change in the identity of its Nominated Payee.

6.3.2. The PCN must provide to the commissioner the identity of the organisation of the proposed Nominated Payee and provide such information as required by the commissioner to enable the commissioner to determine whether the proposed Nominated Payee meets the requirement of section 5.1.2.c.

6.3.3. Where the commissioner is satisfied that the proposed Nominated Payee meets the requirement of section 5.1.2.c:

a. it shall provide its written consent to the PCN; and

b. complete the PCN ODS Change Instruction Notice[23].

6.3.4. The commissioner must also ensure this information aligns to the information contained within the relevant GP payment systems.

6.3.5. The change will take effect on the first day of the month following the month in which the commissioner gave consent and completed the PCN ODS Change Instruction Notice provided that the commissioner submitted the notice by the last working day on or before the 14th day of that month. If submission was later in the month, the change will take effect on the first day of the month following the subsequent month.

6.4. Change in non-Core Network Practice members

6.4.1. Where a PCN changes its non-Core Network Practices members it is not required to notify the commissioner or obtain the commissioner's prior written consent, but it is required to ensure that its Network Agreement reflects the change of members.

6.5. Change in Core Network Practice members

6.5.1. A PCN acknowledges that a practice participating in the Network Contract DES cannot end its participation in the Network Contract DES except as set out in section 4.9. The process for changing Core Network Practice members

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

is separate from the process of a practice ending its participation in the Network Contract DES but there may be situations in which a change is a result of a practice ending its participation.

6.5.2. Once a PCN has been approved in line with the process set out section 4.4 or section 4.9 if relevant, changes to Core Network Practices of the PCN will only be allowed in the exceptional circumstances set out in sections 6.6 to 6.9.

6.5.3. Where a PCN requests consent for a change to its Core Network Practices members due to one of the exceptional circumstances set out in sections 6.6 to 6.9, the PCN will act in accordance with the process set out in the relevant section. A PCN must obtain the prior written consent of the commissioner to any changes of its Core Network Practice members.

6.5.4. A commissioner must, as part of its consideration of the proposed change, ensure that the PCN will at all times satisfy the criteria of a PCN set out in section 5.1. If, the commissioner determines that a PCN does not satisfy the criteria, then the commissioner will allow a Core Network Practice of that PCN to join another Previously Approved PCN (subject to that PCN continuing to satisfy the criteria). If, as a result of any of the circumstances listed in this section 6, a practice that was a Core Network Practice seeks to join a Previously Approved PCN but the Previously Approved PCN is unwilling to enable the practice to be a Core Network Practice of the PCN, then sections 4.6.2 to 4.6.7 apply. If a Core Network Practice cannot join a Previously Approved PCN then section 5.2.2 applies.

6.5.5. A PCN seeking to change its Core Network Practices members must provide to the commissioner details of its view of the impact (if any) of the change on the PCN's baseline for the Additional Roles Reimbursement Sum[24]. As part of its consideration of the proposed change, the commissioner will seek to agree with the PCN the change (if any) to the PCN's baseline for the Additional Roles Reimbursement Sum.

6.5.6. A PCN must promptly provide any information required by the commissioner in relation to the change in Core Network Practice membership.

6.5.7. The commissioner will record a PCN's Core Network Practice members via NHS Digital's Organisation Data Service (ODS). Where the commissioner consents to a change, the commissioner must, before the end of the month in which it gives consent, complete the PCN ODS Change Instruction Notice[25]. The commissioner must submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that

[24] Refer to section 7.2 for details of baselines.
[25] The PCN ODS Change Instruction Notice is available here.

month. The commissioner must also ensure this information aligns to the information contained within the relevant GP payment systems.

6.5.8. The change will take effect on the first day of the month following the month in which the commissioner gives consent and completes the PCN ODS Change Instruction Notice[26] provided that the commissioner submits the notice by the last working day on or before the 14th day of that month. If submission was later in the month, the change will take effect on the first day of the month following the subsequent month.

6.5.9. The PCN must ensure the Network Agreement is updated as soon as reasonably practicable following the change taking effect.

6.6. Change in Core Network Practice membership due to contract expiry/termination

6.6.1. Where the primary medical services contract of a Core Network Practice of a PCN expires or terminates for any reason prior to 31 March 2022, then that Core Network Practice's participation in the Network Contract DES will cease from the date of expiry/termination. In such circumstances:

a. the Core Network Practices of a PCN must, as soon as they are aware of the possibility of a practice no longer being a Core Network Practice of the PCN, notify the commissioner.

b. The commissioner will consider the matter, including holding discussions with all practices within the PCN.

c. The commissioner will consider the consequences of the practice no longer being a Core Network Practice of the PCN. This will include:

i. the likely consequences for the registered patients of the practice when that GP practice is no longer a Core Network Practice of the PCN;

ii. the viability of the PCN including reference to the criteria of a PCN set out in section 5.1.2; and

iii. the impact of any consequences on the financial entitlements set out in this Network Contract DES Specification.

iv. The commissioner will, depending on the likely consequences and following any discussion with the LMC, determine the outcome of such matters including, if relevant, any changes to the information of the

[26] The PCN ODS Change Instruction Notice is available here.

PCN such as changes to the Network Area and/or level of payments due to the PCN under this Network Contract DES specification.

6.6.2. The commissioner may, depending on the likely consequences and at its discretion, determine that where there is a significant influx of new patients registering with a Core Network Practice of a PCN, it is appropriate for payments that are based on practice list size or PCN list size to be based on practice list size or PCN list size as at a date that is more recent than 1 January 2021.

6.6.3. From the date of the expiry or termination of the relevant practice's primary medical services contract:

a. the practice will no longer participate in the Network Contract DES;

b. the practice will no longer be considered a Core Network Practice of the PCN;

c. the PCN must remove that practice from the Network Agreement with effect from that date; and

d. the commissioner must complete and submit the PCN ODS Change Instruction Notice[27].

6.7. Change in Core Network Practice membership due to an irreparable breakdown in relationships or expulsion

6.7.1. Where there is an irreparable breakdown in relationships in respect of a Core Network Practice within a PCN such that the other members of the PCN are minded to expel the Core Network Practice from the PCN, the PCN must first notify the commissioner.

6.7.2. The commissioner will consider the matter, including holding discussions with all practices within the PCN.

6.7.3. The commissioner will consider the consequences of the practice being expelled from the PCN. This will include:

a. the likely consequences for the registered patients of the practice of that practice being expelled the PCN, i.e. whether that practice can join another PCN;

b. the impact of any consequences on the financial entitlements of the Network Contract DES of the PCN which the practice would be expelled from and that of any PCN the practice may seek to join. It is acknowledged that for payments based on practice list size or PCN list size, the

[27] The PCN ODS Change Instruction Notice is available here.

consequence of a practice being expelled from a PCN is likely to be a reduction in the level of payments made to a PCN;

c. the viability of the PCN including reference to the criteria of a PCN set out in section 5.1.2; and

d. any other relevant matters.

6.7.4. The commissioner will, having regard to the likely consequences and any discussion with the LMC, determine the outcome of such matters including whether it consents to any changes to the information of any affected PCN including but not limited to changes to the Core Network Practices, Network Area, Nominated Payee and/or level of payments.

6.7.5. Where, following the process set out in this Network Contract DES Specification, a Core Network Practice is expelled from a PCN, then, from the date the practice leaves the PCN:

a. the practice will no longer be considered a Core Network Practice of the PCN;

b. the PCN must remove that practice from the Network Agreement with effect from that date; and

c. the commissioner must complete and submit the PCN ODS Change Instruction Notice[28].

6.8. Change in Core Network Practice membership due to practice merger/split

6.8.1. Where:

a. two or more Core Network Practices intend to merge and the resulting single practice intends to be a Core Network Practice of the same PCN; or

b. two or more practices intend to be formed from the split of a single Core Network Practice and the resulting practices intend to be Core Network Practices of the same PCN,

the PCN acknowledges that the prior written consent of the commissioner is required for both the merger/split and any resulting changes to the information of the PCN.

6.8.2. The commissioner will consider the application for merger or split and, as part of that consideration, will consider the consequences (if any) on the practice's or practices' membership of the PCN.

[28] The PCN ODS Change Instruction Notice is available here.

6.8.3. The commissioner may require any information from the New Practice formed from a merger/split as a result of the practice remaining with the PCN. The New practice formed from the merger/split will promptly provide such information to the commissioner, including where required with the other members of the PCN. The commissioner will consider this information before indicating to the New Practice whether its participation in the Network Contract DES is confirmed.

6.8.4. Where the commissioner consents to the type of change set out in section 6.8.1 the commissioner acknowledges that, for the purposes of this Network Contract DES, payments due under the Network Contract DES will continue to be made in accordance with this Network Contract DES Specification.

6.8.5. Where the commissioner consents to the type of change set out in section 6.8.1, the commissioner must, before the end of the month in which it gives consent, complete the PCN ODS Change Instruction Notice[29]. The commissioner must submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month. The commissioner must also ensure this information aligns to the information contained within the relevant GP payment systems.

6.8.6. Where:

a. two or more Core Network Practices of a PCN intend to merge and the resulting single practice does not intend to be a Core Network Practice of the same PCN; or

b. two or more practices intend to be formed from the split of a single Core Network Practice and either one or both of the resulting practices do not intend to be Core Network Practices of the same PCN,

the PCN and the practices acknowledge that the prior written consent of the commissioner is required for both the merger/split and any resulting changes to the information of the PCN and any other related PCN.

6.8.7. The commissioner will consider the application for merger or split and, as part of that consideration, will consider the consequences on the practice's or practices' membership of the PCN or other PCNs.

6.8.8. The commissioner's consideration of the consequences of any merger/split on PCN membership will include:

a. the likely consequences for the registered patients of the practice(s);

[29] The PCN ODS Change Instruction Notice is available here.

b. the impact of any consequences on a PCN's financial entitlements due under this Network Contract DES Specification;

c. whether, if consent for the change was provided, any relevant PCN would satisfy the criteria for a PCN set out in section 5.1.2.

6.8.9. Where a Core Network Practice is subject to a split or a merger and:

a. the application of sections 6.8.1 to 6.8.8 in respect of splits or mergers would, in the reasonable opinion of the commissioner, lead to an inequitable result; or

b. the circumstances of the split or merger are such that sections 6.8.1 to 6.8.8 cannot be applied,

the commissioner will consider the resulting effect on the PCN as part of its consideration of the application for merger/split and make a determination on both matters.

6.8.10. Where the commissioner consents to any changes to the details of a PCN as a result of sections 6.8.8 or 6.8.9, the commissioner must complete the PCN ODS Change Instruction Notice[30]. The commissioner must submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month. The commissioner must also ensure this information aligns to the information contained within the relevant GP payment systems.

6.9. Change in Core Network Practice membership due to a PCN merger

6.9.1. Where:

a. all Core Network Practices of two or more Previously Approved PCNs intend to merge to form a new PCN; or

b. all the Core Network Practices of two or more Previously Approved PCNs intend to merge via all the Core Network Practices of one Previously Approved PCN joining the other Previously Approved PCN,

the PCN acknowledges that the prior written consent of the commissioner is required for the merger and any resulting changes to the information of the new or surviving PCN.

6.9.2. A PCN seeking to change its Core Network Practices via a PCN merger must provide to the commissioner:

[30] The PCN ODS Change Instruction Notice is available here.

a. the names and ODS codes[31] of the proposed PCN's Core Network Practices[32];

b. the number of the PCN's Patients as at 1 January 2021[33];

c. a map clearly marking the geographical area covered by the Network Area of the proposed PCN;

d. the Nominated Payee[34] and details of the relevant bank account that will receive funding on behalf of the PCN;

e. the identity of the accountable Clinical Director;

f. the list of care homes for which each PCN has responsibility pursuant to section 8.3.1.a; and

g. details of its view of the impact (if any) of the change on the PCN's baseline for the Additional Roles Reimbursement Sum[35]. As part of its consideration of the proposed change, the commissioner will seek to agree with the PCN the change (if any) to the PCN's baseline for the Additional Roles Reimbursement Sum.

6.9.3. The commissioner will consider the application for PCN merger and, as part of that consideration, will consider the consequences (if any) on the practice's or practices' membership of the PCN and the aligned care homes. A commissioner must, as part of its consideration of the proposed change, ensure that the PCN will at all times satisfy the criteria set out in section 5.1.

6.9.4. Where the commissioner consents to the type of change set out in section 6.9.1 the commissioner acknowledges that, for the purposes of this Network Contract DES, payments due under the Network Contract DES will continue to be made in accordance with this Network Contract DES Specification.

6.9.5. Where the commissioner consents to the type of change set out in section 6.9.1, the commissioner must, before the end of the month in which it gives consent, complete the PCN ODS Change Instruction Notice[36]. The commissioner must submit the notice by the last working day on or before the 14th day of the month for the change to take effect by the end of that month.

---

[31] https://digital.nhs.uk/services/organisation-data-service
[32] This may be a single super practice.
[33] This can be obtained by aggregating the number of persons on the lists of patients for all Core Network Practices as recorded in the registration system approved by NHS England.
[34] Payment nomination would only apply where there is more than one primary medical care contractor in the PCN.
[35] Refer to section 7.2 for details of baselines.
[36] The PCN ODS Change Instruction Notice is available here.

The commissioner must also ensure this information aligns to the information contained within the relevant GP payment systems.

6.9.6. The change will take effect on the first day of the month following the month in which the commissioner gives consent and completes the PCN ODS Change Instruction Notice[37] provided that the commissioner submits the notice by the last working day on or before the 14th day of that month. If submission was later in the month, the change will take effect on the first day of the month following the subsequent month.

6.9.7. The PCN must ensure and confirm prior to service delivery that the practices:

a. have signed a new or updated Network Agreement as soon as reasonably practicable following the change taking effect;

b. agree that payments under the Network Contract DES are made to the PCN's Nominated Payee;

c. will have in place patient record sharing arrangements (as clinically required) and data sharing arrangements of the PCN, in line with data protection legislation and patient opt-out preferences, prior to the start of any service delivery under the Network Contract DES;

d. have notified and engaged with any non-core members of the PCN accordingly,

and have updated any sub-contracting arrangements accordingly.

7. Additional Roles Reimbursement Scheme

7.1. General

7.1.1. A PCN is entitled to funding as part of the Network Contract DES to support the recruitment of new additional staff to deliver health services.

7.1.2. The new additional staff recruited by a PCN or provided under contract as a service from a third-party organisation are referred to in this Network Contract DES Specification as "**Additional Roles**" and this element of the Network Contract DES is referred to as the "**Additional Roles Reimbursement Scheme**".

7.1.3. Where the Additional Role is provided by a third-party organisation under a contract of service:

[37] The PCN ODS Change Instruction Notice is available here.

a. the PCN must ensure that the specification of the service incorporates the requirements set out in Annex B;
b. any obligation in section 4.7.1 and Annex B of the PCN should be read as an obligation that the PCN must procure that the third-party organisation carries out that obligation.

7.2. Principle of additionality

7.2.1. To receive the associated funding, a PCN must show that the staff delivering health services for whom funding is requested, i.e. the Additional Roles, comply with the principle of "additionality". Sections 7.2.2 to 7.2.11 below set out how additionality is measured.

7.2.2. Additionality will be measured on a baseline of staff supporting a GP practice as taken at 31 March 2019 against six of the reimbursable staff roles – clinical pharmacists, social prescribing link workers, first contact physiotherapists, physician associates, pharmacy technicians and paramedics. Two baselines were established[38] during 2019 as follows:

a. A PCN baseline declared by the Core Network Practices of the PCN and agreed with the commissioner. It is comprised of the actual whole time equivalent (WTE) staff across these six reimbursable roles and funded by general practice as at 31 March 2019. The PCN baseline will be fixed until 31 March 2024.

b. A Clinical Commissioning Group (CCG) baseline declared by the CCG. It is comprised of the whole time equivalent (WTE) patient facing or first contact time of staff across the six reimbursable roles deployed to support general practice or primary medical care services - either in a specific practice or in the wider community - funded[39] by the CCG as at 31 March 2019 (regardless of whether funded due to direct CCG employment or through a contract). Any administration, travel, triage or other time directly related to patient care is included in the WTE. The commissioner is required to maintain funding for these baseline posts and will be subject to audit to ensure the funding is maintained.

7.2.3. Subject to section 7.2.4 below, a PCN's Core Network Practices are required to maintain the declared PCN baseline in order to meet the additionality rules under the Network Contract DES Additional Roles Reimbursement Scheme. In

[38] See Network Contract DES: Additional Roles Reimbursement Scheme Guidance 2019/20 for further information.
[39] The six reimbursable roles funded include those directly employed by the CCG.

the event the PCN baseline reduces (meaning a vacancy arises in a Core Network Practice's baseline WTE) during the period 1 April 2020 to 31 March 2024, then the PCN will be subject to an equivalent WTE reduction in workforce funding under the Network Contract DES Additional Roles Reimbursement Scheme. The equivalent WTE reduction will be applicable from three months after the date at which the vacancy arose, resulting in a PCN baseline reduction, subject to the post not having been filled within this period and in accordance with section 10.

7.2.4. With the agreement of the commissioner, which will not be unreasonably withheld, a PCN will be able to substitute between clinical pharmacists, first contact physiotherapists, physician associates and paramedics within the PCN baseline. Where agreement to a substitution has taken place, the PCN will not be subject to an equivalent WTE reduction in workforce funding under the Network Contract DES Additional Roles Reimbursement Scheme.

7.2.5. A PCN is required to demonstrate that claims being made are for new additional staff roles beyond this baseline (including in future years, replacement as a result of staff turnover). The commissioner must be assured that claims meet the additionality principles above.

7.2.6. A PCN baseline will not be established for health and wellbeing coaches, care coordinators, dietitians, podiatrists, occupational therapists, nursing associates, training nursing associates, advanced practitioners or mental health practitioners. While the PCN baseline will not include these nine roles, the additionality principles will still apply as per the additionality principles above. For the avoidance of doubt, this means that a PCN acknowledges that where it claims reimbursement in respect of these nine roles, the PCN is confirming that:

a. the reimbursement is for additional staff engaged or employed since 31 March 2019; and

b. the reimbursement is not being used to subsidise practice-funded roles that existed as at 31 March 2019.

7.2.7. A failure to submit information or the provision of inaccurate workforce information is a breach of the Network Contract DES Specification and may result in commissioners withholding reimbursement pending further enquires in accordance with section 10.2. Reimbursement claims will be subject to validation and any suspicion that deliberate attempts have been made to subvert the additionality principles will result in a referral for investigation as potential fraud.

7.2.8. A PCN that engages new Additional Roles within the reimbursable roles after 31 March 2019 (i.e. above the baseline set and to meet additionality

principles) will be eligible for reimbursement under the Network Contract DES, if those new Additional Roles are delivering the services across the PCN and if the PCN meets the requirements set out in this Network Contract DES specification.

7.2.9. Clinical pharmacists previously employed via the national *Clinical Pharmacist in General Practice Scheme* or those clinical pharmacists or pharmacy technicians employed via the *Medicines Optimisation in Care Homes Scheme* ("**MOCH**")[40] transferred to become PCN staff will be exempt from the additionality principles. For this exemption to apply:

a. clinical pharmacists previously employed via the national *Clinical Pharmacist in General Practice Scheme* must have either:

i. been in post on 31 March 2019 and been transferred to become PCN staff by 31 March 2020 in line with the requirements set out in this Network Contract DES Specification[41]; or

ii. been in post on the scheme on 31 March 2021, become PCN staff by 30 September 2021 in line with the requirements set out in this Network Contract DES Specification, and the post be included in the PCN baseline established as at 31 March 2019, and

b. clinical pharmacists and pharmacy technicians previously employed under the MOCH Scheme, must have either:

i. transferred no later than 31 March 2021 under the relevant requirements for clinical pharmacists or pharmacy technicians within the Network Contract DES Specification that applied to the period 1 April 2020 to 31 March 2021; or

ii. been in post on the scheme on 31 March 2021, become PCN staff by 30 September 2021 in line with the requirements set out in this Network Contract DES Specification, and the post be included in the PCN baseline established as at 31 March 2019.

7.2.10. Where MOCH pharmacists do not transfer before 30 September 2021, the commissioner is required to align the work objectives of the CCG commissioned MOCH team to that of the Enhanced Health in Care Homes service requirements outlined in this Network Contract DES Specification.

7.2.11. The Additional Roles may be employed by a member of the PCN, or another body (e.g. GP Federation, voluntary sector provider, Local Authority or Trust).

---

[40] This will include some pharmacy technicians currently funded by CCGs.
[41] Full details on the transfer arrangements for clinical pharmacists is available in the 2019/20 Network Contract DES Guidance.

If the PCN chooses to commission the health services provided by the Additional Roles from another body, outside of the PCN, which therefore employs the staff, this does not change the general position that the PCN and its Core Network Practices are responsible for ensuring that the requirements of the Network Contract DES are delivered. The PCN is responsible for ensuring that all costs (including any applicable taxes which may include VAT) are met by one or other of the parties to any arrangements the PCN has for obtaining a health service from another body.

7.3. Additional Roles Reimbursement Sum

7.3.1. A PCN must act in accordance with the requirements set out in this section 7 in respect of the Additional Roles and the arrangements in section 10 to receive reimbursement from within a maximum allocated sum. This sum is referred to in this Network Contract DES Specification as the "**Additional Roles Reimbursement Sum**".

7.3.2. From within the allocated Additional Roles Reimbursement Sum, a PCN may claim reimbursement for Additional Roles in accordance with the terms set out in this section 7.3, section 10 and Table 2.

7.3.3. A PCN may claim 50 per cent reimbursement for an adult mental health practitioner (MHP) service from within the allocated Additional Roles Reimbursement Sum and in accordance with the terms set out in this section 7.3, section 10 and Table 2. The adult MHP will be employed by the PCN's local Community Mental Health Provider which will provide the adult MHP service to the PCN in accordance with the local agreement to deliver the relevant service requirements set out in Annex B. A limit of one WTE adult MHP will apply where the PCN's patients number 99,999 or fewer, and a limit of two will apply where the PCN's patients number 100,000 or over.

7.3.4. The PCN and Mental Health Community Provider may additionally agree to the provision of a service to support child and young people's (CYP) mental health. Where this is agreed locally, the PCN will be entitled to claim 50 per cent reimbursement for the provision of a CYP MHP service from within the allocated Additional Roles Reimbursement Scheme Sum and in accordance with the terms set out in this section 7.3, section 10 and Table 2. The CYP MHP will be employed by the PCN's local Community Mental Health Provider which will provide the CYP MHP service to the PCN in accordance with the local agreement. A limit of one WTE CYP MHP will apply where the PCN's patients number 99,999 or fewer, and a limit of two will apply where the PCN's patients number 100,000 or over.

7.3.5. A PCN may claim reimbursement for Advanced Practitioners from within the allocated Additional Roles Reimbursement Sum and in accordance with the terms set out in this section 7.3, section 10 and Table 2. A limit of one WTE Advanced Practitioner will apply where the PCN's patients number 99,999 or fewer, and a limit of two will apply where the PCN's patients number 100,000 or over. The Advanced Practitioner reimbursement is only applicable to the designated roles of Clinical Pharmacists, First Contact Physiotherapists, Dietitians, Podiatrists, Occupational Therapists and Paramedics, and the additional role requirements are outlined in Annex B.

7.4. Additional Role requirements

7.4.1. To ensure satisfactory provision of health services, a PCN must comply with the following requirements in relation to any Additional Roles:

a. Additional Roles must:

i. be embedded within the PCN's Core Network Practices and be fully integrated within the multi-disciplinary team delivering healthcare services to patients;

ii. have access to other healthcare professionals, electronic 'live' and paper-based record systems of the PCN's Core Network Practices, as well as access to admin/office support and training and development as appropriate; and

iii. have access to appropriate clinical supervision and administrative support,

iv. and whether the arrangements are through direct employment or engaged via a service contract from a third party, they must be intended for a minimum of six months, unless the purpose is to provide temporary cover (e.g. sickness or parental leave) for an individual employed through the Additional Roles Reimbursement Scheme.

b. The PCN must consider the appropriateness of, and if considered appropriate, the PCN must (whichever is relevant) either carry out or input to, a review and appraisal process for Additional Roles.

c. The PCN must ensure that any Additional Roles comply with the minimum role requirements set out in Annex B of this Network Contract DES Specification to be eligible for the Additional Roles Reimbursement Sum. A PCN may build upon the requirements set out in Annex B of this

Network Contract DES Specification in relation to any Additional Role job/service description.

d. The PCN must ensure the PCN's approach to deploying the Additional Roles is set out in the Network Agreement.

7.4.2. A PCN must inform the commissioner as soon as reasonably practicable where any change to its Additional Roles arrangements will have an impact on the payments being claimed (for example changes in WTE or new starters).

7.4.3. A PCN must record information on its Additional Roles, whether those Additional Roles are employed by the PCN itself or by another body, in the National Workforce Reporting Service ("NWRS") in line with the existing or updated requirements for general practice staff.

7.4.4. The commissioner must complete and return the six-monthly workforce report to england.primarycareworkforce@nhs.net[42].

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

7.5.1. A PCN must complete and return to the commissioner a workforce plan, using the agreed national workforce planning template[43], providing details of its updated plans for 2021/22 by 31 August 2021 and indicative intentions through to 2023/24 by 31 October 2021.

7.5.2. The commissioner must explore, and must endeavour to procure that the local ICS explores, different ways of supporting the PCN to implement the workforce plan through:

a. offering CCG or ICS staff support to the PCN to help with coordinating and undertaking recruitment and/or engagement exercises;

b. offering collective or batch recruitment across PCNs;

c. brokering arrangements to support full-time direct employment of staff by community partners, or to support rotational working across acute and community providers; and

d. ensuring the NHS workforce plans for the local system are helpful in supporting PCN's workforce plan.

7.5.3. The commissioner must:

[42] Further information is available in the Network Contract DES Guidance.
[43] The workforce planning template will be available at https://www.england.nhs.uk/gp/investment/gp-contract/

a. have shared with the PCN and relevant LMCs; and

b. have agreed with the PCN,

by 30 September 2021 an estimation of the amount of financial entitlements in relation to the PCN under the Additional Roles Reimbursement Scheme that the PCN is unlikely to claim by 31 March 2022. This amount is referred to in this Network Contract DES Specification as the "**Unclaimed Funding**".

7.5.4. The commissioner must base its estimate of the Unclaimed Funding on the PCN's workforce planning information that is returned to the commissioner by the 31 August 2021.

7.5.5. Where the PCN agrees the estimate, the PCN acknowledges that the PCN will no longer have the right to claim the Unclaimed Funding and the commissioner may give other PCNs within the commissioner's boundary the opportunity to bid for the Unclaimed Funding.

7.5.6. Where a commissioner provides the opportunity to PCNs within the commissioner's boundary to bid for any PCN's Unclaimed Funding, the commissioner will indicate when and how PCNs may bid.

7.5.7. A PCN acknowledges that if it bids for Unclaimed Funding and is successful, the Unclaimed Funding allocated to the PCN must be used for the purpose of recruiting or engaging further Additional Roles in accordance with this Network Contract DES Specification. The PCN and the commissioner acknowledge that any payment of the Unclaimed Funding to the PCN is in addition to the PCN's allocated Additional Roles Reimbursement Sum.

7.5.8. Where there are one or more bids for the Unclaimed Funding, the commissioner will assess the bids in accordance with the following criteria:

a. evidence that a bidding PCN has a process in place ready to begin the recruitment or engagement of new Additional Roles to which the Unclaimed Funding relates;

b. evidence that a bidding PCN has the resources and capability to undertake further recruitment or engagement; and

c. whether a bidding PCN is a PCN which:

i. had previously indicated in the workforce planning information that it was unlikely to claim its full financial entitlement but considers it is now in a position to recruit or engage; and

ii. evidences that it is able to meet sections 7.5.8.a and 7.5.8.b

d. whether a bidding PCN currently has staff on paid leave e.g. parental leave or sickness leave;

e. evidence that a PCN is in an area of higher deprivation[44]; and

f. any other factor that the commissioner, acting reasonably, considers is relevant to its decision.

7.5.9. A bidding PCN acknowledges that:

a. the above criteria are in descending order of preference. For the avoidance of doubt, this means that bids satisfying criteria at the top of the list will be preferred over bids that only satisfy criteria further down the list; and

b. the commissioner will give preference to a bid which satisfies the criteria in section 7.5.8.c. over all other bids.

7.5.10. The commissioner will notify each PCN of the outcome of its consideration and indicate to any successful bidding PCN the level of funding allocated to the successful bidding PCN.

7.5.11. Notwithstanding that any payments of Unclaimed Funding are not part of the PCN's allocated Additional Roles Reimbursement Sum and is in addition to the PCN's allocated Additional Roles Reimbursement Sum, payment of the Unclaimed Funding will be made on the same basis as payments of the PCN's Additional Roles Reimbursement Sum.

7.5.12. A successful bidding PCN acknowledges that any additional funding allocated to the PCN only relates to the period from the date the PCN was notified that it was successful to 31 March 2022 and that there is no right for the PCN to require a commissioner to continue paying the additional funding after 31 March 2022.

7.5.13. The commissioner will be responsible for monitoring any Additional Roles Reimbursement Scheme funding redistribution. Where there are repeated occurrences of redistribution from and/or to particular PCNs, the commissioner will be responsible for reviewing this in conjunction with the relevant PCNs and, where appropriate, the LMC and ICS, and take appropriate supportive actions.

8. Service Requirements

[44] Defined by the Indices of Deprivation (IoD), based on seven different domains or facets of deprivation – (1) income deprivation, (2) employment deprivation, (3) education, skills and training deprivation, (4) health deprivation and disability, (5) crime, (6) barriers to housing and services and (7) living environment deprivation. See https://www.gov.uk/government/collections/english-indices-of-deprivation and https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

8.1. Extended Hours Access

8.1.1. A PCN must provide extended hours access in the form of additional clinical appointments in accordance with this Network Contract DES Specification regardless of whether any practices within the PCN are providing any CCG commissioned extended access services in 2021/22 (which are referred to in this Network Contract DES Specification as "**CCG Extended Access Services**").

8.1.2. Where a commissioner is not satisfied that a PCN is delivering extended hours access in accordance with the requirements of this Network Contract DES specification then the commissioner may take action as set out in section 9. If a commissioner determines to withhold payment[45], the amount withheld will be an appropriate proportion of the extended hours access payment and the Core PCN funding payment.

8.1.3. To provide extended hours access, a PCN must provide additional clinical appointments that satisfy all the requirements set out below:

a. are available to all registered patients within the PCN:

b. may be for emergency, same day or pre-booked appointments;

c. are with a healthcare professional or another person employed or engaged by the PCN to assist that healthcare professional in the provision of health services;

d. are held at times outside of the hours that the PCN Core Network Practices' primary medical services contracts[46] require appointments to be provided otherwise than under the Network Contract DES. For the avoidance of doubt, if a Core Network Practice was required under a General Medical Services ("**GMS**") contract to provide core services at its premises until 6:30pm, the additional clinical appointments under this Extended Hours Access requirement could be provided after 6:30pm. If, however, another Core Network Practice in the PCN provided core services at its premises until 8pm, then:

i. any additional clinical appointments provided after 6:30pm but before 8pm must not be provided at the later closing practice's premises (as

[45] Payment withheld in this context would be an appropriate proportion of the payments in relation to both extended hours access and Core PCN funding payments.

[46] For practices with PMS and APMS arrangements, the additional clinical appointments provided in accordance with this Extended Hours Access requirement do not apply to any hours covered by core hours set out in the practice's primary medical services contracts. A PCN will be required to take consideration of this when agreeing the Extended Hours Access offer to the PCN Contractor Registered Population. For practices with GMS arrangements, core hours are from 08:00 to 18:30.

these would not be additional hours appointments) but could be provided at the other practice's premises; and

ii. a proportion of the additional clinical appointments must be provided after 8pm;

e. are demonstrably in addition to any appointments provided by the PCN's practices under the CCG Extended Access Services;

f. are held at times having taken into account the PCN's patients' expressed preferences, based on available data at practice or PCN level and evidenced by patient engagement;

g. equate to a minimum of 30 minutes per 1,000 registered patients per week, calculated using the following formula:

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

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

**this is the total number of persons on the lists of patients of all Core Network Practices of the PCN as at 1 January 2021

h. are provided in continuous periods of at least 30 minutes;

i. are provided on the same days and times each week with sickness and leave of those who usually provide such appointments covered by the PCN; and

j. may be provided face to face, by telephone, by video or by online consultation provided that the PCN ensures a reasonable number of appointments are available for face-to-face consultations where appropriate.

8.1.4. A PCN must set out how the extended hours access appointments will be delivered in the Network Agreement.

8.1.5. A PCN must ensure that all practices in the PCN's membership actively engage in planning of the provision of the extended hours access requirements and acknowledges that nothing in this Network Contract DES Specification requires an individual clinician or practice within the PCN to deliver a particular share of the appointments. The exact number of extended hours access appointments delivered from each member practice premises will be for the PCN to determine subject to complying with the minimum additional minutes set out in section 8.1.3.g.

8.1.6. A PCN's Core Network Practices must ensure that their registered patients are aware of the availability of extended hours access appointments, including any change to published availability, through promotion and publication of the days and times of these appointment through multiple routes. This may include the NHS website[47], the practice leaflet, the practice website, on a waiting room poster, by writing to patients and active offers by staff booking appointments.

8.1.7. Where a PCN cancels any extended hours access appointments or where appointments cannot be offered on the usual days and times (for example, but not limited to, due to a bank holiday falling on the usual day), the PCN must make up the cancelled time by offering additional appointments within a two-week period, unless otherwise agreed with the commissioner. For the avoidance of doubt, any rescheduled appointments offered in a subsequent week are in addition to the minimum minutes that must be offered for that week as set out in section 8.1.3.g. The PCN must ensure that all patients within the PCN are notified of the cancelled and rescheduled appointments.

8.1.8. A commissioner must publicise information to help patients to identify which practices are offering appointments at given times.

8.1.9. Core Network Practices of a PCN must inform patients of any changes to the days and time at which extended hours access appointments are offered, providing reasonable notice to patients.

8.1.10. If any Core Network Practice of a PCN is providing out of hours services to its own list of patients, the PCN must, as part of the Extended Hours Access service provision offer routine extended hours access appointments in addition to the out of hours service.

8.1.11. A PCN must ensure that:

a. no Core Network Practice of the PCN will be closed for half a day on a weekly basis, except where a Core Network Practice has prior written approval from the commissioner; and

b. the PCN's Patients are able to access essential services, which meet the reasonable needs of patients during core hours, from their own practice or from any sub-contractor.

8.1.12. For the avoidance of doubt, unless a practice has prior written approval from the commissioner, all PCN Core Network Practices will not close for half a day on a weekly basis.

8.1.13. The term "prior written approval" in section 8.1.11.a means an explicit agreement between the practice and the commissioner that specifically

[47] https://www.nhs.uk/

includes written approval to close for half a day on a weekly basis for the purposes of the Network Contract DES Specification. The agreement must expressly state that

a. it is pursuant to the Network Contract DES Specification; and

b. it will expire no later than 31 March 2022

8.1.14. Where a Core Network Practice does not have prior written approval to close for half a day on a weekly basis, a Core Network Practice that previously closed for half a day on a weekly basis will need to either:

a. be open for that half a day in the same way that it is open on other days of the week, or

b. have in place appropriate sub-contracting arrangements for the time the practice is closed - in line with Schedule 3, Part 5 para 44 of the GMS Regulations[48] or Schedule 2, Part 5 para 43 of the PMS Regulations[49], as applicable – so that patients continue to have access to essential services which meet their reasonable[50] needs during core hours.

8.2. Structured Medication Review and Medicines Optimisation

8.2.1. A PCN is required to:

a. use appropriate tools to identify and prioritise the PCN's Patients who would benefit from a structured medication review (referred to in this Network Contract DES Specification as a "**SMR**"), which must include patients:

i. in care homes[51];

ii. with complex and problematic polypharmacy, specifically those on 10 or more medications;

iii. on medicines commonly associated with medication errors[52];

---

[48] National Health Service (General Medical Services Contracts) Regulations 2015

[49] National Health Service (Personal Medical Services Agreements) Regulations 2015

[50] NHS England's guidance is that it includes for example: the ability to book and cancel appointments, collect prescriptions, access urgent appointments/advice as clinically necessary, the ability to attend a pre-bookable appointment.

[51] Patients in a 'care home' are those resident in services registered by CQC as care home services with nursing (CHN) and care home services without nursing (CHS).

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

iv. with severe frailty[53], who are particularly isolated or housebound patients, or who have had recent hospital admissions and/or falls; and

v. using one or more potentially addictive medications from the following groups: opioids, gabapentinoids, benzodiazepines and z-drugs;

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;[54]

g. work with community pharmacies to connect patients appropriately to the New Medicines Service which supports adherence to newly prescribed medicines; and

h. in complying with this section 8.1.14.b, have due regard to NHS England and NHS Improvement guidance on Structured Medication Reviews and Medicines Optimisation[55].

---

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

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

[55] NHS England and NHS Improvement guidance on Structured Medication Reviews and Medicines Optimisation

8.3. Enhanced Health in Care Homes

8.3.1. A PCN is required to:

a. have agreed with the commissioner the care homes for which the PCN will have responsibility (referred to as the "**PCN's Aligned Care Homes**" in this Network Contract DES Specification). The commissioner will hold ongoing responsibility for ensuring that care homes within their geographical area are aligned to a single PCN and may, acting reasonably, allocate a care home to a PCN if agreement cannot be reached. Where the commissioner allocates a care home to a PCN, that PCN must deliver the Enhanced Health in Care Homes service requirements in respect of that care home in accordance with this Network Contract DES Specification;

b. have in place with local partners (including community services providers) a simple plan about how the Enhanced Health in Care Homes service requirements set out in this Network Contract DES Specification will operate;

c. support people entering, or already resident in the PCN's Aligned Care Home, to register with a practice in the aligned PCN if this is not already the case; and

d. ensure a lead GP (or GPs) with responsibility for these Enhanced Health in Care Homes service requirements is agreed for each of the PCN's Aligned Care Homes.

8.3.2. By exception, the clinical lead may be a non-GP clinician with appropriate experience of working with care homes, provided this is agreed by the practices in the PCN, the commissioner and the relevant community provider.

8.3.3. A PCN must:

a. work with community service providers (whose contracts will describe their responsibility in this respect) and other relevant partners to establish and coordinate a multidisciplinary team ("**MDT**") to deliver these Enhanced Health in Care Homes service requirements; and

b. have established arrangements for the MDT to enable the development of personalised care and support plans with people living in the PCN's Aligned Care Homes.

8.3.4. A PCN must have in place established protocols between the care home and with system partners for information sharing, shared care planning, use of shared care records, and clear clinical governance.

8.3.5. A PCN must:

a. deliver a weekly ‘home round’ for the PCN’s Patients who are living in the PCN’s Aligned Care Home(s). In providing the weekly home round a PCN:

   i. must prioritise residents for review according to need based on MDT clinical judgement and care home advice (a PCN is not required to deliver a weekly review for all residents);

   ii. must have consistency of staff in the MDT, save in exceptional circumstances;

   iii. must include appropriate and consistent medical input from a GP or geriatrician, with the frequency and form of this input determined on the basis of clinical judgement; and

   iv. may use digital technology to support the weekly home round and facilitate the medical input;

b. using the MDT arrangements referred to in section 8.3.3 develop and refresh as required a personalised care and support plan with the PCN’s Patients who are resident in the PCN’s Aligned Care Home(s). A PCN must:

   i. aim for the plan to be developed and agreed with each new patient within seven working days of admission to the home and within seven working days of readmission following a hospital episode (unless there is good reason for a different timescale);

   ii. develop plans with the patient and/or their carer;

   iii. base plans on the principles and domains of a Comprehensive Geriatric Assessment[56] including assessment of the physical, psychological, functional, social and environmental needs of the patient including end of life care needs where appropriate;

   iv. draw, where practicable, on existing assessments that have taken place outside of the home and reflecting their goals; and

   v. make all reasonable efforts to support delivery of the plan;

c. identify and/or engage in locally organised shared learning opportunities as appropriate and as capacity allows; and

d. support with a patient’s discharge from hospital and transfers of care between settings, including giving due regard to NICE Guideline 27[57].

---

[56] https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-03-12/CGA%20Toolkit%20for%20Primary%20Care%20Practitioners_0.pdf

[57] https://www.nice.org.uk/guidance/ng27

8.3.6. For the purposes of this section 8.3, a 'care home' is defined as a CQC-registered care home service, with or without nursing[58].

8.3.7. A PCN's Core Network Practices must ensure the coding of care home residence is accurately recorded on a continuous basis, using the relevant SNOMED codes as published in the supporting Business Rules[59].

8.4. Early Cancer Diagnosis

8.4.1. A PCN is 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[60] and make use of:

ii. clinical decision support tools;

iii. practice-level data to explore local patterns in presentation and diagnosis of cancer; and

iv. where available the Rapid Diagnostic Centre pathway for people with serious but non-specific symptoms[61];

v. 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 Guideline 12; and

vi. 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; and

---

[58] See https://www.cqc.org.uk/guidance-providers/regulations-enforcement/service-types for further information on the definition of care home services for this purpose. A monthly directory of registered care home services that meet these categories is available at https://www.cqc.org.uk/about-us/transparency/using-cqc-data

[59] The applicable SNOMED codes are available in the relevant business rules published by NHS Digital under the relevant years 'Enhanced Services, Vaccinations and Immunisations and Core Contract components' page.

[60] https://www.nice.org.uk/guidance/ng12

[61] Further detail on the RDC vision and strategy is available here: https://www.england.nhs.uk/wp-content/uploads/2019/07/rdc-vision-and-1920-implementation-specification.pdf. Assessment pathways for specific cancers are published here: https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/

vii. in undertaking section 1.1.1.a.i to 1.1.1.a.vi identify and implement specific actions to address unwarranted variation and inequality in cancer outcomes, including access to relevant services;

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 NHS England and NHS Improvement Regional Public Health Commissioning team and Cancer Alliance – to agree the PCN's contribution to local improvement plans which should build on any existing actions across the PCN's Core Network Practices. This must include at least one specific action to engage with a group with low participation locally, with agreed timescales; and

ii. support the restoration of the NHS Cervical Screening Programme by identifying opportunities across a network to provide sufficient cervical screening sample-taking capacity; and

c. establish a community of practice between practice-level clinical staff to support delivery of the requirements set out in sections 8.4.1.a to 8.4.1.vii. 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; and

iii. identify successful improvement activity undertaken by constituent practices in support of the Quality and Outcomes Framework requirements on early cancer diagnosis. Ensure that successful practice is implemented and developed across the PCN.

8.5. Social Prescribing Service

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

8.5.2. To comply with this, a PCN may:

a. directly employ Social Prescribing Link Workers; or

b. sub-contract provision of the service to another provider,

in accordance with this Network Contract DES Specification.

8.6. Cardiovascular Disease (CVD) Prevention and Diagnosis

8.6.1. From 1 October 2021, a PCN must:

a. improve diagnosis of patients with hypertension, in line with NICE guideline NG136[62], by ensuring appropriate follow-up activity is undertaken to confirm or exclude a hypertension diagnosis where a blood pressure of ≥140/90mmHg in a GP practice, or ≥135/85 in a community setting, is recorded. This will include proactive review of historic patient records, to identify patients who have had a previous elevated blood pressure reading but have not had an appropriate diagnostic follow up; and

b. undertake activity to improve coverage of blood pressure checks, by:

i. increasing opportunistic blood pressure testing where patients do not have a recently recorded reading;

ii. undertaking blood pressure testing at suitable outreach venues, agreeing the approach with local partners and targeting need as informed by local data on health inequalities and potentially at-risk groups; and

iii. working pro-actively with community pharmacies to improve access to blood pressure checks, in line with the NHS community pharmacy hypertension case finding service.

8.7. Tackling Neighbourhood Health Inequalities

8.7.1. From 1 October 2021, a PCN must[63]:

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

b. identify and include all patients with a severe mental illness on the severe mental illness register, and make all reasonable efforts to deliver comprehensive physical health checks for at least 60% of these patients;

c. record the ethnicity of all patients registered with the PCN (or record that the patient has chosen not to provide their ethnicity); and

---

[62] NICE guideline: https://www.nice.org.uk/guidance/ng136

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

d. appoint a lead for tackling health inequalities within the PCN.

8.7.2. By 28 February 2022, a PCN must identify a population within the PCN experiencing inequality in health provision and/or outcomes, and develop a plan to tackle the unmet needs of that population.

8.7.3. To develop that plan, a PCN and commissioner must jointly:

a. utilise available data on health inequalities to identify that selected population, working in partnership with their ICS, including local medical or pharmaceutical committees, and local authority commissioners;

b. hold discussions with local system partner organisations who have existing relationships with the selected population to agree an approach to engagement;

c. begin engagement with the selected population to understand the gaps in, and barriers to their care; and

d. define an approach for identifying and addressing the unmet needs of this population.

8.7.4. The PCN's finalised plan to tackle the unmet needs of the selected population should include:

a. locally defined measures agreed with local commissioners in line with, and co-ordinated between, wider system strategies to tackle drivers of inequalities;

b. delivery of relevant interventions or referrals to services that provide these interventions for the selected population; and

c. ongoing engagement with the selected population.

8.7.5. By 1 March 2022, the PCN must proceed to deliver the plan referred to in section 8.7.4.

9. Contract management

9.1. General

9.1.1. Section 3 of this Network Contract DES Specification states that each Core Network Practice of a PCN is responsible for ensuring that a requirement or obligation of a PCN as set out in this Network Contract DES Specification is carried out on behalf of that PCN.

9.1.2. A PCN acknowledges that, where a requirement or obligation of a PCN is not carried out, each Core Network Practice will be in breach of this Network Contract DES Specification.

9.1.3. A PCN further acknowledges that as the provisions of this Network Contract DES Specification are part of a Core Network Practice's primary medical services contract, the commissioner is able to take any action set out in the relevant primary medical services contracts in relation to a breach of this Network Contract DES Specification.

9.1.4. Where a breach of this Network Contract DES Specification occurs, a commissioner may require a PCN to work with the commissioner to compile and agree a collaborative action plan setting out actions to address non-delivery and timescales for those actions. The commissioner and the PCN will make all reasonable efforts to agree the action plan.

9.1.5. It is not expected that commissioners will need to resort to contract management processes such as issuing of breach or remedial notices due to the support options available across the system and the action plan development process as described in section 9.1.4.

9.1.6. The commissioner acknowledges that the action plan is intended to be a first step towards remedying the breach. If:

a. the commissioner, acting reasonably, determines that an action plan is not appropriate;

b. an action plan cannot be agreed within a reasonable timescale; or

c. a breach is not remedied by an action plan,

the commissioner may take any appropriate action set out in the Core Network Practice's primary medical services contracts in relation to the breach. This may include issue of a breach or remedial notice, withholding of payments or termination.

9.1.7. A PCN (and each Core Network Practice in the PCN) acknowledge that:

a. the legislation underpinning GMS and PMS arrangements include references to "**Contract Sanctions**" and "**Agreement Sanctions**" respectively which enable the commissioner, in certain circumstances, to terminate certain obligations under the primary medical services contracts; and

b. in the unlikely event that a breach cannot be resolved by the application of the provisions of this Network Contract DES Specification and the contract management provisions of the primary medical services contract, the commissioner is able to rely on the Contract Sanctions or Agreement Sanctions, as relevant, to terminate a Core Network Practice's participation in the Network Contract DES while the rest of the obligations in the primary medical services contract are not terminated;

c. if the commissioner is minded to terminate Core Network Practices' participation in the Network Contract DES, it must act in accordance with section 6.6 as if references to the Core Network Practice's primary medical services contract terminating are references to the Core Network Practice's participation in the Network Contract DES terminating; and

d. where a PCN's members include a Core Network Practice which holds an APMS contract, the commissioner must consider if there are corresponding rights in the APMS contract for the commissioner to partially terminate the APMS contract to terminate only the provisions relating to the Network Contract DES. The commissioner acknowledges that if such rights are not included, the need to deal with all PCN Core Network Practices in a similar way may mean that the commissioner is not be able to terminate the PCN's Core Network Practices' participation in the Network Contract DES.

10. Network financial entitlements

10.1. General

10.1.1. A practice participating in the Network Contract DES acknowledges that payments made under the Network Contract DES are dependent on the Core Network Practices of a PCN working together to deliver the requirements of this Network Contract DES.

10.1.2. A PCN acknowledges that where confirmation of participation in the Network Contract DES is required from the commissioner pursuant to section 4, such confirmation may not occur until after 30 April 2021 but that this Network Contract DES Specification sets out certain elements of the Network financial entitlements that will, provided any required criteria or conditions are satisfied, be backdated to April 2021. Any such backdating is set out in the relevant sections of this section 10.

10.1.3. Where information relating to a new proposed PCN is submitted to the commissioner between 1 April 2021 and 31 March 2022, the commissioner will, where a PCN is approved, indicate to the PCN the relevant service delivery commencement date and when payments of the financial entitlements will be made.

10.1.4. Where a new proposed PCN is approved after 1 April 2021, the Core Network Practices of that PCN acknowledge that payments due under the Network Contract DES will be calculated as set out in sections 10.3 and 10.4, and split into 12 monthly instalments. For the purposes of the PCN Leadership and Management payment, the payment starts from 1 October 2021 and will be

split into 6 equal monthly instalments. For the purposes of the PCN Support Payment, the payment starts from 1 December 2021 and will be split into 4 equal monthly payments. The Core Network Practices will only be entitled to receive the monthly instalments for the months they deliver the service requirements of the Network Contract DES.

10.1.5. Where the financial entitlement refers to a payment being based on practice list size or PCN list size, the relevant figure in most cases will be taken from the registration system approved by NHS England as at 1 January 2021 or a later date if the commissioner, in its absolute discretion, considers that a PCN has satisfactorily evidenced that there has been a large fluctuation in its Core Network Practices' lists of patients such that the figure derived from the later date is more appropriate. For the purposes of the PCN Leadership and Management payment, the relevant figure will be taken from the registration system approved by NHS England as at 1 September 2021.

10.1.6. The commissioner must ensure that payments due to a PCN set out in this Network Contract DES are made into the bank account of the Nominated Payee. For the avoidance of doubt, the Network Participation Payment is not a payment due to a PCN as it is payable directly to a Core Network Practice. The PCN must inform the commissioner of the relevant payment details of its Nominated Payee. The PCN will include in the Network Agreement the details of arrangements with the Nominated Payee and may indicate the basis on which the Nominated Payee receives the payments on behalf of the other practices, e.g. as an agent or trustee.

10.1.7. If there is a change to the Nominated Payee that takes effect in accordance with section 6.3 prior to a payment being made, the commissioner will make the payment to the new Nominated Payee. A PCN acknowledges that, where there is any change to the membership of the PCN after 31 March 2022 and before the receipt of a payment that relates to this Network Contract DES, the commissioner will make the payment to the Nominated Payee that relates to the PCN as at the date of the payment and it is for the PCN to manage any distribution of the payment. A PCN acknowledges that, if there is no applicable Nominated Payee, either because the PCN no longer exists or otherwise, the commissioner will make the payment to the bank account of the previously notified Nominated Payee and it is for the controller of that bank account to manage any distribution of the payment.

10.1.8. A PCN and its commissioner acknowledge that:

a. payments made in accordance with this Network Contract DES Specification are not payments for specific services and instead are made in consideration of the PCN delivering the requirements of this Network Contract DES Specification; and

b. the calculation of the payments in accordance with this Network Contract DES Specification are split into separate elements which are listed in more detail in sections 10.3 to 10.6.

10.1.9. Where an ODS Change Instruction Notice needs to be submitted prior to a payment being made, the payment will be made by the end of the month in which the notice was submitted provided the notice was submitted before the end of the last working day on or before the 14th day of that month. If submitted after the end of the last working day on or before the 14th day of the month, payment will be made at the end of the following month. The exact date of payment is subject to local payment arrangements.

10.1.10. If a practice is allocated to a PCN in accordance with section 4.6, an adjustment will be made to reflect that practice's patient list in the calculation of a payment due to the PCN. The adjustment will only apply to payments that are made once the ODS Change Instruction Notice has been submitted in accordance with the timescales in section 10.1.9, which, for the avoidance of doubt, will only occur after the commissioner has confirmed the practice's participation in the Network Contract DES in accordance with section 4.6.5.

10.1.11. The adjustment referred to in section 10.1.10 which is to be made to reflect the practice's patient list in the calculation of a payment due to the PCN is as follows:

a. The relevant payment will be recalculated with the relevant measure of the practice's patient list included;

b. The amount recalculated will be divided into 12 equal monthly instalments; and

c. Each monthly payment to the PCN, made after the ODS Change Instruction Notice has been submitted in accordance with the timescales in section 10.1.9, will be an amount equal to the recalculated monthly instalment; and

d. For the avoidance of doubt, there will be no adjustment to the previous monthly payments that have already been paid to the PCN.

10.2. Administrative provisions relating to payment

10.2.1. Payments under the Network Contract DES are to be treated for accounting and superannuation purposes as gross income of the PCN's Core Network Practices, in the financial year. Where payments are made to the Nominated Payee, how the income is apportioned for accounting and superannuation purposes will depend on the arrangements for the distribution of payments between the Core Network Practices, as set out in the Network Agreement.

Core Network Practices are responsible for ensuring that their arrangements are appropriate.

10.2.2. Payments made in accordance with this Network Contract DES Specification may be changed when there is any change to a PCN, including, but not limited to, where there is a change to the Core Network Practices members.

10.2.3. A PCN (and its Core Network Practices) is required to adhere to current financial probity standards that are in place across the NHS, ensuring that the deployment of resources would stand up to wider scrutiny as an efficient and effective use of NHS funding.

10.2.4. The commissioner will be responsible for post payment verification. This may include auditing claims of the PCN (and a Core Network Practice in relation to the Network Participation Payment) to ensure that they meet the requirements of the Network Contract DES. Where required, PCNs and/or a Core Network Practice as relevant will provide to the commissioner in a timely manner all relevant information and assistance to support assessment of compliance with the requirements of this service and expenditure against the Network Contract DES.

10.2.5. Payments pursuant to the Network Contract DES, or any part thereof, are only payable if a PCN or a Core Network Practice if relevant satisfies the following conditions:

a. the PCN or Core Network Practice as relevant makes available to the commissioner any information under the Network Contract DES, which the commissioner requests and the PCN or Core Network Practice as relevant either has or could be reasonably expected to obtain;

b. the PCN or Core Network Practice as relevant makes any returns required of it (whether computerised or otherwise) to the payment system or CQRS and does so promptly and fully; and

c. all information supplied pursuant to or in accordance with this section 10 must be accurate.

10.2.6. If a commissioner makes a payment under the Network Contract DES and:

a. the recipient was not entitled to receive all or part thereof, whether because it did not meet the conditions for the payment or because the payment was calculated incorrectly (including where a payment on account overestimates the amount that is to fall due); or

b. the commissioner was entitled to withhold all or part of the payment because of a breach of a condition attached to the payment, but is unable to do so because the money has already been paid,

then the commissioner is entitled to repayment of all or part of the money paid. The commissioner may, in this circumstance, recover the money paid by deducting an equivalent amount from any payment payable to the PCN (or if the payment relates to payments of the Network Participation, from any payment to the relevant Core Network Practice), and where no such deduction can be made, it is a condition of the payments made under the Network Contract DES that the PCN[64] or relevant Core Network Practice as relevant must pay to the commissioner that equivalent amount.

10.2.7. Where the commissioner is entitled under the Network Contract DES to withhold all or part of a payment because of a breach of a payment condition and the commissioner does so or recovers the money by deducting an equivalent amount from another payment in accordance with this section 10, it may, where it sees fit to do so, reimburse the PCN or relevant Core Network Practice as relevant the amount withheld or recovered, if the breach is cured.

10.3. Network Participation Payment

10.3.1. Each practice that:

a. is eligible to participate in this Network Contract DES;

b. has submitted information for confirmation of participation in accordance with section 4;

c. has been confirmed as participating in the Network Contract DES as a Core Network Practice of a PCN; and

d. commits to being active members of their PCN as it evolves over the coming years,

will be eligible for a Network Participation Payment ("**NPP**") with effect from 1 April 2021 to support practice engagement.

10.3.2. For the avoidance of doubt:

a. the NPP payment is only made in respect of a PCN of which the practice is a Core Network Practice; and

b. the NPP payment is paid directly to a Core Network Practice and not the PCN's Nominated Payee.

[64] The PCN must agree how it would deal with such a circumstance so as not to disadvantage the Nominated Payee. Where required, the commissioner may consider withholding the SFE payment in accordance with the provisions of the SFE.

10.3.3. For practices to whom the SFE applies, the NPP will be paid in accordance with the SFE and is not a financial entitlement pursuant to this Network Contract DES Specification.

10.3.4. For practices to whom the SFE does not apply, it is a requirement of this Network Contract DES that the commissioner ensures that a payment is made in respect of those practices that equates to the NPP that would have been made to the practice if the SFE applied to that practice.

10.3.5. The NPP for the period 1 April 2021 to 31 March 2022 is calculated as £1.761 multiplied by the practice's **"Contractor Weighted Population"** as at 1 January 2021.

10.3.6. Subject to sections 10.1.4 and 10.3.7, the amount calculated as the NPP is payable in 12 equal monthly instalments and the commissioner must arrange for the relevant payment to be made to a Core Network Practice no later than the last day of the month following the month in which the payment applied and taking into account local payment arrangements.

10.3.7. Subject to section 10.1.9, section 10.3 and local payment arrangements, for a Core Network Practice of a Previously Approved PCN with membership changes the NPP will be made no later than the end of the month following the month in which the participation of all Core Network Practices of that PCN has been confirmed. Where the first payment is paid after May 2021, the first payment will include payment of instalments backdated to 1 April 2021.

10.3.8. A Core Network Practice will no longer be eligible to receive the NPP if under exceptional circumstances it leaves the PCN after 30 April 2021. The change will take effect from the month following the month in which the Core Network Practice leaves the PCN.

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

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

10.4.1A Subject to sections 10.1.4 and 10.4.2A, the amount calculated for the PCN Leadership and Management payment in this section 10.4 is payable in 6 equal monthly instalments and the commissioner must arrange for the

payment to be made no later than the last day of the month in which the payment applies and taking into account local payment arrangements.

10.4.1B A PCN is entitled to the PCN Support Payment for the period 1 December 2021 to 31 March 2022. Subject to sections 10.1.4, 10.4.1C and 10.4.2B, the amount calculated for the PCN Support Payment in this section 10.4 is payable in 4 equal monthly instalments to be made no later than the last day of the month in which the payment applies and taking into account local payment arrangements, with the exception of the December payment which will be made as soon as practicable and no later than the end of January 2022.

10.4.1C A PCN must commit in writing to the commissioner to reinvest any PCN Support Payment into additional workforce, additional primary medical services, and/or other areas of investment in a Core Network Practice (e.g. equipment, premises).

10.4.2. Subject to section 10.1.9 and local payment arrangements, for a Previously Approved PCN with membership changes each of the following payments (Clinical Director, Core PCN Funding, Extended Hours Access and Care Home Premium) in this section 10.4 will be made no later than the end of the month in which the participation of all Core Network Practices of that PCN has been confirmed. Where the first payment is paid after April 2021, the first payment will include instalments backdated to 1 April 2021.

10.4.2A Subject to section 10.1.9 and local payment arrangements, for a Previously Approved PCN with membership changes the Leadership and Management payment in this section 10.4 will be made no later than the end of the month in which the participation of all Core Network Practices of that PCN has been confirmed. Where the first payment is paid after October 2021, the first payment will include instalments backdated to 1 October 2021.

10.4.2B Subject to section 10.1.9 and local payment arrangements, for a Previously Approved PCN with membership changes the PCN Support Payment in this section 10.4 will be made no later than the end of the month in which the participation of all Core Network Practices of that PCN has been confirmed with the exception of the December payment which will be made as soon as practicable and no later than the end of January 2022. Where the first payment is paid after December 2021, the first payment will include instalments backdated to 1 December 2021.

10.4.3. Table 1 sets out the relevant payment calculations for each of the payments which the PCN is entitled to as set out in this section 10.4.

Table 1: PCN Payments for 2021/22

Financial Entitlement	Payment provisions and calculation
Clinical Director Payment	The clinical director payment for the period 1 April 2021 to 31 March 2022 is £0.736[65] per registered patient per annum (which equates to £0.061 per patient per month). This is indicatively calculated using a baseline equivalent of 0.25 WTE (1 WTE is £142,422 in 2021/22) per average PCN (as at 1 January 2021)[66].
Core PCN Funding	The Core PCN Funding for the period 1 April 2021 to 31 March 2022 is calculated as £1.50 multiplied by the PCN registered list size (equating to £0.125 per patient per month). The Commissioner must provide the Core PCN Funding from its CCG core allocations[67] as per the NHS Operational Planning and Contracting Guidance 2020/21[68].
Extended Hours Access Payment	The extended hours access payment for the period 1 April 2021 to 31 March 2022 is calculated as £1.44 multiplied by the PCN registered list size (equating to £0.120 per patient per month).
Care Home Premium	The payment is calculated on the basis of £120 per bed for the period 1 April 2021 to 31 March 2022. The number of beds will be based on Care Quality Commission (CQC) data on beds within services that are registered as care home services with nursing (CHN) and care home services without nursing (CHS) in England[69]. The commissioner must arrange for payment to be made to the PCN on a monthly basis from 1 April 2021 at a rate of £10 per bed per month for the period 1 April 2021 to 31 March 2022 based on the number of relevant beds in the PCN's Aligned Care Homes. The commissioner must ensure that the number of beds on which payment is based is updated on a monthly basis in line with the CQC Care Directory[70]. Payment will only be made where the commissioner is satisfied that the PCN or its Core Network Practices have comprehensively

[65] The additional 6 per cent employer's superannuation will be met centrally.
[66] https://digital.nhs.uk/services/organisation-data-service
[67] Rather than specific primary medical care allocations.
[68] https://www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21/
[69] See https://www.cqc.org.uk/guidance-providers/regulations-enforcement/service-types for further information on the definition of care home services for this purpose.
[70] See https://www.cqc.org.uk/guidance-providers/regulations-enforcement/service-types for further information on the definition of care home services for this purpose.

	coded care home residents using appropriate clinical codes as follows: a. 160734000 – Lives in a nursing home; b. 394923006 – Lives in a residential home; and c. 248171000000108 – Lives in care home (finding).
PCN Leadership and Management Payment	The PCN leadership and management payment for the period 1 October 2021 to 31 March 2022 is calculated as £0.707 multiplied by the PCN Adjusted Population (equating to £0.118 multiplied by the PCN Adjusted Population per month) as at 1 September 2021.
PCN Support Payment	The PCN Support Payment for the period 1 December 2021 to 31 March 2022 is calculated as £1.029 multiplied by the PCN Contractor Weighted Population (equating to £0.257 multiplied by the PCN Contractor Weighted Population per month) as at 1 January 2021.

10.5. Workforce

10.5.1. Subject to sections 10.5.6 to 10.5.10, a PCN is entitled to claim 100 per cent reimbursement of the aggregate WTE actual[71] salary (including employer on-costs for NI and pension[72]) up to the maximum amount per role as outlined in Table 2 and within that PCN's overall Additional Roles Reimbursement Sum, for the delivery of health services.

10.5.2. Subject to sections 10.5.6 to 10.5.10, a PCN is entitled to claim 50 per cent reimbursement of the aggregate WTE actual[73] salary (including employer on-costs for NI and pension[74]) for adult MHPs (or CYP MHPs if agreed locally), up to the maximum amount per role as outlined in Table 3 and within that PCN's overall Additional Roles Reimbursement Sum, for the delivery of health services.

10.5.3. Subject to sections 10.5.6 to 10.5.10, a PCN within the London Region is entitled to claim the inner or outer London maximum reimbursement rate for its engaged Additional Roles:

a. up to the relevant maximum reimbursable amount per role as outlined in Tables 2 and 3 for actual salary plus employer (NI and pension) on costs;

b. within the PCN's overall Additional Roles Reimbursement Sum; and

c. eligibility for either an inner or outer London maximum reimbursement rate will be determined by the commissioner based on the geographical location of the PCN's Core Network Practices and the definition of the areas as outlined in Annex 8 of Agenda for Change. Where a PCN has Core Network Practices in both the inner and outer areas, or Core Network Practices in both the outer area and outwith the outer area, the commissioner will have discretion to determine which of the London maximum reimbursable rates (or, in the case of the latter, whether either of the London maximum reimbursable rates) applies. The commissioner must ensure this discretion is consistently applied across the PCNs within its area.

10.5.4. A PCN's Additional Roles Reimbursement Sum equates to £12.314 multiplied by the PCN Contractor Weighted Population as at 1 January 2021. Further details of the method for determining Additional Roles Reimbursement Sum are set out in the Network Contract DES Guidance.

---

[71] If relevant the percentage will be appropriately apportioned to PCN related activity.
[72] This does not include the additional 6 per cent employer contributions.
[73] If relevant the percentage will be appropriately apportioned to PCN related activity.
[74] This does not include the additional 6 per cent employer contributions.

10.5.5. A PCN must use the mandatory electronic online portal to submit the monthly workforce claim. The PCN acknowledges that any relevant maximum amount per role figure used for the purpose of a claim pursuant to this section 10.5 will be divided by twelve for the purpose of the monthly workforce claim.

10.5.6. The following conditions apply to any claim made pursuant to sections 10.5.1, 10.5.2 and10.5.3:

a. The commissioner will arrange for payment to be made on a monthly basis in arrears following the start of employment of the relevant Additional Role or the commencement of service provision where a PCN engages a third party organisation to provide a service related to the relevant Additional Role. The commissioner will only make payments following the start of the employment or commencement of service provision.

b. The Nominated Payee must, in accordance with local payment arrangements, submit a claim for the reimbursement of the cost relating to the previous month.

c. The commissioner must make payments no later than the last day of the month following the month to which the payment relates and taking into account local payment arrangements (for example, a payment relating to April 2021 is to be made on or by the end May 2021).

d. The claim must relate to reimbursement of costs referred to in sections 10.5.1, 10.5.2 and 10.5.3 from the roles covered by the Additional Roles Reimbursement Scheme in accordance with section 7.

e. A PCN must demonstrate that claims being made are for additional staff roles beyond the baseline (including in future years, replacement as a result of staff turnover) as set out in this Network Contract DES Specification. The commissioner will be required to ensure the claims meet the 'additionality rules' set out in section 7.

f. A PCN (and Core Network Practices) not adhering to the additionality rules and principles will not be eligible for workforce reimbursement under this Network Contract DES Specification and could be subject to the recovery of funds and referral for investigation of fraud.

g. The commissioner will carry out audit appropriately and a PCN must co-operate fully in providing the relevant information. Failure by a PCN to provide the requested information will enable the commissioner to withhold or reclaim reimbursements.

h. A PCN must ensure that clinical pharmacists, reimbursed under the national *Clinical Pharmacists in General Practice Scheme,* and any pharmacists reimbursed under the *MOCH Scheme*, that have been

transferred[75] between 1 April 2021 and 30 September 2021 to receive funding under the Network Contract DES, meet the terms set out in this Network Contract DES Specification. The PCN must ensure that the clinical pharmacists and pharmacists work across the PCN and carry out the relevant duties pursuant to section 7 in the delivery of health services.

i. The commissioner will make any payments due under this section 0 to the Nominated Payee.

j. Tables 2 and 3 set out two figures for the maximum annual reimbursement rate for each role – the original figure and the updated figure. The original figure applies to all workforce claims made pursuant to this section 10.5 that relate to any month within the period April 2021 to 30 September 2021. The original figure will also apply to claims made pursuant to this section 10.5that relate to any month within the period 1 October 2021 to 31 March 2022 except that where the PCN has awarded a pay uplift to an Additional Role that takes effect within the period 1 October 2021 to 31 March 2022, then, for the purpose of any monthly workforce claim that covers a period for which the Additional Role is being paid the uplifted amount, the relevant maximum reimbursement rate for that role will be the updated figure set out in Tables 2 and 3. For the avoidance of doubt, the existence of the updated maximum reimbursement rates does not affect the overall value of a PCN's overall Additional Roles Reimbursement Sum.

10.5.7. For the purposes of this section 0, "**WTE**" is defined as 37.5 hours in line with AfC terms, but this may vary for non-AfC posts. Where AfC does not apply, a PCN should calculate the relevant WTE according to the normal full-time hours for that role in the employing organisation with reimbursement being made on a pro-rata basis accordingly.

10.5.8. If the person delivering the health services is employed by a non-PCN body, the contribution will be the aggregate WTE equivalent actual salary and employer on-costs (NI and pension only) up to the maximum reimbursable amount for the role as outlined in Table 2 and 3, that have been appropriately apportioned to PCN-related activity.

10.5.9. In addition to the reimbursement of 100 per cent of actual WTE equivalent salary and employer on costs (pension and national insurance contributions), where a PCN does not employ a Social Prescriber Link Worker and sub-contracts the delivery of the social prescribing service, a PCN may claim a contribution towards additional costs charged by the sub-contracted provider for the provision of the social prescribing service. A PCN may claim a

[75] Information regarding the transition arrangements is available in the Network Contract DES guidance.

contribution of up to £200 per month (£2,400 per year) for each whole WTE that the sub-contracted provider has appropriately apportioned to PCN-related activity provided that:

a. a claim for the contribution towards additional costs charged by the sub-contracted provider must not exceed £200 in respect of any month; and

b. the total annual amount claimed by the PCN in respect of the social prescribing element in respect of each WTE does not exceed the maximum reimbursable amount set out in Table 2 and 3. For the avoidance of doubt, the contribution towards additional costs charged by the sub-contracted provider is included when considering whether the total annual amount is within the maximum reimbursable amount.

Table 2: Maximum reimbursement amounts per role for 2021/22

Role	**AfC band**		**Annual maximum reimbursable amount per role[76]** **£**	**Annual maximum reimbursable amount per role for inner London** **£**	**Annual maximum reimbursable amount per role for outer London** **£**
Clinical pharmacist	7-8a	Original	56,829	65,660	63,010
		Updated	57,318	66,414	63,684
Advanced practitioner (Clinical pharmacist, Physiotherapist, Dietitian, Podiatrist, Occupational therapist, Paramedic)	8a	Original	62,705	71,536	68,886
		Updated	63,243	72,340	69,610
Pharmacy technician	5	Original	36,114	43,581	41,714
		Updated	36,428	43,958	42,076
Social prescribing link worker	Up to 5	Original	36,114	43,581	41,714

[76] The maximum reimbursable amount is the sum of (a) the weighted average salary for the specified AfC band plus (b) associated employer on-costs. These amounts do not include any recruitment and reimbursement premiums that PCNs may choose to offer. If applicable, the on-costs will be revised to take account of any pending change in employer pension contributions. The maximum reimbursement amount in subsequent years will be confirmed in line with applicable AfC rates.

Role	AfC band		Annual maximum reimbursable amount per role[76] £	Annual maximum reimbursable amount per role for inner London £	Annual maximum reimbursable amount per role for outer London £
		Updated	36,428	43,958	42,076
Health and wellbeing coach	Up to 5	Original	36,114	43,581	41,714
		Updated	36,428	43,958	42,076
Care coordinator	4	Original	29,726	35,916	34,577
		Updated	29,987	36,228	34,983
Physician associate	7	Original	54,841	63,673	61,022
		Updated	55,313	64,410	61,680
First contact physiotherapist	7-8a	Original	56,829	65,660	63,010
		Updated	57,318	66,414	63,684
Dietitian	7	Original	54,841	63,673	61,022
		Updated	55,313	64,410	61,680
Podiatrist	7	Original	54,841	63,673	61,022
		Updated	55,313	64,410	61,680
Occupational therapist	7	Original	54,841	63,673	61,022
		Updated	55,313	64,410	61,680
Trainee Nursing Associate	3	Original	26,188	31,921	31,038
		Updated	26,418	32,325	31,415
Nursing Associate	4	Original	29,726	35,916	34,577
		Updated	29,987	36,228	34,983
Paramedic	7	Original	54,841	63,673	61,022

Role	AfC band		Annual maximum reimbursable amount per role[76] £	Annual maximum reimbursable amount per role for inner London £	Annual maximum reimbursable amount per role for outer London £
		Updated	55,313	64,410	61,680

Table 3: Maximum reimbursement amount for MHPs for 2021/22

Role	AfC band		Annual maximum reimbursable amount per band[77] £	Annual maximum reimbursable amount per band for inner London £	Annual maximum reimbursable amount per band for outer London £
Adult Mental Health Practitioner CYP Mental Health Practitioner	5	Original	18,057	21,790	20,857
		Updated	18,214	21,979	21,038
	6	Original	22,443	26,859	25,533
		Updated	22,637	27,186	25,820
	7	Original	27,421	31,836	30,511
		Updated	27,657	32,205	30,840
	8a	Original	31,352	35,768	34,443

[77] The maximum reimbursable amount is 50 per cent of the sum of (a) the weighted average salary for the specified AfC band plus (b) associated employer on-costs. These amounts do not include any recruitment and reimbursement premiums that PCNs may choose to offer. If applicable, the on-costs will be revised to take account of any pending change in employer pension contributions. The maximum reimbursement amount in subsequent years will be confirmed in line with applicable AfC rates.

Role	AfC band		Annual maximum reimbursable amount per band[77] £	Annual maximum reimbursable amount per band for inner London £	Annual maximum reimbursable amount per band for outer London £
		Updated	31,622	36,170	34,805

10.5.10. A PCN will only be eligible for payment where all of the following requirements have been met:

a. For workforce related claims, the PCN has met the requirements as set out in section 7 for the relevant roles against which payment is being claimed.

b. The employing organisation (whether this is a PCN member or a third-party organisation) continues to employ the individual(s) for whom payments are being claimed and the PCN continues to have access to those individual(s);

c. The PCN makes available to commissioners any information under the Network Contract DES, which the commissioner needs and the PCN either has or can be reasonably expected to obtain in order to establish that the PCN has fulfilled the requirements of the Network Contract DES Specification;

d. The PCN complies with the relevant local payment arrangements including submitting a workforce related claim prior to the expiration of any deadline set by the local commissioner as part of the local payment arrangements;

e. The PCN makes any returns required of it and does so promptly and fully; and

10.5.11. All information supplied pursuant to or in accordance with this Network Contract DES Specification is complete and accurate.

10.6. Investment and Impact Fund

10.6.1. A PCN is entitled to additional funding by virtue of the Investment and Impact Fund (“IIF”).

10.6.2. Subject to adherence to the provisions of this section 10.6, a PCN is entitled to the following payments in relation to the IIF:

a. Achievement payments in respect of any indicators that are listed in Annex D and are identified as being eligible for in year payment, as set out in Annex C, section C7 (“In Year Achievement Payments”).

b. Achievement payments in respect of any indicators that are listed in Annex D and are not identified as being eligible for in year payment in Annex C section C7 (the “Year End Achievement Payment”).

10.6.3. A PCN acknowledges that:

a. it will earn points based on its performance in relation to the IIF indicators (the “Indicators”)[78];

b. every Indicator has been allocated a certain number of points;

c. it will earn a number of points for each Indicator between zero and the maximum number of points allocated to that Indicator;

d. there are a total of 389 points across all Indicators; and

e. each point is worth £200.00.

10.6.4. In relation to the Indicators, a PCN acknowledges that each indicator will be classed as ‘Qualitative’ or ‘Quantitative’.

10.6.5. In relation to Qualitative indicators, a PCN acknowledges that:

a. Each indicator consists of:

i. a criterion or set of criteria that must be met.

ii. the number of points that can be earned (A).

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

10.6.6. In relation to the Quantitative Indicators, a PCN acknowledges that these will be further classed as ‘Binary’, ‘Standard’ or ‘Improvement’ in relation to how performance is assessed.

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

a. Performance and earnings depend on:

i. a numerator (N);

[78] IIF Indicators are set out in Annex D.

ii. a denominator (D);

iii. a prevalence numerator (E);

iv. a performance threshold (T); and

v. a maximum number of points that can be earned (A).

b. The Indicator value, also referred to as performance (X), equals the numerator divided by the denominator (X=N/D).

c. The maximum number of points that can be earned (A) will have an integer value.

d. The desired direction of performance for an individual Indicator may be upwards or downwards. The desired direction of performance for each Indicator is set out in the descriptions of the Indicators in Annex D.

e. If the desired direction of performance is upwards, a higher value of performance means better performance, while a lower value of performance means worse performance.

f. If the desired direction of performance is downwards, a lower value of performance means better performance, while a higher value of performance means worse performance.

g. If a PCN's performance (X) is equal to or better than the performance threshold (T), it will earn all the points available for that Indicator.

h. If a PCN's performance (X) is worse than the performance threshold (T), it will earn no points for that Indicator.

i. The performance threshold will be the same for all PCNs.

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

a. Performance and earnings depend on:

i. a numerator (N);

ii. a denominator (D);

iii. a prevalence numerator (E);

iv. a lower performance threshold (L);

v. an upper performance threshold (U); and

vi. a maximum number of points that can be earned (A).

b. The Indicator value, also referred to as performance (X), equals the numerator divided by the denominator (X=N/D).

c. The maximum number of points that can be earned (A) will have an integer value. The points earned by each PCN in relation to each indicator will be calculated exactly, based on their performance.

d. The desired direction of performance for an individual Indicator may be upwards or downwards. The desired direction of performance for each Indicator is set out in the descriptions of the Indicators in Annex D.

e. If the desired direction of performance is upwards, a higher value of performance means better performance, while a lower value of performance means worse performance.

f. If the desired direction of performance is downwards, a lower value of performance means better performance, while a higher value of performance means worse performance.

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

a. Performance and earnings depend on:

i. a baseline numerator (N0);

ii. a baseline denominator (D0);

iii. a numerator (N);

iv. a denominator (D);

v. a prevalence numerator (E);

vi. a lower performance threshold (L);

vii. an upper performance threshold (U); and

viii. a maximum number of points that can be earned (A).

b. The Indicator value, also referred to as performance (X), equals the numerator divided by the denominator minus the baseline numerator divided by the baseline denominator (X = N/D – N0/D0).

c. The maximum number of points that can be earned (A) will have an integer value. The points earned by each PCN in relation to each indicator will be calculated exactly, based on their performance.

d. The desired direction of performance for an individual Indicator may be upwards or downwards. The desired direction of performance for each Indicator is set out in the descriptions of the Indicators in Annex D.

e. If the desired direction of performance is upwards, a higher value of performance means better performance, while a lower value of performance means worse performance.

f. If the desired direction of performance is downwards, a lower value of performance means better performance, while a higher value of performance means worse performance.

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

a. It will earn points depending on how its performance relates to the lower and upper performance thresholds.

b. If a PCN's performance is worse than or equal to the lower performance threshold, it will not earn any points for that indicator.

c. If a PCN's performance is equal to or better than the upper performance threshold, it will earn the maximum points available for that Indicator.

d. A PCN will incrementally earn additional points for each improvement in performance from the lower performance threshold to the upper performance threshold.

e. If the desired direction of performance is upwards, the upper performance threshold will be greater than the lower performance threshold. If the desired direction of performance is downwards, the upper performance threshold will be smaller than the lower performance threshold.

f. The lower performance threshold will be the same for all PCNs, and the upper performance threshold will be the same for all PCNs.

10.6.11. The commissioner will calculate a PCN's Year End Achievement Payment in accordance with the five steps listed below, each of which is set out in more detail in Annex C:

a. Step 1: For each Quantitative Indicator, a numerator and denominator will be calculated for the PCN by adding up the corresponding practice-level numerators and denominators for the Core Network Practices of the PCN. In addition, for each Improvement Quantitative Indicator, a baseline numerator and baseline denominator will be calculated for the PCN by adding up the corresponding practice-level baseline numerators and baseline denominators for the Core Network Practices of the PCN.

b. Step 2: For each Indicator, the performance of the PCN will be calculated.

c. Step 3: For each Indicator, the number of points ("Achievement Points") earned by the PCN will be calculated.

d. Step 4: For each Indicator, the level of payment ("Achievement Payment") will be calculated.

e. Step 5: The Year End Achievement Payment for the PCN (the sum of Achievement Payments across all Indicators not eligible for in year payment) will be calculated.

10.6.12. For indicators not eligible for in year payment, the commissioner will calculate the Year End Achievement Payment in respect of a PCN after 31 March 2022.

10.6.13. The commissioner will, in a timely manner after 31 March 2022, make available to a PCN a summary of the data and calculations (including Achievement Points and Achievement Payments) in relation to it for Indicators not eligible for in year payment from GP systems.

10.6.14. To be eligible to receive the Year End Achievement Payment, a PCN must review and declare the data and calculations provided under section 10.6.13 and extracted from GP systems or manually submitted, during the 'declaration window'.

a. The 'declaration window' will last from whenever declaration is made available until:

i. 30 April 2022, if declaration is made available before 16 April 2022.

ii. 14 calendar days after declaration is made available, if declaration is made available on or after 16 April 2022.

b. Declaration means that the PCN confirms that:

i. The data extracted from GP systems or manually submitted is an accurate summary of its performance in relation to the Indicators.

ii. Any calculations performed in relation to data extracted from GP systems or manually submitted are also accurate.

c. If a PCN believes that the data and calculations provided under section 10.6.13 and extracted from GP systems or manually submitted are inaccurate for any reason, the PCN may decline to declare its achievement when given the opportunity to do so, and may enter into correspondence with the commissioner. If, after reviewing any evidence submitted, the commissioner agrees that there is an inaccuracy, the commissioner may at its sole discretion resubmit accurate data on behalf of the PCN, before final performance and achievement is calculated. For avoidance of doubt, irrespective of the circumstances or any other facts, failure to declare achievement within the declaration window means that any deadlines pertaining to end of year Achievement Payments do not apply.

10.6.15. A PCN must nominate two persons to act as the Nominated Persons on behalf of the PCN's Core Network Practices prior to the release of the data.

The commissioner must approve these nominations and make the necessary arrangements for the Nominated Persons to have access to CQRS. The data extracted from GP systems or manually submitted and provided under section 10.6.13 must be declared on a PCN's behalf by either of the Nominated Persons. Where the commissioner receives the declaration from either of the Nominated Persons, it will consider that the PCN has declared the data in accordance with this section 10.6. If the PCN needs to change the identity of one or both Nominated Persons at any time after nomination, the PCN must provide the identity and contact details of the new Nominated Person(s) prior to the date the commissioner makes available the summary of data as set out in section 10.6.13. Where a PCN nominates the Nominated Persons to the commissioner, each Core Network Practice of the PCN warrants that:

a. it has agreed the nomination of the Nominated Persons;

b. in respect of the data about which this section 10.6 requires declaration, it consents to that data being disclosed to the Nominated Persons; and

c. it has ensured that the Nominated Persons have the necessary authority and authorisation to review and declare the relevant data to the commissioner on its behalf.

10.6.16. The declaration process described in section 10.6.14 does not apply to data sources other than GP systems or manually submitted. In relation to data from sources other than GP systems, PCNs will not have the opportunity to resubmit data that they believe to be incorrect, but will instead be referred to existing routes for querying and correcting errors in such data.

10.6.17. Where a Year End Achievement Payment in respect of IIF is due to a PCN, the commissioner will make that payment by 31 August 2022. Where an In Year Achievement Payment in respect of IIF is due to a PCN, the commissioner will make that payment by the date specified in Annex C, section C7. The commissioner will make any payment due to the Nominated Payee of the PCN. If there is a change to the Nominated Payee or PCN prior to the payment being made, the commissioner will comply with section 10.1.7.

10.6.18. A list of indicators eligible for in year payment is set out in Annex C, section C7. Declaration is not required in relation to indicators eligible for in year payment, as all such indicators will involve manual submission to the commissioner by the PCN to confirm that it has met the relevant criterion or

criteria[79]. Annex C, section C7, provides further details concerning the timing of calculation and payment for indicators eligible for in year payment.

10.6.19. To be eligible to receive any In Year Achievement Payment or Year End Achievement Payment, a PCN must:

a. commit in writing to the commissioner to reinvest any IIF Achievement Payment into additional workforce, additional primary medical services, and/or other areas of investment in a Core Network Practice (e.g. equipment, premises);

b. undertake the clinical coding required of it to calculate performance and achievement in relation to Indicators, including the recording of any Personalised Care Adjustments ("PCAs", defined in Annex C). Further details of the codes used to calculate performance and achievement, and to record PCAs, are provided in the Network Contract DES Guidance and Network Contract DES Service Business Rules[80]. In the event of any discrepancy, the Network Contract DES Service Business Rules are the definitive statement of the codes that will be used to calculate performance and achievement in relation to the IIF;

c. consent to extraction of data required to calculate performance and achievement and to the use of extracted data for the purpose of calculating performance and achievement;

d. make any manual return required of it to enable calculation of performance and achievement and consent to the use of the returned data for this purpose;

e. ensure that all the information made available (whether by an automated extract or otherwise) for the purpose of calculating performance and achievement is accurate and reliable;

f. declare any data extracted from GP systems or manually submitted requiring declaration that is made available to it concerning its performance in relation to the Indicators;

g. ensure that it is able to provide to the commissioner any information that may reasonably be requested to demonstrate that it is entitled to each Achievement Point to which it says it is entitled, and make that information available to the commissioner on request. In verifying that

[79] Details of the steps required for manual submission were detailed to PCNs in guidance in advance of 30 June 2021

[80] Network Contract DES Service Business rules are available in the relevant business rules published by NHS Digital under the relevant years 'Enhanced Services, Vaccinations and Immunisations and Core Contract components' page.

information has been correctly recorded, the commissioner may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator;

h. co-operate fully with any reasonable inspection or review that the commissioner or another relevant statutory authority wishes to undertake in respect of the Achievement Points to which it says it is entitled; and

i. ensure that all information supplied pursuant to or in accordance with this paragraph is accurate.

10.6.20. If the conditions set out in section 10.6.19 are not met, the commissioner may withhold payment of all or part of the In Year or Year End Achievement Payment that is otherwise payable.

Annex A - Network Contract DES Participation and Notification of Change Form

The Network Contract DES Participation and Notification of Change Form is available at https://www.england.nhs.uk/publication/network-contract-des-participation-and-notification-form-2021-22/.

Annex B - Additional Roles Reimbursement Scheme - Minimum Role Requirements

B.1. Clinical Pharmacist

B1.1. Where a PCN employs or engages a Clinical Pharmacist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Clinical Pharmacist is enrolled in, or has qualified from, an approved 18-month training pathway or equivalent that equips the Clinical Pharmacist to:

a. be able to practice and prescribe safely and effectively in a primary care setting (for example, the CPPE Clinical Pharmacist training pathways[81,82]); and

b. deliver the key responsibilities outlined in section B1.2.

B1.2. Where a PCN employs or engages a Clinical Pharmacist under the Additional Roles Reimbursement Scheme, the PCN must ensure this is a minimum 0.5 WTE.

B1.3. Where a PCN employs or engages one or more Clinical Pharmacists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Clinical Pharmacist has the following key responsibilities in relation to delivering health services:

a. work as part of a multi-disciplinary team in a patient facing role to clinically assess and treat patients using their expert knowledge of medicines for specific disease areas;

b. be a prescriber, or completing training to become prescribers, and work with and alongside the general practice team;

c. be responsible for the care management of patients with chronic diseases and undertake clinical medication reviews to proactively manage people with complex polypharmacy, especially the elderly, people in care homes, those with multiple co-morbidities (in particular frailty, COPD and asthma) and people with learning disabilities or autism (through STOMP – Stop Over Medication Programme);

d. provide specialist expertise in the use of medicines whilst helping to address both the public health and social care needs of patients at the PCN's practice(s) and to help in tackling inequalities;

---

[81] https://www.cppe.ac.uk/career/clinical-pharmacists-in-general-practice-education#navTop
[82] https://www.cppe.ac.uk/wizard/files/general-practice/clinical-pharmacists-in-general-practice-education-brochure.pdf

e. provide leadership on person-centred medicines optimisation (including ensuring prescribers in the practice conserve antibiotics in line with local antimicrobial stewardship guidance) and quality improvement, whilst contributing to the quality and outcomes framework and enhanced services;

f. through structured medication reviews, support patients to take their medications to get the best from them, reduce waste and promote self-care;

g. have a leadership role in supporting further integration of general practice with the wider healthcare teams (including community and hospital pharmacy) to help improve patient outcomes, ensure better access to healthcare and help manage general practice workload;

h. develop relationships and work closely with other pharmacy professionals across PCNs and the wider health and social care system;

i. take a central role in the clinical aspects of shared care protocols, clinical research with medicines, liaison with specialist pharmacists (including mental health and reduction of inappropriate antipsychotic use in people with learning difficulties), liaison with community pharmacists and anticoagulation; and

j. be part of a professional clinical network and have access to appropriate clinical supervision. Appropriate clinical supervision means:

    i. each clinical pharmacist must receive a minimum of one supervision session per month by a senior clinical pharmacist[83];

    iii. the senior clinical pharmacist must receive a minimum of one supervision session every three months by a GP clinical supervisor;

    iv. each clinical pharmacist will have access to an assigned GP clinical supervisor for support and development; and

    v. a ratio of one senior clinical pharmacist to no more than five junior clinical pharmacists, with appropriate peer support and supervision in place.

B.2. Pharmacy Technicians

[83] This does not need to be a senior clinical pharmacist within the PCN but could be part of a wider local network, including from secondary care or another PCN.

B2.1. Where a PCN employs or engages a Pharmacy Technician under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Pharmacy Technician:

a. is registered with the General Pharmaceutical Council (GPhC);

b. meets the specific qualification and training requirements as specified by the GPhC criteria[84] to register as a Pharmacy Technician;

c. enrolled in, undertaking or qualified from, an approved training pathway. For example, the Primary Care Pharmacy Educational Pathway (PCPEP) or Medicines Optimisation in Care Homes (MOCH); and

d. is working under appropriate clinical supervision to ensure safe, effective and efficient use of medicines

in order to deliver the key responsibilities outlined in section B2.2.

B2.2. Where a PCN employs or engages one or more Pharmacy Technicians under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Pharmacy Technician has the following key clinical, and technical and administrative responsibilities, in delivering health services:

B2.2.1. Clinical responsibilities of the Pharmacy Technician:

a. undertake patient facing and patient supporting roles to ensure effective medicines use, through shared decision-making conversations with patients;

b. carry out medicines optimisation tasks including effective medicine administration (e.g. checking inhaler technique), supporting medication reviews, and medicines reconciliation. Where required, utilise consultation skills to work in partnership with patients to ensure they use their medicines effectively;

c. support, as determined by the PCN, medication reviews and medicines reconciliation for new care home patients and synchronising medicines for patient transfers between care settings and linking with local community pharmacists.

d. provide specialist expertise, where competent, to address both the public health and social care needs of patients, including lifestyle advice, service information, and help in tackling local health inequalities;

[84] The training requirements for Pharmacy Technicians are currently in transition and further information is available on the General Pharmaceutical Council (GPhC) website. This information will provide the specific criteria to register as a pharmacy technician – see https://www.pharmacyregulation.org/i-am-pharmacy-technician

e. take a central role in the clinical aspects of shared care protocols and liaising with specialist pharmacists for more complex patients;

f. support initiatives for antimicrobial stewardship to reduce inappropriate antibiotic prescribing;

g. assist in the delivery of medicines optimisation and management incentive schemes and patient safety audits;

h. support the implementation of national prescribing policies and guidance within GP practices, care homes and other primary care settings. This will be achieved through undertaking clinical audits (e.g. use of antibiotics), supporting quality improvement measures and contributing to the Quality and Outcomes Framework and enhanced services;

B2.2.2. Technical and Administrative responsibilities of the Pharmacy Technician:

a. work with the PCN multi-disciplinary team to ensure efficient medicines optimisation, including implementing efficient ordering and return processes, and reducing wastage;

b. supervise practice reception teams in sorting and streaming general prescription requests, so as to allow GPs and clinical pharmacists to review the more clinically complex requests;

c. provide leadership for medicines optimisation systems across PCNs, supporting practices with a range of services to get the best value from medicines by encouraging and implementing Electronic Prescriptions, safe repeat prescribing systems, and timely monitoring and management of high-risk medicines;

d. provide training and support on the legal, safe and secure handling of medicines, including the implementation of the Electronic Prescription Service (EPS); and

e. develop relationships with other pharmacy technicians, pharmacists and members of the multi-disciplinary team to support integration of the pharmacy team across health and social care including primary care, community pharmacy, secondary care, and mental health.

B.3. Social Prescribing Link Workers

B3.1. A PCN must provide to the PCN's patients access to a social prescribing service. To comply with this, a PCN may:

a. directly employ Social Prescribing Link Worker(s); or

b. sub-contract provision of the service to another provider

in accordance with this Network Contract DES Specification.

B3.2. Where a PCN employs or engages a Social Prescribing Link Worker under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Social Prescribing Link Worker:

a. has completed the NHS England and NHS Improvement online learning programme[85]

b. is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute[86]; and

c. attends the peer support networks run by NHS England and NHS Improvement at ICS level;

in order to deliver the key responsibilities outlined in section B3.3.

B3.3. Where a PCN employs or engages one or more Social Prescribing Link Workers under the Additional Roles Reimbursement Scheme or sub-contracts provision of the social prescribing service to another provider, the PCN must ensure that each Social Prescribing Link Worker providing the service has the following key responsibilities in delivering the service to patients:

a. as members of the PCN's team of health professionals, take referrals from the PCN's Core Network Practices and from a wide range of agencies[87] to support the health and wellbeing of patients;

b. assess how far a patient's health and wellbeing needs can be met by services and other opportunities available in the community;

c. co-produce a simple personalised care and support plan to address the patient's health and wellbeing needs by introducing or reconnecting people to community groups and statutory services, including weight management support and signposting where appropriate and it matters to the person;

d. evaluate how far the actions in the care and support plan are meeting the patient's health and wellbeing needs[88];

---

[85] https://www.e-lfh.org.uk/programmes/social-prescribing/

[86] https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

[87] These agencies include but are not limited to: the PCN's members, pharmacies, multi-disciplinary teams, hospital discharge teams, allied health professionals, fire service, police, job centres, social care services, housing associations and voluntary, community and social enterprise (VCSE) organisations.

[88] Including considering if the persons needs are met (for example, reasonable adjustments, interpreter etc).

e. provide personalised support to patients, their families and carers to take control of their health and wellbeing, live independently, improve their health outcomes and maintain a healthy lifestyle;

f. develop trusting relationships by giving people time and focus on 'what matters to them';

g. take a holistic approach, based on the patient's priorities and the wider determinants of health, including supporting people to take up employment, training and welfare support;

h. explore and support access to a personal health budget where appropriate;

i. manage and prioritise their own caseload, in accordance with the health and wellbeing needs of their population; and

j. where required and as appropriate, refer patients back to other health professionals within the PCN.

B3.4. A PCN's Core Network Practices must identify a first point of contact for general advice and support and (if different) a GP to provide supervision for the Social Prescribing Link Worker(s). This could be provided by one or more named individuals within the PCN. A PCN's Core Network Practices must provide monthly access to clinical supervision with a relevant health professional.

B3.5. A PCN will ensure the Social Prescribing Link Worker(s) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.

B3.6. A PCN must ensure referrals to the Social Prescribing Link Worker(s) are recorded within GP clinical systems using the new national SNOMED codes (see section 7.4.1 and 5.4.7).

B3.7. Where a PCN employs or engages one or more Social Prescribing Link Workers under the Additional Roles Reimbursement Scheme or sub-contracts provision of the social prescribing service to another provider, the PCN must ensure that each Social Prescribing Link Worker has the following key wider responsibilities:

a. draw on and increase the strength and capacity of local communities, enabling local Voluntary, Community and Social Enterprise (VCSE) organisations and community groups to receive social prescribing referrals from the Social Prescribing Link Worker;

b. work collaboratively with all local partners to contribute towards supporting the local VCSE organisations and community groups to become

sustainable and that community assets are nurtured, through sharing intelligence regarding any gaps or problems identified in local provision with commissioners and local authorities;

c. have a role in educating non-clinical and clinical staff within the PCN through verbal or written advice or guidance on what other services are available within the community and how and when patients can access them;

B3.8. A PCN must be satisfied that organisations and groups to whom the Social Prescribing Link Workers(s) directs patients:

a. have basic safeguarding processes in place for vulnerable individuals; and

b. provide opportunities for the patient to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence.

B3.9. A PCN must ensure that all staff working in practices that are members of the PCN are aware of the identity of the Social Prescribing Link Worker(s) and the process for referrals.

B3.10. A PCN must work in partnership with commissioners, social prescribing schemes, Local Authorities and voluntary sector leaders to create a shared plan for social prescribing which must include how the organisations will build on existing schemes and work collaboratively to recruit additional social prescribing link workers to embed one in every PCN and direct referrals to the voluntary sector.

B.4. Health and Wellbeing Coach

B4.1. Where a PCN employs or engages a Health and Wellbeing Coach under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Health and Wellbeing Coach:

a. is enrolled in, undertaking or qualified from appropriate health coaching training covering topics outlined in the NHS England and NHS Improvement Implementation and Quality Summary Guide[89], with the training delivered by a training organisation listed by the Personalised Care Institute[90];

[89] https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/
[90] https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

b. adheres to a code of ethics and conduct in line with the NHS England and NHS Improvement Health coaching Implementation and Quality Summary Guide;

c. has formal individual and group coaching supervision which must come from a suitably qualified or experienced individual; and

d. working closely in partnership with the Social Prescribing Link Worker(s) or social prescribing service provider to identify and work alongside people who may need additional support, but are not yet ready to benefit fully from social prescribing

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

B4.2. Where a PCN employs or engages one or more Health and Wellbeing Coaches under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Health and Wellbeing Coach has the following key responsibilities, in delivering health services:

a. manage and prioritise a caseload, in accordance with the health and wellbeing needs of their population through taking an approach that is non-judgemental, based on strong communication and negotiation skills, while considering the whole person when addressing existing issues. Where required and as appropriate, the Health and Wellbeing Coach will refer people back to other health professionals within the PCN;

b. utilise existing IT and MDT channels to screen patients, with an aim to identify those that would benefit most from health coaching;

c. provide personalised support to individuals, their families, and carers to support them to be active participants in their own healthcare; empowering them to manage their own health and wellbeing and live independently through:

i. coaching and motivating patients through multiple sessions to identify their needs, set goals, and supporting patients to achieve their personalised health and care plan objectives;

ii. providing interventions such as self-management education and peer support;

iii. supporting patients to establish and attain goals that are important to the patient;

iv. supporting personal choice and positive risk taking while ensuring that patients understand the accountability of their own actions and decisions, thus encouraging the proactive prevention of further illnesses;

v. working in partnership with the social prescribing service to connect patients to community-based activities which support them to take increased control of their health and wellbeing; and

vi. increasing patient motivation to self-manage and adopt healthy behaviours;

d. work in partnership with patients to support them to develop their level of knowledge, skills and confidence enabling them to engage with their health and well-being and subsequently supporting them in shared decision-making conversations;

e. utilise health coaching skills to support to develop the knowledge, skills, and confidence to manage their health and wellbeing, whilst increasing their ability to access and utilise community support offers; and

f. explore and support patient access to a personal health budget, where appropriate, for their care and support.

B4.3. The following sets out the key wider responsibilities of Health and Wellbeing Coaches:

a. develop collaborative relationships and work in partnership with health, social care, and community and voluntary sector providers and multi-disciplinary teams to holistically support patients' wider health and well-being, public health, and contributing to the reduction of health inequalities;

b. provide education and specialist expertise to PCN staff, supporting them to improve their skills and understanding of personalised care, behavioural approaches and ensuring consistency in the follow up of people's goals with MDT input; and

c. raise awareness within the PCN of shared decision-making and decision support tools.

B4.4. A PCN must be satisfied that organisations and groups to whom its Health and Wellbeing Coach(es) directs patients:

a. have basic safeguarding processes in place for vulnerable individuals; and

b. provide opportunities for the patient to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence.

B4.5. A PCN's Core Network Practices must identify a first point of contact for general advice and support and (if different) a GP to provide supervision for the PCN's Health and Wellbeing Coach(es). This could be provided by one or more named individuals within the PCN. The Health and Wellbeing Coach must have access to regular supervision from a health coaching mentor. In

addition to this, formal and individual group coaching supervision must come from a suitably qualified or experienced health coaching supervisor.

B4.6. A PCN will ensure the PCN's Health and Wellbeing Coach(es) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures (e.g. abuse, domestic violence and support with mental health) with a relevant GP.

B4.7. A PCN must ensure that all staff working in practices that are members of the PCN are aware of the identity of the PCN's Health and Wellbeing Coach(es).

B.5. Care Coordinator

B5.1. Where a PCN employs or engages a Care Coordinator under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Care Coordinator:

a. is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute[91]; and

b. works closely and in partnership with the Social Prescribing Link Worker(s) or social prescribing service provider and Health and Wellbeing Coach(es),

in order to deliver the key responsibilities outlined in section B5.2.

B5.2. Where a PCN employs or engages one or more Care Coordinators under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Care Coordinator has the following key responsibilities, in delivering health services:

a. utilise population health intelligence to proactively identify and work with a cohort of patients to deliver personalised care;

b. support patients to utilise decision aids in preparation for a shared decision-making conversation;

c. holistically bring together all of a person's identified care and support needs, and explore options to meet these within a single personalised care and support plan (PCSP), in line with PCSP best practice, based on what matters to the person;

d. help people to manage their needs through answering queries, making and managing appointments, and ensuring that people have good quality written or verbal information to help them make choices about their care,

[91] https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/

using tools to understand peoples level of knowledge, confidence in skills in managing their own health;

e. support people to take up training and employment, and to access appropriate benefits where eligible for example, through referral to social prescribing link workers;

f. assist people to access self-management education courses, peer support or interventions that support them to take more control of their health and wellbeing;

g. explore and assist people to access personal health budgets where appropriate;

h. provide coordination and navigation for people and their carers across health and care services, working closely with social prescribing link workers, health and wellbeing coaches, and other primary care professionals; and

i. support the coordination and delivery of MDTs within the PCN.

B5.3. The following sets out the key wider responsibilities of Care Coordinators:

a. work with the GPs and other primary care professionals within the PCN to identify and manage a caseload of patients, and where required and as appropriate, refer people back to other health professionals within the PCN;

b. raise awareness within the PCN of shared decision-making and decision support tools; and

c. raise awareness of how to identify patients who may benefit from shared decision making and support PCN staff and patients to be more prepared to have shared decision-making conversations.

B5.4. A PCN must be satisfied that organisations and groups to whom its Care Coordinator directs patients:

a. have basic safeguarding processes in place for vulnerable individuals; and

b. provide opportunities for the patient to develop friendships and a sense of belonging, as well as to build knowledge, skills and confidence.

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

B5.6. A PCN will ensure the PCN's Care Coordinator(s) can discuss patient related concerns and be supported to follow appropriate safeguarding procedures

(e.g. abuse, domestic violence and support with mental health) with a relevant GP.

B5.7. A PCN must ensure that all staff working in practices that are members of the PCN are aware of the identity of the PCN's Care Coordinator(s).

B.6. Physician Associates

B6.1. Where a PCN employs or engages a Physician Associate under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Physician Associate:

a. has completed a post-graduate physician associate course (either PG Diploma or MSc);

b. has maintained professional registration with the Faculty of Physician Associates and/or the General Medical council following implementation of statutory regulation, working within the latest code of professional conduct (CIPD);

c. has passed the UK Physician Associate (PA) National Re-Certification Exam, which needs to be retaken every six years;

d. participates in continuing professional development opportunities by keeping up to date with evidence-based knowledge and competence in all aspects of their role, meeting clinical governance guidelines for continuing professional development (CPD), and

e. is working under supervision of a doctor as part of the medical team,

in order to deliver the key responsibilities outlined in section B6.2.

B6.2. Where a PCN employs or engages one or more Physician Associates under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Physician Associate has the following key responsibilities, in delivering health services:

a. provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems by utilising history-taking, physical examinations and clinical decision-making skills to establish a working diagnosis and management plan in partnership with the patient (and their carers where applicable);

b. support the management of patient's conditions through offering specialised clinics following appropriate training including (but not limited to) family planning, baby checks, COPD, asthma, diabetes, and anticoagulation;

c. provide health/disease promotion and prevention advice, alongside analysing and actioning diagnostic test results;

d. develop integrated patient-centred care through appropriate wording with the wider primary care multi-disciplinary team and social care networks;

e. utilise clinical guidelines and promote evidence-based practice and partake in clinical audits, significant event reviews and other research and analysis tasks;

f. participate in duty rotas; undertaking face-to-face, telephone, and online consultations for emergency or routine problems as determined by the PCN, including management of patients with long-term conditions;

g. undertake home visits when required; and

h. develop and agree a personal development plan (PDP) utilising a reflective approach to practice, operating under appropriate clinical supervision.

B6.3. A PCN's Core Network practices must identify a suitable named GP supervisor for each physician associate, to enable them to work under appropriate clinical supervision.

B.7. First Contact Physiotherapists

B7.1. Where a PCN employs or engages a First Contact Physiotherapist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the First Contact Physiotherapist:

a. has completed an undergraduate degree in physiotherapy;

b. is registered with the Health and Care Professional Council;

c. holds the relevant public liability insurance;

d. has a Masters Level qualification or the equivalent specialist knowledge, skills and experience;

e. can demonstrate working at Level 7 capability in MSK related areas of practice or equivalent (such as advanced assessment diagnosis and treatment);

f. can demonstrate ability to operate at an advanced level of practice,

in order to deliver the key responsibilities outlined in section B7.2.

B7.2. Where a PCN employs or engages one or more First Contact Physiotherapists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each First Contact Physiotherapist has the following key responsibilities, in delivering health services:

a. work independently, without day to day supervision, to assess, diagnose, triage, and manage patients, taking responsibility for prioritising and managing a caseload of the PCN's Registered Patients;

b. receive patients who self-refer (where systems permit) or from a clinical professional within the PCN, and where required refer to other health professionals within the PCN;

c. work as part of a multi-disciplinary team in a patient facing role, using their expert knowledge of movement and function issues, to create stronger links for wider services through clinical leadership, teaching and evaluation;

d. develop integrated and tailored care programmes in partnership with patients, providing a range of first line treatment options including self-management, referral to rehabilitation focussed services and social prescribing;

e. make use of their full scope of practice, developing skills relating to independent prescribing, injection therapy and investigation to make professional judgements and decisions in unpredictable situations, including when provided with incomplete or contradictory information. They will take responsibility for making and justifying these decisions;

f. manage complex interactions, including working with patients with psychosocial and mental health needs, referring onwards as required and including social prescribing when appropriate;

g. communicate effectively with patients, and their carers where applicable, complex and sensitive information regarding diagnoses, pathology, prognosis and treatment choices supporting personalised care;

h. implement all aspects of effective clinical governance for own practice, including undertaking regular audit and evaluation, supervision and training;

i. develop integrated and tailored care programmes in partnership with patients through:

    i. effective shared decision-making with a range of first line management options (appropriate for a patient's level of activation);

    ii. assessing levels of patient activation to support a patient's own level of knowledge, skills and confidence to self-manage their conditions, ensuring they are able to evaluate and improve the effectiveness of self-management interventions, particularly for those at low levels of activation;

iii. agreeing with patient's appropriate support for self-management through referral to rehabilitation focussed services and wider social prescribing as appropriate; and

iv. designing and implementing plans that facilitate behavioural change, optimise patient's physical activity and mobility, support fulfilment of personal goals and independence, and reduce the need for pharmacological interventions;

j. request and progress investigations (such as x-rays and blood tests) and referrals to facilitate the diagnosis and choice of treatment regime including, considering the limitations of these investigations, interpret and act on results and feedback to aid patients' diagnoses and management plans; and

k. be accountable for decisions and actions via Health and Care Professions Council (HCPC) registration, supported by a professional culture of peer networking/review and engagement in evidence-based practice.

B7.3. The following sets out the key wider responsibilities of First Contact Physiotherapists:

a. work across the multi-disciplinary team to create and evaluate effective and streamlined clinical pathways and services;

b. provide leadership and support on MSK clinical and service development across the PCN, alongside learning opportunities for the whole multi-disciplinary team within primary care;

c. develop relationships and a collaborative working approach across the PCN, supporting the integration of pathways in primary care;

d. encourage collaborative working across the wider health economy and be a key contributor to supporting the development of physiotherapy clinical services across the PCN;

e. liaising with secondary and community care services, and secondary and community MSK services where required, using local social and community interventions as required to support the management of patients within the PCN; and

f. support regional and national research and audit programmes to evaluate and improve the effectiveness of the First Contact Practitioner (FCP) programme. This will include communicating outcomes and integrating findings into own and wider service practice and pathway development.

B.8. Dietitians

B8.1. Where a PCN employs or engages a Dietitian under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Dietitian:

a. has a BSc or pre-reg MSc in Dietetics under a training programme approved by the British Dietetic Association (BDA);

b. is a registered member of the Health and Care Professionals Council (HCPC);

c. is able to operate at an advanced level of practice; and

d. has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis,

in order to deliver the key responsibilities outlined in section B8.2.

B8.2. Where a PCN employs or engages one or more Dietitians under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Dietitian has the following key responsibilities, in delivering health services:

a. provide specialist nutrition and diet advice to patients, their carers, and healthcare professionals through treatment, education plans, and prescriptions;

b. educate patients with diet-related disorders on how they can improve their health and prevent disease by adopting healthier eating and drinking habits;

c. provide dietary support to patients of all ages (from early-life to end-of-life care) in a variety of settings including nurseries, patient homes and care homes;

d. work as part of a multi-disciplinary team to gain patient's cooperation and understanding in following recommended dietary treatments;

e. develop, implement and evaluate a seamless nutrition support service across the PCN, working with community and secondary care where appropriate, and aimed at continuously improving standards of patient care and wider multi-disciplinary team working;

f. work with clinicians, multi-disciplinary team colleagues and external agencies to ensure the smooth transition of patients discharged from hospital back into primary care, so that they can continue their diet plan;

g. make recommendations to PCN staff regarding changes to medications for the nutritional management of patients, based on interpretation of biochemical, physiological, and dietary requirements; and

h. implement all aspects of effective clinical governance for own practice, including undertaking regular audit and evaluation, supervision and training.

B8.3. The following sets out the key wider responsibilities of Dietitians:

a. undertake a range of administrative tasks such as ensuring stock levels are maintained and securely stored, and equipment is kept in good working order; and

b. ensure delivery of best practice in clinical practice, caseload management, education, research, and audit, to achieve corporate PCN and local population objectives.

B.9. Podiatrists

B9.1. Where a PCN employs or engages a Podiatrist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Podiatrist:

a. has a BSc or pre-reg MSc in Podiatry under a training programme approved by the College of Podiatry;

b. is a registered member of the Health and Care Professionals Council (HCPC);

c. is able to operate at an advanced level of practice; and

d. has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis,

in order to deliver the key responsibilities outlined in section B9.2.

B9.2. Where a PCN employs or engages one or more Podiatrists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Podiatrist has the following key responsibilities, in delivering health services:

a. work as part of a PCN's multi-disciplinary team to clinically assess, treat, and manage a caseload of patients of all ages with lower limb conditions and foot pathologies, using their expert knowledge of podiatry for specific conditions and topics;

b. utilise and provide guidance to patients on equipment such as surgical instruments, dressings, treatment tables and orthotics;

c. prescribe, produce, and fit orthotics and other aids and appliances;

d. provide specialist treatment and support for high-risk patient groups such as the elderly and those with increased risk of amputation;

e. support patients through the use of therapeutic and surgical techniques to treat foot and lower leg issues (e.g. carrying out nail and soft tissue surgery using local anaesthetic);

f. deliver foot health education to patients;

g. implement all aspects of effective clinical governance for their own practice, including undertaking regular audit and evaluation, supervision, and training;

h. liaise with PCN multi-disciplinary team, community and secondary care staff, and named clinicians to arrange further investigations and onward referrals;

i. communicate outcomes and integrate findings into their own and wider service practice and pathway development; and

j. develop, implement and evaluate a seamless podiatry support service across the PCN, working with community and secondary care where appropriate, and aimed at continuously improving standards of patient care and wider multi-disciplinary team working.

B9.3. The following sets out the key wider responsibilities of Podiatrists:

a. undertake continued professional development to understand the mechanics of the body in order to preserve, restore, and develop movement for patients;

b. provide leadership and support on podiatry clinical service development across the PCN, alongside learning opportunities for the whole multi-disciplinary team within primary care;

c. provide education and specialist expertise to PCN staff, raising awareness of good practice in good foot health;

d. ensure delivery of best practice in clinical practice, caseload management, education, research, and audit, to achieve corporate PCN and local population objectives; and

e. undertake a range of administrative tasks such as ensuring stock levels are maintained and securely stored, and equipment is kept in good working order.

B.10. Occupational Therapists

B10.1. Where a PCN employs or engages an Occupational Therapist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Occupational Therapist:

a. has a BSc in or pre-reg MSc in Occupational Therapy under a training programme approved by the Royal College of Occupational Therapists;

b. is a registered member of the Health and Care Professionals Council (HCPC);

c. is able to operate at an advanced level of practice; and

d. has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis,

in order to deliver the key responsibilities outlined in section B10.2.

B10.2. Where a PCN employs or engages one or more Occupational Therapists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Occupational Therapist has the following key responsibilities, in delivering health services:

a. assess, plan, implement, and evaluate treatment plans, with an aim to increase patients' productivity and self-care;

b. work with patients through a shared-decision making approach to plan realistic, outcomes-focused goals;

c. undertake both verbal and non-verbal communication methods to address the needs of patients that have communication difficulties;

d. work in partnership with multi-disciplinary team colleagues, physiotherapists and social workers, alongside the patients' families, teachers, carers, and employers in treatment planning to aid rehabilitation;

e. where appropriate, support the development of discharge and contingency plans with relevant professionals to arrange on-going care in residential, care home, hospital, and community settings;

f. periodically review, evaluate and change rehabilitation programmes to rebuild lost skills and restore confidence;

g. as required, advise on home, school, and workplace environmental alterations, such as adjustments for wheelchair access, technological needs, and ergonomic support;

h. advise patients, and their families or carers, on specialist equipment and organisations that can help with daily activities;

i. help patients to adapt to and manage their physical and mental health long-term conditions, through the teaching of coping strategies; and

j. develop, implement and evaluate a seamless occupational therapy support service across the PCN, working with community and secondary

care where appropriate, and aimed at continuously improving standards of patient care and wider multi-disciplinary team working.

B10.3. The following sets out the key wider responsibilities of Occupational Therapists:

a. provide education and specialist expertise to PCN staff, raising awareness of good practice occupational therapy techniques; and

b. ensure delivery of best practice in clinical practice, caseload management, education, research, and audit, to achieve corporate PCN and local population objectives.

B.11. Nursing Associate

B11.1. Where a PCN employs or engages a Nursing Associate under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Nursing Associate:

a. meets the specific qualification and training requirements as specified in the Nursing Midwifery Standards of proficiency by having undertaken and completed the two-year Foundation Degree delivered by a Nursing and Midwifery Council (NMC) - approved provider; and

b. is registered with the NMC and revalidation is undertaken in line with NMC requirements.

B11.2. Where a PCN employs or engages one or more Nursing Associates under the Additional Roles Reimbursement Scheme, the PCN must ensure that each nursing associate has the following key responsibilities in relation to delivering health services:

a. work as part of the PCN's MDT to provide and monitor care, under direct or indirect supervision[92];

b. improve safety and quality of care at every opportunity;

c. contribute to the delivery of integrated care;

d. work with the PCN MDT to ensure delivery of nursing associate duties complement existing workforce;

e. provide support and supervision to training nursing associates, healthcare assistants, apprentices, and those on learning assignments/placements as required;

[92] For example, as set out in the NMC Standards for Nursing Associates

f. support registered nurses to enable them to be able to focus on the more complex clinical care;

g. develop relationships across the MDT to support integration of the role across health and social care including primary care, secondary care, and mental health;

h. perform and record clinical observations such as blood pressure, temperature, respirations, and pulse;

i. after undertaking additional training, provide flu vaccinations, ECGs, and venepuncture, and other relevant clinical tasks as required by the PCN, in line with the competencies of the role;

j. promote health and well-being to all patients, for example undertaking the NHS health check;

k. care for individuals with dementia, mental health conditions, and learning disabilities;

l. advise patients on general healthcare and promote self-management where appropriate, including signposting patients to personalised care colleagues and local community and voluntary sector services;

m. communicate proactively and effectively with all MDT colleagues across the PCN, attending and contributing to meetings as required;

n. maintain accurate and contemporaneous patient health records; and

o. enhance own performance through continuous professional development, imparting own knowledge and behaviours to meet the needs of the service.

B11.3. A PCN must ensure that the postholder has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis.

B.12. Trainee Nursing Associate (TNA)

B12.1. Where a PCN employs or engages a training nursing associate (TNA) under the Additional Roles Reimbursement Scheme, the PCN must ensure that the TNA:

a. has a minimum of GCSE Maths and English at grade 9 to 4 (A to C) or Functional Skills Level 2 in Maths and English;

b. is working towards completion of the Nursing Associate Apprenticeship programme; and

c. is enrolled on a foundation degree awarded by a Nursing and Midwifery Council (NMC) - approved provider over a 2-year period.

B12.2. Where a PCN employs or engages one or more TNAs under the Additional Roles Reimbursement Scheme, the PCN must ensure that each TNA has the following key responsibilities in relation to delivering health services:

a. delivery of high quality, compassionate care whilst undertaking specific clinical and care tasks under the direction of a registered nurse (or other registered care professional dependent on PCN), with a focus on promoting good health and independence;

b. work as part of a PCN's multidisciplinary team (MDT), delivering a high standard of care that focuses on the direct needs of the patient;

c. work with a supervisor to take responsibility for developing own clinical competence, leadership, and reflective practice skills within the workplace, while on placements and through attending the Nursing Associate Training Programme; and

d. develop by the end of the Nursing Associate Training Programme the ability to work without direct supervision, at times delivering care independently in line with the individual's defined plan of care, within the parameters of the nursing associate role, accessing clinical and care advice when needed.

B12.3. Over the course of the 2-year TNA programme, develop the skills and knowledge to provide direct care to patients and families which may include:

a. after undertaking additional training, provide flu vaccinations, ECGs, venepuncture, and other relevant clinical tasks as required by the PCN, in line with the competencies of the role;

b. supporting individuals and their families and carers when faced with unwelcome news and life-changing diagnoses, for example by providing relevant information on the diagnosis, signposting patients to further information, or referral to social prescribing link workers etc;

c. performing and recording clinical observations such as blood pressure, temperature, respirations, and pulse;

d. discussing and sharing information with registered nurses on patients' health conditions, activities, and responses; and

e. developing an understanding of caring and supporting people with dementia, mental health conditions, and learning disabilities.

B12.4. A PCN must ensure that the postholder has access to appropriate clinical supervision and an appropriate named individual in the PCN to provide general advice and support on a day to day basis.

B.13. Paramedics

B13.1. Where a PCN employs or engages a Paramedic under the Additional Roles Reimbursement Scheme, the PCN must ensure that the paramedic:

a. is educated to degree/diploma level in Paramedicine or equivalent experience;

b. is registered with the Health and Care Professions Council (HCPC);

c. has completed their two-year 'Consolidation of Learning' period as a "newly qualified paramedic";

d. has a further three years' experience as a band 6 (or equivalent) paramedic; and

e. is working towards developing Level 7 capability in paramedic areas of practice and, within six months of the commencement of reimbursement for that individual (or a longer time period as agreed with the commissioner), has completed and been signed off formally within the clinical pillar competencies of the Advanced Clinical Practice Framework.

B13.2. Where a PCN employs or engages a Paramedic to work in primary care under the Additional Roles Reimbursement Scheme, if the Paramedic cannot demonstrate working at Level 7 capability in paramedic areas of practice or equivalent (such as advanced assessment diagnosis and treatment) the PCN must ensure that each Paramedic is working as part of a rotational model, in which they have access to regular supervision and support from clinicians signed off at clinical practice level 7.

B13.3. Where a PCN employs or engages one or more Paramedics under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Paramedic has the following key responsibilities, in delivering health services:

a. work as part of a MDT within the PCN;

b. assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team;

c. advise patients on general healthcare and promote self-management where appropriate, including signposting patients to the PCN's social prescribing service, and where appropriate, other community or voluntary services;

d. be able to:

i. perform specialist health checks and reviews within their scope of practice and in line with local and national guidance;

ii. perform and interpret ECGs;

iii. perform investigatory procedures as required; and

iv. undertake the collection of pathological specimens including intravenous blood samples, swabs, and other samples within their scope of practice, and within line of local and national guidance;

e. support the delivery of 'anticipatory care plans' and lead certain community services (e.g. monitoring blood pressure and diabetes risk of elderly patients living in sheltered housing);

f. provide an alternative model to urgent and same day GP home visit for the network and clinical audits;

g. communicate at all levels across organisations ensuring that an effective, person-centred service is delivered;

h. communicate proactively and effectively with all colleagues across the multi-disciplinary team, attending and contributing to meetings as required;

i. maintain accurate and contemporaneous health records appropriate to the consultation, ensuring accurate completion of all necessary documentation associated with patient health care and registration with the practice; and

j. communicate effectively with patients, and where appropriate family members and their carers, where applicable, complex and sensitive information regarding their physical health needs, results, findings, and treatment choices.

B.14. Mental Health Practitioners

B14.1. The mental health practitioner role may be undertaken by any registered clinical role operating at Agenda for Change Band 5 or above including, but not limited to, a Community Psychiatric Nurse, Clinical Psychologist, Mental Health Occupational Therapist or other clinical registered role, as agreed between the PCN and community mental health service provider.

B14.2. Where a PCN engages one or more Mental Health Practitioners under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Mental Health Practitioner has the following key responsibilities, in delivering health services:

a. provide a combined consultation, advice, triage and liaison function, supported by the local community mental health provider;

b. work with patients to:

   i. support shared decision-making about self-management;

   ii. facilitate onward access to treatment services; and

   iii. provide brief psychological interventions, where qualified to do so and where appropriate;

c. work closely with other PCN-based roles to help address the potential range of biopsychosocial needs of patients with mental health problems. This will include the PCN's MDT, including, for example, PCN clinical pharmacists for medication reviews, and social prescribing link workers for access to community-based support; and

d. may operate without the need for formal referral from GPs, including accepting some direct bookings where appropriate, subject to agreement on volumes and the mechanism of booking between the PCN and the provider.

B14.3. A PCN must ensure that the postholder is supported through the local community mental health services provider by robust clinical governance structures to maintain quality and safety, including supervision where appropriate.

B.15. Advanced Practitioners

B15.1 Advanced Practitioners are designated to the Network Contract DES roles for Clinical Pharmacists, First Contact Physiotherapists, Dietitians, Podiatrists, Occupational Therapists and Paramedics.

B15.2 Where a PCN employs or engages an Advanced Practitioner as outlined in B15.1 under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Advanced Practitioner:

a. has a master's degree level in the relevant area of expertise;

b. is working at a master's level aware or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competencies[93],

in order to deliver the key responsibilities outlined in section B15.

B15.3 Where a PCN employs or engages an Advanced Practitioner under the Additional Roles Reimbursement Scheme, the PCN must ensure that each

[93] Multi-professional framework for advanced clinical practice in England

Advanced Practitioner has the following additional key responsibilities to those outlined in the relevant section of this Annex B, in delivering health services:

a. assess and triage patients, including same day triage, and as appropriate provide definitive treatment (including prescribing medications following policy, patient group directives, NICE (national) and local clinical guidelines and local care pathways) or make necessary referrals to other members of the primary care team;

b. manage undifferentiated undiagnosed condition and identify red flags and underlying serious pathology and take appropriate action;

c. use complex decision making to inform the diagnosis, investigation, complete management of episodes of care within a broad scope of practice;

d. actively take a personalised care approach and population centred care approach to enable shared decision making with the presenting person; and

e. complete the relevant training in order to provide multi-professional clinical practice and CPD supervision to other roles within primary care, for example first contact practitioners and the personalised care roles.

Annex C - Investment and Impact Fund Calculation of Achievement[94]

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

C1.1 For each Quantitative Indicator set out in Annex D, a denominator will be collected for each Core Network Practice in the PCN which is equal to the size of the target cohort for that Core Network Practice and Indicator.

a. For all Quantitative Indicators, the 'size of the target cohort' will be a count of eligible patients or interventions (e.g. medications) delivered to a set of eligible patients.

b. For Quantitative Indicators eligible for Personalised Care Adjustments (defined in Annex C, section C6 below), the size of the target cohort for each Core Network Practice will be calculated by omitting any patient eligible for a Personalised Care Adjustment unless the intervention in question has been delivered, in which case the patient shall remain included.

C1.2 For each Quantitative Indicator, a PCN-level denominator (D) will be calculated by adding up all the denominators for the Core Network Practices of the PCN.

C1.3 For each Quantitative Indicator, a numerator will be collected for each Core Network Practice in the PCN.

a. For Quantitative Indicators with a desired direction of upwards, the numerator will capture the extent to which a desired intervention or event has occurred.

b. For Quantitative Indicators with a desired direction of downwards, the numerator will capture the extent to which an undesired intervention or event has occurred.

C1.4 For each Quantitative Indicator, a PCN-level numerator (N) will be calculated by adding up all the numerators for the Core Network Practices of the PCN.

C1.5 For all Improvement Quantitative indicators set out in Annex D, a PCN-level baseline numerator (N0) and denominator (D0) will be calculated by adding,

[94] Throughout Annex C, for the purpose of any calculation, all percentages (including, where relevant, performance, the lower performance threshold, and the upper performance threshold) will take the form of the fraction corresponding to the percentage. For instance, performance of 77 per cent would be entered into any calculation as 0.77, not as 77.

respectively, up all the baseline numerators and baseline denominators for the Core Network Practices of the PCN.

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

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

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

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

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

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

a. If the PCN's performance is worse than the performance threshold (X<T), the PCN will earn zero points for the indicator: Q=0.

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

C3.3 For Binary Quantitative Indicators, where the desired direction is downwards:

a. If the PCN's performance is worse than the performance threshold (X>T), the PCN will earn zero points for the indicator: Q=0.

b. If the PCN's performance is better than or equal to the performance threshold (X<T or X=T), the PCN will earn all the points available for the indicator: Q=A.

C3.4 For Standard or Improvement Quantitative Indicators, points achieved by the PCN (Q) will be calculated on a linear sliding scale between the lower performance threshold (L) and upper performance threshold (U).

C3.5 For Standard or Improvement Quantitative Indicators where the desired direction is upwards (L<U):

a. If the PCN's performance is worse than or equal to the lower performance threshold (X<L or X=L), the PCN will earn zero points for the indicator: Q=0.

b. If the PCN's performance is strictly between the lower and upper performance thresholds (L<X<U), points earned by the PCN will be calculated as follows:

   i. Subtract the lower performance threshold from performance, and call this number V: V=X-L.

   ii. Subtract the lower performance threshold from the upper performance threshold, and call this number W: W=U-L.

   iii. The points earned by the PCN will then be equal to the number of points available (A), multiplied by V, divided by W: Q=A*V/W.

c. If the PCN's performance is better than or equal to the upper performance threshold (X>U or X=U), the PCN will earn the maximum points available for the indicator: Q=A.

C3.6 For Standard or Improvement Quantitative Indicators where the desired direction is downwards (L>U):

a. If the PCN's performance is worse than or equal to the lower performance threshold (X>L or X=L), the PCN will earn zero points for the indicator: Q=0.

b. If the PCN's performance is strictly between the lower and upper performance thresholds (L>X>U), points earned by the PCN will be calculated as follows:

   i. Subtract performance from the lower performance threshold, and call this number V: V=L-X.

   ii. Subtract the upper performance threshold from the lower performance threshold, and call this number W: W=L-U.

   iii. The points earned by the PCN will then be equal to the number of points available (A), multiplied by V, divided by W: Q=A*V/W.

c. If the PCN's performance is better than or equal to the upper performance threshold (X<U or X=U), the PCN will earn the maximum points available for the indicator: Q=A.

C4. Step 4: For each Indicator, calculate Achievement Payments for the PCN

C4.1 For each Indicator, payments earned by the PCN will incorporate a List Size Adjustment. For each Quantitative Indicator, payments earned by the PCN will also incorporate a Prevalence Adjustment, which may in some cases be equal to 1 for all PCNs i.e. there is no prevalence adjustment. All references to practice list size, PCN list size and List Size Adjustment in relation to the IIF refer to registered unweighted list size. The IIF calculations do not make any use of weighted list size.

C4.2 For each PCN, 'prevalence' (C) for a Quantitative indicator is defined as being equal to a 'prevalence numerator' (E) divided by registered unweighted PCN list size (S): C=E/S. This prevalence numerator (E) will often, though not always, be defined as being equal to the Indicator denominator (D): E=D. The prevalence numerator for each Quantitative Indicator is defined in Annex D.

C4.3 For each Quantitative Indicator, national prevalence (K) is defined as the sum of prevalence numerators (E) divided by the sum of all registered unweighted PCN list sizes (S).

C4.4 For each Quantitative Indicator, the Prevalence Adjustment for a PCN will be equal to PCN-level prevalence (C) divided by national prevalence (K).

C4.5 National average registered unweighted PCN list size (T) is equal to the sum of all registered unweighted PCN list sizes (S) divided by the number of PCNs.

C4.6 The List Size Adjustment for a PCN will be the same for all Indicators and will be equal to registered unweighted PCN list size (S) divided by national average registered unweighted PCN list size (T).

C4.7 For each Quantitative Indicator, payments earned by the PCN (M) will be calculated by multiplying points earnt (Q), by the value of an IIF point (P), by the Prevalence Adjustment (C/K), by the List Size Adjustment (S/T): M=Q*P*(C/K)*(S/T).

C4.8 For each Qualitative Indicator, payments earned by the PCN (M) will be calculated by multiplying points earnt (Q), by the value of an IIF point (P), by the List Size Adjustment (S/T): M=Q*P*(S/T).

C5. Step 5: For the PCN, calculate Year End Achievement Payment

C5.1 For the PCN the Year End Achievement Payment is equal to the sum of Achievement Payments for each Indicator, excluding those eligible for in year payment.

C6. Personalised Care Adjustments

C6.1 A **PCA** may be applied for the Indicators and reasons set out in this paragraph. The effect of applying a PCA to a patient for a given Indicator will be to remove that patient, and any services or interventions they receive, from the denominator for that Indicator – *unless* the patient (or any services or interventions they receive) meet the success criteria outlined in the numerator for that indicator, in which case they shall be retained in the denominator and counted as success in the numerator. The Indicators and reasons to which a PCA may be applied are (see Annex D for details of each indicator, further details will be available in Investment and Impact Fund Implementation Guidance 2021/22):

a. VI-01, VI-02, VI-03: Clinically unsuitable, Patient chose not to receive the intervention, Patient did not reply to two invitations for the intervention in their preferred method of communication.

C7. Indicators eligible for in year payment

C7.1 The following Indicator shall be eligible for in year payment: ACC-01. For Indicators specified as being eligible for in year payment:

a. The period of operation of the Indictors will be from 1 April 2021 to 31 July 2021.

b. The commissioner will calculate the Achievement Payment set out in Step 4 of section 10.6.11 as soon as practicable after 31 July 2021.

c. Where an In Year Achievement Payment in respect of IIF is due to a PCN, the commissioner will make that payment as soon as practicable after 31 July 2021, and by 31 October 2021 at the latest.

C8. Timing conventions and payment calculation period

C8.1 Unless otherwise stated or unless any of the provisions of section C9 apply, the following timing conventions will be employed for the purpose of calculating performance, Achievement Points and Achievement Payments for Indicators not eligible for in year payment. Timing conventions for Indicators eligible for in year payment are set out in section C7. If any of the provisions of section C9 apply, the following timing conventions will apply to the extent they are compatible with the provisions of section C9.

a. Calculations in respect of the Indicators will be made in relation to one of three periods: 1 April 2021 to 31 March 2022, or 1 October 2021 to 31 March 2022, or 1 January 2022 to 31 March 2022 (Annex D provides details for each indicator). The time periods to which calculations are

applied shall be employed regardless of when the participation of a PCN's Core Network Practices was confirmed.

b. PCN membership will be defined using ODS PCN membership as at 31 March 2022.

   i. This definition also applies to the calculation of baseline PCN-level numerators and denominators (N0 and D0) for Improvement Quantitative indicators, i.e. N0 and D0 shall be constructed from the underlying practice-level data based on PCN membership as at 31 March 2022. A PCN may propose to vary this principle if there is a compelling case for doing so, but agreement to any such proposal shall be at the sole discretion of the commissioner. Where the commissioner agrees to such a variation, if the indicator is subject to declaration the PCN may decline to declare its achievement and the commissioner may manually vary the baseline numerators and denominators in accordance with whatever is agreed between the PCN and commissioner. If the indicator is not subject to declaration, any such variation must be implemented via a manual adjustment outside of the main process of calculating IIF achievement.

c. The following uses of practice list size or PCN list size in the calculations set out here will be based on the registered unweighted practice list size or registered unweighted PCN list size as at 1 January 2022:

   i. The Prevalence Adjustment for each Quantitative indicator.

   ii. The List Size Adjustment.

d. For all Qualitative indicators (defined in Annex D) not eligible for in year payment, data on achievement will be manually submitted via the Calculating Quality Reporting System (CQRS).

e. Except where explicitly noted below for all Quantitative indicators (defined in Annex D):

   i. The denominators will be measured by an extract using the General Practice Extraction Service ("GPES") on 31 March 2022.

   ii. The numerators will also be measured by an extract using GPES. The numerator will be defined with respect to the denominator defined on 31 March 2022 and, except where explicitly noted in the indicator definition, will count all activity undertaken between 1 April 2021 and 31 March 2022.

C8.2 Unless otherwise stated, the following timing conventions will be employed for the purpose of calculating performance, Achievement Points and Achievement Payments for indicators eligible for in year payment:

a. Except where explicitly noted below, calculations in respect of the Indicators will be made in relation to the period 1 April 2021 to 31 July 2021. The time periods to which calculations are applied shall be employed regardless of when the participation of a PCN's Core Network Practices was confirmed.

b. PCN membership will be defined using the ODS mapping of practices to PCNs as at 31 July 2021.

c. Unless otherwise noted in this text or Network Contract DES Guidance, all uses of practice list size or PCN list size in the calculations set out here will be based on the registered unweighted practice list size or registered unweighted PCN list size as at 1 January 2021. This includes the following uses of practice list size:

   i. The List Size Adjustment.

d. Where a Core Network Practice of a PCN ceases (for whatever reason) to be a Core Network Practice of that PCN before 31 July 2021:

   i. That Core Network Practice's performance in relation to IIF Indicators will not enter in any way into the calculation of that PCN's performance.

   ii. That Core Network Practice's practice list size will not enter into the calculation of PCN list size.

C9. Impact of PCN changes on calculation of Year End Achievement Payment

C9.1 Where a Core Network Practice of a PCN ceases (for whatever reason) to be a Core Network Practice of that PCN before 31 March 2022:

a. That Core Network Practice's performance in relation to IIF Indicators will not enter in any way into the calculation of that PCN's performance.

b. That Core Network Practice's practice list size will not enter into the calculation of PCN list size.

c. That Core Network Practice's denominator and practice list size will not enter into the calculation of PCN prevalence.

C9.2 Where a practice (for whatever reason but provided it is not a New Practice) becomes a Core Network Practice of a PCN at any time after 1 April 2021, and remains a Core Network Practice of that PCN on 31 March 2022, then that

Core Network Practice's performance in relation to the Indicators for the entire period from 1 April 2021 to 31 March 2022, where specified in Section C8) will enter into the calculation of that PCN's Achievement Points and Achievement Payments, including that portion of the period from 1 April 2021 to 31 March 2022 during which the practice was not a Core Network Practice of the PCN.

C9.3 Where a New Practice becomes a Core Network Practice of a PCN at any time after 30 April 2021, and remains a Core Network Practice of that PCN on 31 March 2022 then that practice's performance in relation to the Indicators from the period it became a New Practice to 31 March 2022 will enter into the calculation of that PCN's Achievement Points and Achievement Payments with no adjustment in that practice's performance to account for any portion of the period from 1 April 2021 to it becoming a New Practice.

C9.4 If a new PCN is approved (for whatever reason) in the period 1 April 2021 to 31 March 2022, and at least one Core Network Practice of the new PCN was previously a Core Network Practice of a different PCN, then the performance of the Core Network Practices in relation to the Indicators for the period from 1 April 2021 to 31 March 2022 will enter into the calculation of that PCN's Achievement Points and Achievement Payments, including that portion of the period from 1 April 2021 to 31 March 2022 during which the PCN did not exist.

Annex D - Investment and Impact Fund Indicators

D1. Prevention and Tackling Health Inequalities domain

D1.1 A PCN is able to earn up to 362 points in the Prevention and Tackling Health Inequalities domain. The following indicator definitions apply for this domain.

ID	Description	Numerator (N)	Denominator (D)	Prevalence numerator (E)	Indicator Type; Points; Desired Direction; Thresholds
Vaccination & immunisation (VI) area					
VI-01	Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September and 31 March	Of the denominator, the number who received a seasonal influenza vaccination between 1 September and 31 March	Number of patients aged 65 and over	Indicator denominator	Standard Quantitative; 40; Upwards; 80% (LT) / 86% (UT)
VI-02	Percentage of patients aged 18 to 64 years and in a clinical at-risk group[95] who received a seasonal influenza vaccination between 1 September and 31 March	Of the denominator, the number who received a seasonal influenza vaccination between 1 September and 31 March	Number of patients aged 18 to 64 years and in a clinical at-risk group	Indicator denominator	Standard Quantitative; 88; Upwards; 57% (LT) / 90% (UT)
VI-03	Percentage of children aged 2 to 3 who received a seasonal influenza vaccination between 1 September and 31 March	Of the denominator, the number who received a seasonal influenza vaccination between 1 September and 31 March	Number of children aged 2 to 3 on 31 August	Indicator denominator	Standard Quantitative; 14; Upwards; 45% (LT) / 82% (UT)

[95] "At-risk" refers to patients in the following cohorts (those subject to national call and recall system): Chronic respiratory disease, Chronic heart disease, Chronic kidney disease, Chronic liver disease, Chronic neurological disease, Learning disabilities (as captured by being on the QOF Learning Disability register), Diabetes, Immunosuppression, Asplenia or dysfunction of the spleen, Morbid obesity, People in long stay residential or homes. For further information, see: https://www.england.nhs.uk/wp-content/uploads/2020/05/Letter_AnnualFlu_2020-21_20200805.pdf.

COV-01	Confirmation that, unless (in exceptional circumstances) the commissioner has agreed with one or more practices that they should not participate, all practices within the PCN were (a) signed up to Phase 3 of the COVID-19 Vaccination Enhanced Service as at 31 December 2021, (b) remained signed up until 31 March 2022, and (c) were actively delivering Covid-19 vaccinations during this period.	N/A	Qualitative; 220

D2. Providing High Quality Care domain

D2.1 A PCN is able to earn up to 27 points in the Providing High Quality Care domain. The following indicator definitions apply for the indicators in this domain.

ID	Description	Numerator (N)	Denominator (D)	Prevalence numerator (E)	Indicator Type; Points; Desired Direction; Thresholds
Access (ACC) area					
ACC-01	Confirmation that, by 31 July 2021, 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			N/A	Qualitative; 27; N/A; N/A

Classification: Official

Publication approval reference: PAR1219

Network Contract Directed Enhanced Service

Investment and Impact Fund 2021/22: Updated Guidance

20 December 2021

Contents

1. Introduction

1.1 The Investment and Impact Fund (IIF) forms part of the Network Contract Directed Enhanced Service (DES). It will support primary care networks (PCNs) to deliver high quality care to their population, as well as supporting the delivery of priority objectives articulated in the NHS Long Term Plan and in *Investment and Evolution; a five-year GP contract framework to implement the NHS Long Term Plan*.

1.2 In line with the wider Network Contract DES, the IIF for 2021/22 has been designed to support PCNs during their ongoing response to and recovery from the COVID-19 pandemic. This includes focusing on preventative activity for cohorts at particular risk of poor health outcomes from COVID-19, and in tackling health inequalities more directly and proactively.

1.3 In response to the emergence of the Omicron variant of Covid-19 and the need to accelerate the delivery of booster vaccinations in Q3/Q4 2021/22, NHSEI has changed the structure and approach of the IIF for 2021/22. Full details of these changes can be found in this letter to systems and in the Variation to the Network Contract DES. To summarise:

- VI-01, VI-02, VI-03 and ACC-01 will continue to operate as planned (i.e. on the basis of PCN performance) in 2021/22.
- All other indicators have been suspended. Funding allocated for these (£112.1m) will be repurposed as follows:
    - £62.4m of the allocated funding will be provided to PCNs via a PCN Support Payment, which will be administered on a weighted patient basis.
    - £49.7m will be allocated to a new binary IIF indicator, paid on the basis that all practice within a PCN are a) signed up to phase 3 of the Covid-19 Vaccination Enhanced Service by 31 December 2021, b) remain signed up by 31 March 2022, and c) are actively delivering vaccinations during this period.

1.4 The previous version of this document, published in October 2021, provided guidance for both the initial set of indicators that commenced in April 2021, and a second set of indicators which commenced in October 2021. Guidance for the indicators which have not been suspended still applies.

1.5 Guidance for those indicators which have been suspended for 2021/22 can still be found in Section 5. Likewise, the below table summarises all 2021/22 IIF indicators, including those that have been suspended, those that remain live, and the new qualitative indicator rewarding participation in the COVID-19 Vaccination Enhanced Service.

1.6 The IIF is a financial incentive scheme. It focuses on resourcing high quality care in areas where PCNs can contribute significantly towards the 'triple aim':

- Improving health and saving lives (e.g. through improvements in the uptake of seasonal influenza vaccinations)
- Improving the quality of care for people with multiple morbidities (e.g. through increasing referrals to social prescribing services)
- Helping to make the NHS more sustainable.

1.7 *Investment and Evolution* set out that the IIF will be worth £150 million in 2021/22, rising to at least £225 million in 2022/23 and £300 million in 2023/24. As a result of the suspension of IIF in December 2021 to support the COVID-19 Vaccination programme, the IIF will now be worth £87.8m in 2021/22.

1.8 This document provides guidance on the IIF for 2021/22, including key details of the individual indicators. Information on how performance and achievement will be calculated is also included, and should be read alongside the relevant sections of the 2021/22 Network Contract DES specification (Sections 10.6 and Annexes C and D). For indicators sourced from the GP Extraction Service (GPES), the business rules published by NHS Digital provide full details of how the indicators are constructed from information in GP systems. In addition, CQRS guidance provides details on the submission and reporting of data for all indicators.

2. Structure of the IIF

2.1. This section introduces the key elements of the IIF in 2021/22:

- Domains, areas, and indicators
- Indicator structure, performance, exclusions and exceptions (personalised care adjustments)
- Achievement points
- Achievement payments, prevalence adjustment and list size adjustment
- Monitoring IIF performance.

Domains, areas, and indicators

2.2 The IIF is divided into three domains: (i) prevention and tackling health inequalities, (ii) providing high quality care and (iii) a sustainable NHS. Each domain consists of several areas, which in turn consist of a number of indicators.

2.3 The domains, areas, and indicators for the IIF in 2021/22 are set out in the summary table below, along with respective start dates for each indicator.

Live 2021/22 indicators

Domain	Area	Start	Indicators
Prevention and tackling health inequalities	Vaccination and immunisation	**Apr 21**	**VI-01**: Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September and 31 March
		Apr 21	**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
		Apr 21	**VI-03:** Percentage of patients aged two or three years on 31 August of the relevant financial year who received a seasonal influenza vaccination between 1 September and 31 March
		Dec 21	**COV-01:** Confirmation that, unless (in exceptional circumstances) the commissioner agreed with one or more practices that they

Domain	Area	Start	Indicators
			should not participate, all practices within the PCN were (a) signed up to Phase 3 of the COVID-19 Vaccination Enhanced Service as at 31 December 2021, (b) remained signed up until 31 March 2022, and (c) were actively delivering COVID-19 vaccinations during this period.
Providing high quality care	Access	**Apr 21**	**ACC-01:** Confirmation that, by 31 July 2021, 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

Suspended 2021/22 indicators

Domain	Area	Start	Indicators
Prevention and tackling health inequalities	Tackling health inequalities	**Apr 21**	**HI-01:** Percentage of patients on the QOF Learning Disability register aged 14 or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan
		Oct 21	**HI-02:** Percentage of registered patients with a recording of ethnicity
	CVD prevention	**Oct 21**	**CVD-01:** Percentage of patients aged 18 or over with an elevated blood pressure reading (≥140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension
		Oct 21	**CVD-02:** Percentage of registered patients on the QOF Hypertension Register
	Personalised care	**Apr 21**	**PC-01**: Percentage of registered patients referred to social prescribing

Domain	Area	Start	Indicators
Providing high quality care	Enhanced health in care homes	**Oct 21**	**EHCH-01:** Number of patients aged 18 years or over and recorded as living in a care home, as a percentage of care home beds eligible to receive the Network Contract DES Enhanced Health in Care Homes service
		Oct 21	**EHCH-02:** Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed
		Oct 21	**EHCH-03:** Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review
		Oct 21	**EHCH-04:** Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident aged 18 years or over
	Access	**Oct 21**	**ACC-02:** Number of online consultation submissions received by the PCN on or after 1 January per 1000 registered patients
		Oct 21	**ACC-03:** By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions.
		Oct 21	**ACC-04:** Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacy Consultation Service by no later than 31 March 2022.
		Oct 21	**ACC-05**: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups.

Domain	Area	Start	Indicators
A Sustainable NHS	Environmental sustainability	**Oct 21**	**ES-01:** Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 years or over on or after 1 October
		Oct 21	**ES-02:** Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO2e)

Indicator structure and performance calculation

2.4 IIF indicators are either 'Qualitative' or 'Quantitative'. Quantitative indicators are further divided into 3 assessment categories: Binary, Standard, or Improvement.

2.5 **Qualitative** indicators consist of a criterion or set of criteria. A PCN can either earn all the points available, or no points, based on whether the criterion or set of criteria are met. Where there are multiple criteria, failure to meet any one of the criteria means that no points are earnt.

2.6 **Quantitative** indicators are constructed from the ratio of a numerator and denominator. For **Binary** and **Standard** Quantitative indicators, this represents the indicator performance (Performance X = Numerator (N)/Denominator (D)). For **Improvement** Quantitative indicators, performance is based on the change in this ratio relative to a base period (Performance X = N/D – N0/D0).[1]

2.7 The desired direction of performance may be upwards or downwards. If it is upwards, a higher indicator value means better performance and a lower one means worse performance; and if it is downwards, a lower indicator value means better performance and a higher one means worse performance.

[1] N0/D0 represents the ratio of a PCN's numerator and denominator from an earlier period e.g. the previous year.

2.8 The denominator of each Quantitative indicator is the target cohort for the intervention in question. In 2021/22 IIF, the target cohort for all Quantitative indicators is a count of eligible patients or interventions (e.g. medications) delivered to a set of eligible patients. For example, for indicator HI-01 the target cohort is people on the QOF Learning Disability Register aged 14 and over.

Exclusions and Exceptions (Personalised Care Adjustments)

2.9 Exclusions may be applied to some Quantitative indicators, removing patients, and any services or interventions they receive, from the denominator for that indicator. Exclusions are applied prior to assessment and are therefore removed even if action or intervention that the IIF indicator seeks to reward has happened. The exact circumstances in which Exclusions apply to IIF indicators are provided in the tables below.

2.10 Personalised care adjustments (PCAs), previously known as 'Exceptions', may be applied to some Quantitative indicators, removing patients, and any services or interventions they receive, from the denominator for that indicator – unless the action or intervention being incentivised by the indicator has occurred, in which case they will be retained. The exact circumstances in which PCAs apply to IIF indicators are provided in the tables below.

2.11 An example of how PCAs would be applied to VI-01 is as follows: A PCN has 1,000 patients aged 65 and over, of whom 600 received a seasonal influenza vaccination. If a practice's clinical system records that 100 of the 1,000 eligible patients were offered a seasonal influenza vaccination but refused and it was also deemed clinically inappropriate to administer the seasonal influenza vaccination to a further 100, then PCN performance in relation to indicator VI-01 would be 75% (= 600/800), not 60% (= 600/1,000).

Achievement points

2.12 The IIF is a points-based scheme. For 2021/22, each PCN can earn a maximum of 389 IIF points and the value of a point will be £200.00 (adjusted for list size and prevalence – see paragraphs 2.18-2.19). Each indicator is worth an agreed number of points, and how these are achieved depends on whether the indicator is Qualitative, Binary Quantitative, Standard Quantitative or Improvement Quantitative.

2.13 A PCN can earn either all the points or no points for Qualitative indicators, based on whether they meet all the criteria, and for Binary Quantitative indicators, based on whether performance meets the indicator performance threshold.

2.14 The points a PCN can earn for Standard and Improvement Quantitative indicators will depend on how their performance relates to an upper performance threshold and a lower performance threshold.

2.15 The upper performance threshold (or single threshold for Binary Quantitative indicators) for each Standard Quantitative indicator is based on clinical or other expert opinion concerning good practice. Reflecting the aim of reducing unwarranted variation, the lower performance threshold for each indicator has typically been set with reference to the 40th centile of performance in 2019/20 (where baseline data is available).

2.16 Upper and lower thresholds for Improvement Quantitative indicators represent changes from each PCN's baseline e.g. 1 and 2 percentage point increases from the percentage performance recorded in the previous year. These may also be based on clinical/expert opinion but may also factor in previous trends over time or natural variation.

2.17 If a PCN's performance for a Standard or Improvement Quantitative indicator is better than or equal to the upper performance threshold, it will earn all the points available for that indicator; if a PCN's performance is worse than or equal to the lower performance threshold, it will earn zero points; and if performance is between the upper and lower thresholds, it will earn some but not all of the points available for that indicator. Consider a hypothetical Standard Quantitative indicator worth 50 points with an upwards desired direction, a lower performance threshold of 50% and an upper performance threshold of 75%. Then, two IIF points are earnt for every percentage point improvement in performance (50 points/ (75%-50%) = 2 points per percentage point). If a PCN's performance is 70%, it will earn 40 of the 50 available achievement points – because 70% is 4/5ths of the way from 50% (the lower performance threshold) to 75% (the upper performance threshold).

Achievement payments

2.18 For each indicator, a PCN's achievement payment equals its achievement points multiplied by the value of an IIF point (£200.00 in 2021/22), multiplied

by a list size adjustment, and in the case of Quantitative indicators, multiplied by a prevalence adjustment. The value of an IIF point will be subject to annual revision.

2.19 The purpose of the prevalence adjustment and list size adjustment is to more closely relate PCN payments to the effort that a PCN must undertake to earn IIF points. The points-based system means that, for Standard and Improvement Quantitative indicators, every PCN will earn the same number of *points* for a given percentage point improvement in performance (and for Qualitative and Binary Quantitative indicators, no points or the same number of agreed points depending on whether the criterion or criteria, or performance threshold have been met). However, differences in prevalence and in list size mean that PCNs may have to make different levels of effort to achieve a given percentage point improvement in performance. Annex A explains how applying a prevalence adjustment and a list size adjustment takes account of these differences.

2.20 In 2021/22, PCNs are entitled to two types of payment under the IIF: 'In Year Achievement Payments' and 'Year End Achievement Payments'. Payments will in most cases take the form of Year End Achievement Payments based on performance covering the period 1 April 2021 to 31 March 2022. Indicator ACC-01 (launched 1 April) is eligible for an In Year Achievement Payment as performance is based on the period 1 April 2021 to 31 July 2021.

2.21 To be eligible to receive achievement payments, a PCN must comply with the conditions set out in the 2021/22 Network Contract DES specification (section 10.6.14). Crucially, the PCN must provide a simple written commitment to their commissioner that any money earned through the IIF will be reinvested into additional workforce, additional primary medical services, and/or other areas of investment in a Core Network Practice that support patient care (e.g. equipment or premises). The written commitment does not have to detail the precise areas of spend: this is for PCNs to determine .

Monitoring IIF performance

2.22 Each PCN is able to monitor its indicative performance against IIF indicators on the PCN Dashboard, which is available through NHS ViewPoint. To access the dashboard, please either register on the Insights Platform or log in in using your existing Insights Platform account, and then select the NHS

ViewPoint product. A user guide is available to help navigate the dashboard. The Dashboard can be accessed directly via this link.

2.23 The dashboard supports PCNs to understand their local population health priorities and the benefits that they are delivering for their patients. It also helps PCNs to identify opportunities to reduce unwarranted variation in performance within their PCN and between PCNs, to improve services. Performance against each IIF indicator is expected to be available monthly by PCN from Autumn 2021.

2.24 All IIF indicators, including suspended indicators, will continue to be collected and reported on the PCN Dashboard. Data on all IIF indicators drawn from GPES, including suspended indicators, will continue to be available in CQRS and published on the NHS Digital website as part of the NCD service/extract. Plans to incorporate suspended IIF indicators drawn from non-GPES data sources into CQRS have been paused, and will now take place in early 2022/23.

3. Prevention and tackling health inequalities domain

3.1 The prevention and tackling health inequalities domain aims to support delivery of the ambitions outlined in Chapter Two of the NHS Long Term Plan. A key focus of the Network Contract DES is prevention – the aim being to help people stay healthy, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life. Indicators in this domain will contribute to the Government's ambition to add five years to healthy life expectancy by 2035.

Vaccination and immunisation area

3.2 Indicators in the Vaccination and immunisation area support the ambitions of the NHS Long Term Plan to ensure and expand access to vaccines.

VI-01, VI-02, VI-03: Seasonal influenza vaccination			
Rationale for inclusion	Improving the coverage and uptake of vaccinations is a key public health priority and was a NHS Long Term Plan commitment (p15, p39). Securing high coverage is even more important in the context of COVID-19.		
Indicator type	Standard Quantitative		
Indicator	**VI-01**: Percentage of patients aged 65 or over who received a seasonal influenza vaccination between 1 September and 31 March	**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	**VI-03**: Percentage of children aged 2 to 3 who received a seasonal influenza vaccination between 1 September and 31 March
Running period	1 April 2021 – 31 March 2022		
Denominator	Number of patients aged 65 and over	Number of patients aged 18 to 64 and in a clinical at-risk group (as defined in	Number of children aged 2 to 3 on 31 August

VI-01, VI-02, VI-03: Seasonal influenza vaccination			
		Appendix A in the national influenza immunisation programme update for 2020/21)[2]	
Numerator	Of the denominator, the number who received a seasonal influenza vaccination between 1 September and 31 March	Of the denominator, the number who received a seasonal influenza vaccination between 1 September and 31 March	Of the denominator, the number who received a seasonal influenza vaccination between 1 September and 31 March
	The flu vaccine can be provided in any patient setting (e.g. general practice, community pharmacy), provided provision is coded in GP IT systems.		
Prevalence numerator	Indicator denominator		
Exclusions	Patients on end of life care		
Personalised care adjustments	Patients who declined the offer of a seasonal influenza vaccination Situations in which it is not clinically appropriate to provide a seasonal influenza vaccination. Patient did not reply to two separately coded invites to receive a seasonal influenza vaccination using their preferred method of communication		
Desired direction	Upwards		
Thresholds	80% (LT),	57% (LT),	45% (LT),

[2] Including the following at-risk groups eligible for a free influenza vaccination:
Chronic respiratory disease; Chronic heart disease; Chronic kidney disease; Chronic liver disease; Chronic neurological disease; Learning disabilities (as captured by being on the QOF Learning Disability register); Diabetes; Immunosuppression; Asplenia or dysfunction of the spleen; Morbidly obese; People in long stay residential or homes.
Excluding the following at-risk groups eligible for a free influenza vaccination, on the basis that membership of these groups is not reliably recorded in GP systems:
Pregnant women; Household contact of immunocompromised individual; Household contact of person on NHS shielded patient list; Social care worker; Hospice worker.

VI-01, VI-02, VI-03: Seasonal influenza vaccination			
	86% (UT)	90% (UT)	82% (UT)
Points	40	88	14
Data source	General Practice Extraction Service (GPES)		
Subject to declaration?	Yes		
Additional information	NICE Quality Standard 190 on improving seasonal influenza vaccination uptake was published in January 2020. Responsibility for providing seasonal influenza vaccinations in primary care is currently shared between general practice and community pharmacy. To encourage collaboration and discourage competition across a network, a parallel indicator for delivery to the over 65s was included in the Pharmacy Quality Scheme (PQS) for 2020/21 and continues to be included in the 2021/22 scheme. Achievement for both the IIF and PQS seasonal influenza vaccination incentives will be based on the total number of vaccines provided within the network, irrespective of who delivered the vaccine. The IIF seasonal influenza vaccination indicators supplement the existing seasonal influenza vaccination Enhanced Service in general practice, which makes an item of service payment of £10.06 (at the time of publishing this guidance) for each seasonal influenza vaccination provided. Clinical leadership at a PCN level can promote uptake, identifying areas for improvement and disseminating good practice to increase vaccination rates and reduce variation across eligible patient cohorts. • PCN clinical directors should, in partnership with the identified CCG flu lead and national commissioners, engage with: • General practices in the PCN to agree how they will collaborate with each other, and discuss how they will collaborate with community pharmacies in relation to seasonal influenza vaccination uptake • The pharmacy PCN lead, where available, to agree how general practices will collaborate with community pharmacies in relation to seasonal influenza vaccination uptake.		

COV-01: Confirmation that, unless (in exceptional circumstances) the commissioner agreed with one or more practices that they should not participate, all practices within the PCN were (a) signed up to Phase 3 of the COVID-19 Vaccination Enhanced Service as at 31 December 2021, (b) remained signed up until 31 March 2022, and (c) were actively delivering COVID-19 vaccinations during this period.	
Rationale for inclusion	This indicator recognises PCNs for signing up to the Phase 3 of the COVID-19 Vaccination Enhanced Service, in order to help maximise primary care capacity for the delivery of the booster campaign.
Indicator type	Qualitative
Running period	31 Dec 2021 – 31 March 2022
Denominator	N/A
Numerator	N/A
Prevalence numerator	N/A
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	N/A
Thresholds	N/A
Points	220
Data source	Manual confirmation of completion via CQRS.
Subject to declaration?	Yes
Additional information	£49.7m will be allocated to a new binary IIF indicator, paid on the basis of all practices within a PCN being signed up to phase 3 of the COVID-19 Vaccination Enhanced Service as at

COV-01: Confirmation that, unless (in exceptional circumstances) the commissioner agreed with one or more practices that they should not participate, all practices within the PCN were (a) signed up to Phase 3 of the COVID-19 Vaccination Enhanced Service as at 31 December 2021, (b) remained signed up until 31 March 2022, and (c) were actively delivering COVID-19 vaccinations during this period.	
	31 December 2021, remaining signed up until 31 March 2022, and actively delivering the programme. Where, in exceptional circumstances, the commissioner agrees with one or more practices that they should not participate in the COVID-19 Vaccination Enhanced Service (as a result of wider access, performance or patient safety issues) then the PCN may still receive payment with those practices excluded from consideration. The payment will not apply if any practice in the PCN otherwise declines to participate in the programme. The remaining £62.4m of the funding originally allocated to suspended IIF indicators will be provided to PCNs via a PCN Support Payment, which will be administered on a weighted patient basis

4. Providing high quality care domain

Access area

4.1 Improving access to general practice services is a core aim of both the NHS Long Term Plan and *Investment and Evolution*. The response of primary care to COVID-19 has also seen rapid and widespread changes in how patients access general practice services. IIF indicators in this area are designed to support improvements in access to general practice by recognising PCNs for helping more patients to access the right care, in the right place, at the right time.

ACC-01: Confirmation that, by 31 July, 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	
Rationale for inclusion	The development of a comprehensive and structured dataset describing access to general practice based on better and more consistent recording of appointment data via consistent established standards is a commitment set out in *Investment and Evolution* (para 5.29) and reinforced in *Update to the GP contract agreement 2020/21 to 2023/24* (para 4.3). This dataset will provide comprehensive, granular and timely information about activity in general practice.
Indicator type	Qualitative
Running period	1 April 2021 to 31 July 2021
Denominator	N/A
Numerator	N/A
Prevalence numerator	N/A
Exclusions	N/A
Personalised care adjustments	N/A

ACC-01: Confirmation that, by 31 July, 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	
Desired direction	N/A
Thresholds	N/A
Points	27
Data source	Manual PCN submission to commissioners. Full details including value of payment were provided to PCNs and commissioners in advance of 30 June via Future NHS
Subject to declaration?	N/A
Additional information	In August 2020, NHS England and NHS Improvement and the British Medical Associated published guidance on *More accurate general practice appointment data*, to ensure all appointments are being recorded in general practice appointment books, and to fully capture the scale of work and workload in general practice. This guidance document introduced an agreed definition of an appointment, and asked general practice to start applying this systematically, as an important first step to improving data quality. Technical system-specific advice and guidance to support practices with configuring appointment books has been published by NHS Digital. A new standardised set of GP appointment categories across general practice in England have also been introduced. New functionality to map local slot types to this new set of standard national GP appointment categories has also been provided in GP appointment systems. Each appointment slot type needs to be mapped to one of the categories. Guidance to support practices to do this is available. PCNs will be recognised through this indicator for completing both the mapping and improvements in overall appointment data quality and therefore confirming they are submitting high quality appointment data. The recording improvements and self-declaration should be completed by 31 July and any necessary validation will be undertaken prior to the payment deadline of 31 October.

ACC-01: Confirmation that, by 31 July, 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	
	Further information More accurate general practice appointment guidance Appointment category guidance

5. Suspended 2021/22 indicators

Prevention and tackling health inequalities domain

Tackling health inequalities area

5.1 The social and economic environment in which we are born, grow up, live, work and age, as well as the decisions we make for ourselves, have a significant impact on our health. The COVID-19 pandemic has also highlighted the imbalance in health outcomes and differential experiences of healthcare services between different groups, communities, and regions. IIF indicators in the tackling health inequalities area are designed to help to ensure that everyone gets access to the care they need and focus interventions on groups who experience health inequalities.

HI-01: Percentage of patients on the QOF Learning Disability register aged 14 or over, who received a learning disability Annual Health Check and have a completed Health Action Plan [suspended]	
Rationale for inclusion	To tackle the causes of morbidity and preventable deaths in people with a learning disability and/or autism, the NHS Response to COVID Phase 3 letter reiterates the importance of people with a learning disability being identified on their local register and having annual health checks completed. People with a learning disability often have poorer physical and mental health and are four times more likely to die of preventable illnesses than the general population (Disability Rights Commission, 2006). Groups who already experience disproportionately poor health outcomes have also been seen to have additional risks from COVID-19. An annual health check can help to improve the health of people with a learning disability by identifying health concerns at an early stage. The health action plan is an integral part of the requirements around a learning disability health check and so encouraging this requirement will ensure that the Health Check Scheme is seen as a required two-part process, necessary for supporting individuals in any actions or follow up to support their health and well-being. NICE Quality Standard 187 provides the quality standard for learning disability health checks.
Indicator type	Standard Quantitative

HI-01: Percentage of patients on the QOF Learning Disability register aged 14 or over, who received a learning disability Annual Health Check and have a completed Health Action Plan [suspended]	
Running period	1 April 2021 – 31 March 2022
Denominator	Number of patients on the QOF Learning Disability register aged 14 years and over.
Numerator	Of the denominator, the number who received a learning disability Annual Health Check and have a completed Health Action Plan
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	Patient refused the offer of a learning disability health check.
Desired direction	Upwards
Thresholds	49% (LT), 80% (UT)
Points	0 (was 36)
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	This IIF indicator supplements the item of service payment (£140 at the time of publishing this guidance) for annual Learning Disability health checks, which is paid as an Enhanced Service. This IIF indicator complements the 2021/22 QOF Quality Improvement Module Supporting people with Learning Disabilities which is focused on the quality of care that General Practices deliver for patients with a learning disability. PCNs should also ensure patients with a learning disability are accurately coded. Improving identification of people with a learning disability; guidance for general practice, published in October 2019, states GP practices need to review and update their register and also identify patients who may have a learning disability. The IIF supports case identification by employing a

HI-01: Percentage of patients on the QOF Learning Disability register aged 14 or over, who received a learning disability Annual Health Check and have a completed Health Action Plan [suspended]	
	prevalence adjustment and list size adjustment to Achievement Payments. The combined effect of these adjustments is to make a PCN's earning ability in respect of indicator HI-01 proportional to the number of patients on the learning disability register. Further details of these adjustments are provided in Annex A. PCNs and practices are also asked to ensure that patient's ethnicity status and their level of learning disability is recorded in the GP system. In addition to increased levels of health inequality, increasing levels of premature mortality are noted in people with a learning disability aged 18-49 from an ethnic minority. **Further Information** NHS England: Learning Disability Annual Health Checks Mencap charity: Leaflets and resources to encourage people to take up an annual health check Contact (charity): Annual health checks: Factsheet for parents Public Health England: Annual Health Checks and people with learning disabilities guidance includes evidence for an annual heath check and further resources including videos on how to complete an annual health check. RCGP Toolkit NDTI resources

HI-02: Percentage of registered patients with a recording of ethnicity [suspended]	
Rationale for inclusion	COVID-19 has highlighted and exacerbated significant health inequalities in the delivery, experience, and outcomes of care. In response, NHS England and NHS Improvement committed in Autumn 2020 to a number of short-term actions which would aim to urgently address these. One such action is to dramatically improve the recording of patient ethnicity data in primary care, to support local and national analytical work, and enable services and outreach work to be targeted at individuals and communities who may benefit most.

HI-02: Percentage of registered patients with a recording of ethnicity [suspended]	
	This indicator supports this aim by recognising PCNs for the accurate and complete recording of patient ethnicity information in clinical systems.
Indicator type	Standard Quantitative
Running period	1 October 2021 – 31 March 2022
Denominator	Total number of registered patients
Numerator	Of the denominator, the number with a recording of ethnicity on their patient record
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	None – note that, for the purposes of this indicator, a patient recorded as having chosen not to state their ethnicity after having been given the opportunity to do so will be counted as a valid recording of ethnicity (and therefore as a 'success', *not* as a Personalised Care Adjustment).
Desired direction	Upwards
Thresholds	81% (LT), 95% (UT)
Points	0 (was 45)
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	This indicator recognises PCNs for recording ethnicity information for patients for which this information is missing in GP records. Patients should not feel obligated to state their ethnicity if they prefer not to do so. In accordance with this principle, this indicator recognises PCNs for giving patients the opportunity to state their

HI-02: Percentage of registered patients with a recording of ethnicity [suspended]	
	ethnicity, irrespective of whether they choose to do so. This means that, for this indicator, the following are treated as a successful recording of ethnicity: • Ethnicity recorded as not stated (Z code in NHS Data Dictionary ethnic category field) • 1024701000000100 Ethnicity not stated • 763726001 Refusal by patient to provide information about ethnic group (situation) The NHS Data Dictionary states that "National code Z should be used where the person has been given the opportunity to state their ethnic category but chose not to." As such, it should **not** be used in situations where patient ethnicity data is simply missing or unknown.

Cardiovascular disease prevention area

5.2 The NHS Long Term Plan commits to the prevention of 150,000 strokes, heart attacks and dementia cases by 2029 through the earlier detection and treatment of cardiovascular disease (CVD) risk factors. CVD is strongly associated with health inequalities – the most deprived quintile of the population is four times more likely to die from CVD than the least deprived. Of the A, B, C of CVD risk factors (atrial fibrillation, high blood pressure, and cholesterol), hypertension (high blood pressure), has the highest level of undetected prevalence. According to modelling by Public Health England, more than 30% of hypertension cases remain undiagnosed, with the prevalence gap (difference between prevalence and diagnosis) increasing in younger age groups. This is expected to have worsened over the past year due to the impact of COVID-19 on routine blood pressure (BP) monitoring. One of the central aims of the Network Contract DES Cardiovascular Disease Prevention & Diagnosis service requirements is to facilitate actions to reduce the gap between identified and estimated prevalence in order to minimise population-level CVD risk.

CVD-01: Percentage of patients aged 18 years or over, not on the QOF Hypertension Register as of 30 September 2021, who have **(i) a last recorded blood pressure reading in the two years prior to 1 October 2021 ≥ 140/90mmHg, OR;** **(ii) a blood pressure reading ≥ 140/90mmHg on or after 1 October 2021,** **for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022 [suspended]**	
Rationale for inclusion	From October 2021 to March 2022, the Network Contract DES Cardiovascular Disease Prevention & Diagnosis service requirements will focus solely on hypertension case finding and diagnosis. An estimated 3 million people have a recorded reading of high blood pressure (BP) on GP systems, but have not had appropriate follow up to confirm or rule out a hypertension diagnosis. This issue is expected to have been exacerbated during the pandemic, which has seen a significant reduction in blood pressure readings taking place in primary care. This indicator encourages PCNs to follow up more patients with an elevated BP reading (including through proactive outreach, where possible) to assess them for hypertension, typically through provision of Ambulatory or Home Blood Pressure Monitoring.
Indicator type	Standard Quantitative
Running period	1 October 2021 – 31 March 2022
Denominator	Number of patients aged 18 years or over, not on the QOF Hypertension Register as of 30 September 2021, and who have (i) a last recorded blood pressure reading in the two years prior to 1 October 2021 ≥ 140/90mmHg or (ii) a blood pressure reading ≥ 140/90mmHg on or after 1 October 2021

CVD-01: Percentage of patients aged 18 years or over, not on the QOF Hypertension Register as of 30 September 2021, who have **(i) a last recorded blood pressure reading in the two years prior to 1 October 2021 ≥ 140/90mmHg, OR;** **(ii) a blood pressure reading ≥ 140/90mmHg on or after 1 October 2021,** **for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022 [suspended]**	
Numerator	Of the denominator, those patients for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022. Clinically appropriate follow-up includes: 1. Initial BP reading < 140/90 mmHg (only relevant for patients in (i)) OR 2. Initial BP reading ≥ 140/90 mmHg AND a. (Subsequent change of medication AND subsequent blood pressure reading of <140/90 mmHg) OR b. Subsequent occurrence of Ambulatory Blood Pressure Monitoring OR c. Subsequent occurrence of Home Blood Pressure Monitoring OR d. (Addition to QOF Hypertension Register AND same day referral for specialist assessment) OR e. (Addition to QOF Hypertension Register AND (subsequent commencement of antihypertensive therapy OR patient declined antihypertensive therapy)).
Prevalence numerator	Number of patients on the QOF Hypertension Register
Exclusions	Patients receiving end of life care
Personalised care adjustments	1. Patients included in part (ii) of the denominator with an initial elevated BP recorded between 1 October 2021 and 31 March 2022 inclusive, who are not followed up by the end of the financial year (patients will carry over to the denominator of CVD-01 in 2022/23). 2. Patient declined ambulatory/home blood pressure testing (Patient chose not to receive intervention). N.B. Patients declining a BP reading alone will **not** trigger a PCA.

CVD-01: Percentage of patients aged 18 years or over, not on the QOF Hypertension Register as of 30 September 2021, who have (i) a last recorded blood pressure reading in the two years prior to 1 October 2021 ≥ 140/90mmHg, OR; (ii) a blood pressure reading ≥ 140/90mmHg on or after 1 October 2021, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension by 31 March 2022 [suspended]	
Desired direction	Upward
Thresholds	20% (LT), 25% (UT)
Points	0 (was 53)
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	BP readings and clinical follow up can occur in general practice or in a community pharmacy and will still count towards achievement of this indicator, provided this activity is coded in GP clinical systems in accordance with the business rules. See guidance for the Network Contract DES CVD Prevention and Diagnosis service requirements for further information and advice on PCN actions to improve hypertension diagnosis. These service requirements are based on the Hypertension diagnosis and management NICE guidelines – particularly Section 1.2. The improved identification of hypertension risk will also be pursued by the Community Pharmacy Hypertension Case Finding service, which will provide increased opportunities for people to have their blood pressure managed in pharmacies.

CVD-02: Percentage of registered patients on the QOF Hypertension Register [suspended]	
Rationale for inclusion	This indicator further recognises PCNs for the hypertension diagnoses which can be expected from CVD-01 and the addition of these patients to the QOF Hypertension Register, along with the addition of other patients to the register who did not meet the requirements of CVD-01.
Indicator type	Improvement Quantitative
Running period	1 October 2021 – 31 March 2022 (but increases in QOF Hypertension Register size between 1 April and 30 September will count towards achievement)
Denominator	Total number of registered patients
Numerator	Of the denominator, the number on the QOF Hypertension Register
Prevalence numerator	Number of patients on the QOF Hypertension Register on 31 March 2021
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	0.2 percentage point increase (LT), 0.3 percentage point increase (UT)
Points	0 (was 27)
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Hypertension diagnosis can occur in general practice or as a result of blood pressure monitoring in a community pharmacy, but must be coded in GP clinical systems.

CVD-02: Percentage of registered patients on the QOF Hypertension Register [suspended]	
	This indicator recognises PCNs on the basis of improving their performance relative to a base period – in this case, PCNs will be recognised for increases in the percentage of registered patients on the QOF Hypertension Register, as compared with 31 March 2021. CVD-02 is intended as a complement to CVD-01. While CVD-01 is a process indicator recognising PCNs for undertaking actions that should lead to increased hypertension diagnosis, CVD-02 is an 'outcome' indicator that recognises PCNs for actually achieving those increased diagnoses. Thresholds for this indicator have been chosen to ensure that (i) they align with the number of new hypertension diagnoses expected to arise from achievement of CVD-01, and (ii) they do not incentivise more diagnoses than are known to be needed based on estimates of the size of the prevalence gap.

Providing high quality care domain

Access area

5.3 Improving access to general practice services is a core aim of both the NHS Long Term Plan and *Investment and Evolution*. The response of primary care to COVID-19 has also seen rapid and widespread changes in how patients access general practice services. IIF indicators in this area are designed to support improvements in access to general practice by recognising PCNs for helping more patients to access the right care, in the right place, at the right time.

ACC-02: Number of online consultation submissions received by the PCN on or after 1 January per 1000 registered patients [suspended]	
Rationale for inclusion	PCNs have been encouraged over the last few years to put in place digital access routes for patients – known as 'online consultation systems'. Having an online access route in place for patients via an online consultation system will become a contractual requirement from 1 October 2021. The purpose of

ACC-02: Number of online consultation submissions received by the PCN on or after 1 January per 1000 registered patients [suspended]	
	this indicator is to recognise PCN member practices for providing and promoting online access for those patients who choose to use it and who find it beneficial, and to recognise that effective implementation of online systems takes time and effort.
Indicator type	Binary Quantitative
Running period	1 January to 31 March 2022
Denominator	Total number of registered patients divided by 1000
Numerator	Number of online consultation submissions received by the PCN on or after 1 January
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Threshold	65 over 3 months (Single Threshold)
Points	0 (was 27)
Data source	Denominator: General Practice Extraction Service (GPES) Numerator: OCVC Collection (from OCVC suppliers)
Subject to declaration?	No – Data for this indicator will be provided on behalf of practices by Online Consultation System suppliers. If a PCN believes that their data for this indicator is incorrect, they are advised to contact their Online Consultation system supplier to query the discrepancy.
Additional information	The numerator will count all online consultation submissions received by all Core Network Practices of the PCN, irrespective of whether they relate to a clinical issue or an administrative issue. It

ACC-02: Number of online consultation submissions received by the PCN on or after 1 January per 1000 registered patients [suspended]	
	will **not** count online consultation submissions by patients registered at a Core Network Practice of the PCN that are signposted away from the practice/PCN, e.g. to NHS 111. Online access is not a replacement for other access routes and will not be suitable for all patients' needs or circumstances. Online access should, therefore, always be available alongside other access options. PCNs should agree their models of access and how their online consultation system is used alongside other access routes, taking into consideration the needs of their local community. The activity level called for by this indicator has been set at a **minimal** level, as its purpose is to demonstrate that practices in the PCN have a functioning online route to access care, for those patients that choose to use it. As such, this IIF indicator is based on a single activity threshold for online consultation submissions received by the PCN – this threshold has been set at a modest level, corresponding to five online consultation submissions received by the PCN per 1000 registered patients per week. This constitutes the minimum activity level needed to be able to demonstrate that member practices have an online access route and that patients are able to use the system to seek care or advice. To earn points in relation to this indicator, PCNs must ensure that member practices sign up to any Data Provision Notice (DPN) that may be issued in relation to the OCVC Collection that will be used to provide the numerator of this indicator. If a member practice does not sign up to any DPN that may be issued, any online consultation submissions it receives will not be provided by online consultation platform suppliers as part of this data collection, and will not therefore count towards achievement of this indicator. However, any patients registered at that practice **will** be included in the denominator of this indicator. PCNs are therefore advised to ensure that all member practices are signed up to any DPN that may be issued in relation to the OCVC Collection, so that all online consultation submissions received by the practice can be properly counted for the purposes of this indicator. **Further information** • Guidance on implementing an online consultation system: NHS England » Using online consultations in primary care: implementation toolkit.

ACC-02: Number of online consultation submissions received by the PCN on or after 1 January per 1000 registered patients [suspended]	
	• Guidance on implementing a 'total triage' process using online consultation systems: Report template - NHSI website. • Further guidance and resources are available on the Digital Primary Care - FutureNHS Collaboration Platform (requires login).

ACC-03: By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions [suspended]	
Rationale for inclusion	Reducing unnecessary A&E attendances and emergency admissions is a key Long Term Plan commitment. Strategies for achieving this aim may encompass a variety of approaches, and data analysis and planning are important to ensure efforts are appropriately directed according to local factors.
Indicator type	Qualitative
Running period	1 October 2021 to 31 March 2022
Denominator	N/A
Numerator	N/A
Prevalence numerator	N/A
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	N/A
Thresholds	N/A
Points	0 (was 56)
Data source	Manual confirmation of completion via CQRS

ACC-03: By 31 March 2022, analyse and discuss the implications of data on Type 1 A&E attendance rates for minor conditions with the local ICS, making a plan to reduce unnecessary attendances and admissions [suspended]	
Subject to declaration?	Yes
Additional information	The plan developed in fulfilment of the requirements of this indicator should take the form of a written document prepared by the PCN with input from all member practices, submitted to their CCG. The plan should cover the following areas: 1. Ensuring that local services are comprehensively mapped and accurately recorded in the Directory of Services. • This should include (but not be limited to) the following services: Urgent Community Response (UCR), Urgent Treatment Centres (UTC), Mental Health crisis and community services, Falls services, Social Care. 2. Ensuring that current activity and referral pathways are fully understood and documented for all services. 3. Making use of all available demand and capacity tools in order to understand the gap between current capacity and demand. 4. Identifying optimal service provision on a cross-PCN / ICS wide footprint.

ACC-04: Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacist Consultation Service, with referral levels increasing by no later than 31 March 2022 [suspended]	
Rationale for inclusion	The Community Pharmacist Consultation Service (CPCS) was launched in 2019 to integrate community pharmacy into provision of local NHS urgent care services. The CPCS provides a mechanism for patients to be referred either by NHS111 or by general practice to community pharmacy for minor illness. It provides patients with more convenient treatment closer to home by connecting them with the skills and medicines knowledge of pharmacists, which can in turn alleviate pressure on GP appointments and emergency departments. This preparatory indicator recognises PCNs for engaging with their local community pharmacies and agreeing a plan to either begin or increase referrals to CPCS. PCNs are asked to have a plan in place with referrals increasing by no later than 31 March 2022. From 1 April 2022, a new indicator will be introduced

ACC-04: Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacist Consultation Service, with referral levels increasing by no later than 31 March 2022 [suspended]	
	which recognises PCNs for making an increased number of referrals to CPCS within the 2022/23 financial year.
Indicator type	Qualitative
Running period	1 October 2021 to 31 March 2022
Denominator	N/A
Numerator	N/A
Prevalence numerator	N/A
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	N/A
Thresholds	N/A
Points	0 (was 56)
Data source	Manual confirmation of completion via CQRS
Subject to declaration?	Yes
Additional information	PCNs are encouraged to consult this toolkit for GP and PCN staff. It is a practical guide on how patients can be referred from general practice to community pharmacy via CPCS. Full details of the CPCS, including an Advanced Service specification, can be found here. The plan developed in fulfilment of the requirements of this indicator should take the form of a written document prepared by the PCN with input from all member practices, submitted to their

ACC-04: Work collaboratively with local community pharmacy colleagues to develop and commence delivery of a plan to increase referrals to the Community Pharmacist Consultation Service, with referral levels increasing by no later than 31 March 2022 [suspended]	
	CCG. When developing and agreeing this plan, PCNs and community pharmacies may want to consider the following areas: • The structure and geography of pharmacies and PCNs in the local area • Who within PCNs and community pharmacies should lead on implementation • Digital availability in the local area – more details on digital referral opportunities can be found on the PCN NHS Futures page here. • How practice teams will be trained to deliver the referral pathway. • Having a process in place where any incidents related to patient safety, near misses, or problems with the referral process or operational issues will be raised, investigated and mitigated in future. • How referral volumes will increase by 31 March.

ACC-05: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups [suspended]	
Rationale for inclusion	This indicator will recognise PCNs for taking steps to improve access to general practice for patient groups who have historically experienced poor access. It will support preparation for commencement of the new patient experience survey, which will measure patient experience of access to general practice.
Indicator type	Qualitative
Running period	1 October 2021 to 31 March 2022
Denominator	N/A
Numerator	N/A

ACC-05: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups [suspended]	
Prevalence numerator	N/A
Exclusions	N/A
Personalised care adjustments	N/A
Desired direction	N/A
Thresholds	N/A
Points	0 (was 56)
Data source	Manual confirmation of completion via CQRS
Subject to declaration?	Yes
Additional information	This indicator asks that, by 31 March 2022, PCNs should make use of the 2020/21 General Practice Patient Survey (GPPS) results for member practices to (i) identify patient groups experiencing inequalities in their experience of access to general practice, and (ii) develop and implement a plan to improve access for these patient groups. We particularly suggest that PCNs review the following GPPS questions, as well as considering feedback directly from their patient population: • Q16 – why patients who wanted an appointment did not receive one • Q19 – patients who avoided making an appointment • Q20 – patients' overall experience of making an appointment • Q30 – overall experience This plan should take the form of a written document prepared by the PCN with input from all member practices, submitted to their CCG that states the patient groups being targeted and sets out a plan for improving access for these patient groups. Progress will contribute to reducing health inequalities and improving patient experience, which will be measured by a new real time measure

ACC-05: By 31 March 2022, make use of GP Patient Survey results for practices in the PCN to identify patient groups experiencing inequalities in their experience of access to general practice, and develop and implement a plan to improve access for these patient groups [suspended]	
	of patient experience, derived from the new patient experience survey in 2022/23.

Personalised care area

5.3 Personalised care is one of the five major practical changes to the NHS service model set out in the NHS Long Term Plan. The Long Term Plan commits to (i) rolling out the NHS Personalised Care model across the country, reaching 2.5 million people by 2023/24 and then aiming to double that again within a decade; (ii) widening, diversifying and making more accessible the range of support available to people across the country; (iii) ensuring the delivery of person-centred care; and (iv) expanding the choice and control that people have over the care that they receive.

PC-01: Percentage of registered patients referred to social prescribing [suspended]	
Rationale for inclusion	Social prescribing is one of six key components of the NHS England comprehensive model for personalised care, and is a way for primary care staff and local agencies to refer people to a link worker. Social Prescribing Link Workers give people time to talk and focus on what matters to them as a person, as identified through shared decision-making or personalised care and support planning. They connect people to community groups and agencies for practical and emotional support. In the context of COVID-19, and ongoing self-isolation for some individuals, provision of high-quality social prescribing services can help prevent loneliness, or worsening physical health for at risk individuals. The NHS Long Term Plan commits to achieving 900,000 social prescribing referrals by 2023/24. To help deliver this ambition, the Update to the GP contract agreement 2020/21-2023/24 states that each PCN must provide access to a social prescribing service from 2020/21. Funding for employment of social prescribing link workers has been available to PCNs via the Additional Roles Reimbursement Scheme since April 2019.

PC-01: Percentage of registered patients referred to social prescribing [suspended]	
Indicator type	Standard Quantitative
Running period	1 April 2021 – 31 March 2022
Denominator	Total number of registered patients
Numerator	Of the denominator, the number referred to a social prescribing service
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	None
Desired direction	Upwards
Thresholds	0.8% (LT), 1.2% (UT)
Points	0 (was 20)
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	Please note: Where a valid referral has been made (i.e. to a social prescribing service provided in fulfilment of the Network Contract DES requirements relating to social prescribing), the following SNOMED code should be used: • 871731000000106 | Referral to social prescribing service (procedure) This indicator **only** counts referrals made to a social prescribing service**,** as captured by the SNOMED code provided above. This SNOMED code, denoting referral to a social prescribing service, should be used even when the social prescribing service is provided within the practice or PCN – e.g. if a Social Prescribing Link Worker is employed under the Additional Roles

PC-01: Percentage of registered patients referred to social prescribing [suspended]	
	Reimbursement Scheme. In this case, the referral is internal to the practice/PCN, but it is still a referral to a distinct service. This indicator does **not** count **offers** of social prescribing because it is necessary to know whether the offer has been accepted. It therefore only counts completed **referrals** to a social prescribing service. The purpose of this indicator is to count referrals to a service, **not** unique patient contacts. As such, this indicator does not count recording (by any means) of unique patient contacts by Social Prescribing Link Workers or any other type of health care professional (e.g. Care Coordinators or Health and Wellbeing Coaches). **Further Information** Welcome and induction pack for link workers in PCNs. NHS England: Social prescribing Reference guide for PCNs – information on setting up social prescribing services, including support for recruitment, induction and supervision. This guide also outlines quality assurance measures and explains how to gather information to develop a consistent evidence base for social prescribing. NHS England: Summary guide – describes what a good social prescribing scheme looks like, and includes a common outcomes framework to help measure the impact of social prescribing on people, the local system and the voluntary and community sector. Future NHS Social Prescribing Workspace – a space for social prescribing link workers and PCNs to access resources and updates about social prescribing, including national webinars, case studies, forums and contacts for local peer support and development opportunities. Social Prescribing - e-Learning – programme hosted by E-learning for Health and Health Education England aimed at link workers in PCNs.

Enhanced health in care homes area

5.4 The Enhanced Health in Care Homes (EHCH) Vanguards programme demonstrated that outcomes for care home residents can be improved by provision of a coordinated care model delivering clinical support in care

homes. The NHS Long Term Plan committed in 2019 to rolling out this framework across England between 2020 and 2024.

5.5 The Network Contract DES Enhanced Health in Care Homes Service Requirements embed this framework into the clinical support provided for care homes by PCNs. Indicators in this area support the implementation of the EHCH service requirements by recognising PCNs for strong delivery of key elements of the care model.

EHCH-01: Number of patients aged 18 years or over and recorded as living in a care home, as a percentage of care home beds eligible to receive the Network Contract DES Enhanced Health in Care Homes service [suspended]	
Rationale for inclusion	The successful delivery of the Enhanced Health in Care Homes service by PCNs requires the accurate and complete recording of care home resident status in GP systems. However, a significant number of care home residents in England are not recorded as being care home residents in GP clinical systems. This indicator recognises PCNs for more completely recording resident occupancy in care homes which are aligned to them.
Indicator type	Standard Quantitative
Running period	1 October 2021 – 31 March 2022
Denominator	Number of care home beds aligned to the PCN and eligible to receive the Network Contract DES Enhanced Health in Care Homes service, as reflected in the calculation of the care home bed premium.
Numerator	Number of patients aged 18 years or over and recorded as living in a care home (including a residential home or nursing home, and including both permanent and temporary residents)
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	None

EHCH-01: Number of patients aged 18 years or over and recorded as living in a care home, as a percentage of care home beds eligible to receive the Network Contract DES Enhanced Health in Care Homes service [suspended]	
Desired direction	Upwards
Thresholds	30% (LT), 85% (UT)
Points	0 (was 18)
Data source	Denominator: Manual submission via the Calculating Quality Reporting Service (CQRS) Numerator: General Practice Extraction Service (GPES)
Subject to declaration?	Yes
Additional information	The denominator of this indicator will be populated by manual submission via CQRS of the number of care home beds for which the PCN is paid the care home bed premium, as defined in the Network Contract DES. The numerator of this indicator will count the number of registered patients aged 18 years or over and recorded as living in a care home by looking for the presence of one of the following four SNOMED codes: • 160734000 Living in nursing home • 394923006 Living in residential home • 248171000000108 Lives in care home (finding) • 1240291000000104 Living temporarily in care home (finding) The first three codes can have been added at any point in the past, provided that no alternative code has since been added denoting that the patient is no longer a care home resident. The fourth code must have been added in the previous twelve months.

EHCH-02 & EHCH-03: Delivery of Network Contract DES Enhanced Health in Care Homes Service Requirements [suspended]	
Rationale for inclusion	These indicators recognise PCNs for strong delivery of key elements of the Network Contract DES EHCH service requirements, namely Personalised Care and Support Plans (PCSPs) and Structured Medication Reviews (SMRs).

EHCH-02 & EHCH-03: Delivery of Network Contract DES Enhanced Health in Care Homes Service Requirements [suspended]		
Indicator type	Standard Quantitative	
Running period	1 October 2021 – 31 March 2022 (but PCSPs and SMRs delivered between 1 April 2021 and 30 September 2021 will count towards achievement)	
Indicator	Percentage of care home residents aged 18 years or over who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	Percentage of permanent care home residents aged 18 years or over who received a Structured Medication Review
Denominator	Number of care home residents aged 18 years or over	Number of permanent care home residents aged 18 years or over
Numerator	Of the denominator, the number who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	Of the denominator, the number who received a Structured Medication Review
Prevalence numerator	Indicator denominator	Indicator denominator
Exclusions	Patients not living in care home at end of reporting period	
Personalised care adjustments	Patient chose not to receive the intervention Registration with general practitioner practice aligned to care home declined Care home residents are eligible to receive the additional support provided via Network Contract DES Enhanced Health in Care Homes service when they are registered at a practice that is part of the PCN that their care home is aligned to. When a care home resident is registered at a practice that is part of a different PCN, they should be offered the opportunity to re-register at a practice that is part of the PCN that their care home is aligned to. If they decline this offer, they are not eligible to receive this additional support and a Personalised Care Adjustment may be recorded by application of the above SNOMED code to their patient record at the general practice of registration.	

EHCH-02 & EHCH-03: Delivery of Network Contract DES Enhanced Health in Care Homes Service Requirements [suspended]		
Desired direction	Upwards	
Thresholds	80% (LT), 98% (UT)	80% (LT), 98% (UT)
Points	0 (was 18)	0 (was 18)
Data source	General Practice Extraction Service (GPES)	
Subject to declaration?	Yes	
Additional information	Information and best practice advice guidance for the delivery these interventions can be found in the full guidance for the Network Contract DES EHCH Service Requirements. Further advice can also be found here: • Care Provider Alliance: EHCH - A guide for care homes. • Animation: "The care home weekly round: What does good look like?"	

EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident aged 18 years or over [suspended]	
Rationale for inclusion	Provision of a weekly care home round lies at the heart of the Network Contract DES EHCH service requirements. This indicator will recognise delivery of the weekly care home round, as recorded in practice appointment books.
Indicator type	Standard Quantitative
Running period	1 October 2021 – 31 March 2022
Denominator	Number of care home residents aged 18 years or over
Numerator	Number of appointments on or after 1 October with a slot type mapped to the "Patient contact as part of weekly care home round" appointment category and with Status of "Attended", "Booked" or "Did Not Attend"

EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident aged 18 years or over [suspended]	
Prevalence numerator	Indicator denominator
Exclusions	None
Personalised care adjustments	Registration with general practitioner practice aligned to care home declined • See EHCH-02 and EHCH-03 for further information about this Personalised Care Adjustment. • As EHCH-04 uses a different data source for the numerator and the denominator, this indicator does not apply the usual principle of Personalised Care Adjustments (PCAs), by which patients are retained in the denominator if they receive the intervention in question. Rather, care home residents to whom this PCA is applied are subtracted from the denominator, irrespective of the extent to which they have received the intervention in question.
Desired direction	Upwards
Thresholds	Mean of 3 patient contacts per care home resident over 6 months (LT), Mean of 4 patient contacts per care home resident over 6 months (UT)
Points available	0 (was 13)
Data source	Denominator: General Practice Extraction Service (GPES) Numerator: General Practice Appointments Data (GPAD)
Subject to declaration?	Yes
Additional information	A new set of national appointment categories was announced in March 2021 – one of these categories is "Patient contact as part of weekly care home round". In 2021/22, IIF indicator ACC-01 recognises PCNs for mapping appointment slot types to these new national categories, as well as for confirming compliance with the August 2020 guidance on *More accurate general practice appointment data*, published by NHS England and NHS Improvement and the British Medical Association. A key principle

EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident aged 18 years or over [suspended]	
	of the August 2020 guidance is that each patient contact should be recorded as a separate appointment. This indicator builds on these improvements in the quality of general practice appointment data by recognising PCNs for delivery of the weekly care home round, as captured by the number of appointments that are mapped to the "Patient contact as part of weekly care home round" appointment category. This category should only be used to record patient-facing contacts – it should not be used, for example, to record instances where a patient is discussed at a Multi-Disciplinary Team meeting when the patient is not present. The thresholds for this indicator have been calculated based on the expected number of patient-facing contacts that will occur as part of the weekly care home round over a six month period. This indicator will count any appointment mapped to the "Patient contact as part of weekly care home round" category, irrespective of appointment mode – the appointment need not necessarily be face-to-face. Any appointment with the status "Attended", "Booked" or "Did Not Attend" will be counted towards the numerator of this indicator. No age restrictions are applied to the indicator, even though the denominator only counts care home residents aged 18 years or over. It is recognised that different patients have different needs – there is no expectation that each individual patient should receive a particular number of contacts as part of the weekly care home round. To reflect this recognition, the numerator for this indicator will be calculated by adding up all the appointments delivered as part of a weekly care home round, across all care home residents. Signing up to the GPAD Data Provision Notice (DPN) has since October 2020 been a core GMS contractual requirement. If a practice is signed up to the Network Contract DES but is not signed up to the GPAD DPN, any patient contacts recorded in its appointment books will not be extracted as part of the GPAD collection, and will not therefore count towards achievement of this indicator. However, any patients registered at that practice and recorded as living in a care home **will** be included in the denominator of this indicator. PCNs are therefore advised to ensure that all member practices are signed up to the GPAD DPN, so that all patient contacts delivered as part of weekly care home rounds are properly counted for the purposes of this indicator.

EHCH-04: Mean number of patient contacts as part of weekly care home round on or after 1 October per care home resident aged 18 years or over [suspended]	
	Further information In addition to the PCN Dashboard discussed in paragraphs 2.22 and 2.23 above, a breakdown of appointment volumes by each of the new appointment categories will be made available via an interactive General Practice Appointments Data (GPAD) private dashboard hosted by NHS Digital. This private dashboard will display a range of appointment data to practices and PCNs, with access to be controlled via the user's NHS smartcard. Practice-level appointment data has been available since September 2021, with PCN-level appointment data to be made available in Autumn 2021. Click here for a user guide to the NHS Digital GPAD private dashboard, which contains details on how to obtain access; for further information, email ssd.nationalservicedesk@nhs.net.

A sustainable NHS domain

Inhalers area

5.6 Medicines account for 25% of emissions within the NHS.

5.7 Inhalers alone are responsible for 3% of the NHS carbon footprint. Most of these emissions come from the propellants used in metered dose inhalers (MDIs) to deliver the medicine, rather than the medicine itself. Optimising the choice of inhaler, as part of a shared decision making conversation between the patient and the clinician, can play a significant role in achieving the NHS net zero target.

ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over on or after 1 October [suspended]	
Rationale for inclusion	People with asthma (3.9 million)[3] are the largest patient group using MDIs in England. Patterns observed in other healthcare systems across the world demonstrate that it is possible to significantly reduce the use of MDIs, and therefore the

[3] QOF 2019/20.

ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over on or after 1 October [suspended]	
	associated carbon emissions, while maintaining high standards of care. Dry Powder Inhalers (DPI) and Soft Mist Inhalers (SMIs), for example, offer a lower-carbon clinical alternative to MDIs. For most patients, MDIs do not confer any additional clinical advantages over DPIs. This indicator recognises PCNs for a reduction in the number of MDI prescriptions, as a percentage of all non-salbutamol inhaler prescriptions.
Indicator type	Standard Quantitative
Running period	1 October 2021 – 31 March 2022
Denominator	Number of non-salbutamol inhaler prescriptions issued to patients aged 12 years or over on or after 1 October
Numerator	Of the denominator, the number of Metered Dose Inhaler (MDI) prescriptions
Prevalence numerator	Indicator denominator
Exclusions	Prescriptions to patients to whom the “Dry powder inhaler not indicated” SNOMED code has been applied
Personalised care adjustments	None – but note that “Dry powder inhaler not indicated” will function similarly to a “not clinically suitable” PCA.
Desired direction	Downwards
Thresholds	53% (LT), 44% (UT)
Points	0 (was 27)
Data source	General Practice Extraction Service (GPES)
Subject to declaration?	Yes

ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over on or after 1 October [suspended]	
Additional information	It is important that any decision to change a patient's asthma inhaler is clinically appropriate and done as the outcome of a shared decision-making conversation. Moving a patient from an MDI to an alternative type of inhaler may not be appropriate for some patients and may disrupt disease control or threaten their safety. Good inhaler technique is essential for inhaler treatment to be effective, irrespective of the type of device. Appropriate training and regular technique checks are required to ensure patients use their inhaler optimally and maximise the benefit of their medication. This is especially important when patients are prescribed a different type of inhaler. Feedback, to be published later in the year, suggests that the majority of asthma patients using MDIs would change device for environmental reasons so long as the new inhaler was efficacious, easy to use and fitted their current routine, and that they could change back if needed. Additional guidance and advice will therefore be provided alongside rollout of this indicator to support shared decision making and patient choice of inhaler. Pharmacies will be actively encouraging return of unwanted or used inhalers for more sustainable disposal and can provide a New Medicine Service consultation focused on improved adherence and an inhaler technique check for patients who are prescribed an inhaler for the first time, or who are changing or have changed to a new inhaler device during the pandemic. **Further information for clinicians** • Further resources are available in the "Tools & Resources" section of the Greener NHS programme's FutureNHS workspace: https://future.nhs.uk/sustainabilitynetwork (for any access queries, please email sustainabilitynetwork-manager@future.nhs.uk). • NICE: Patient decision aid • RightBreathe: Information for clinicians on different kinds of inhalers • Primary Care Respiratory Society: Position statement on the environmental impact of inhalers • British Thoracic Society Position Statement: The environment and lung health • UK Inhaler Group: Inhaler standards and competency document: Guidance on optimal inhaler technique

ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over on or after 1 October [suspended]	
	Further information for patients Asthma UK & British Lung Foundation • What does good asthma control look like? • Your personalised asthma action and support plan • Asthma review: Guidance on how to use your inhaler most effectively, tailored to your device

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e) [suspended]	
Rationale for inclusion	Salbutamol Metered Dose Inhalers (MDIs) are the single biggest source of carbon emissions from NHS medicines prescribing. Where a salbutamol inhaler is required, this indicator encourages PCNs to consider prescribing a lower carbon option. This does not necessarily mean changing the type of inhaler that the patient receives (e.g. MDI to Dry Powder Inhaler or DPI), since different salbutamol MDI inhalers can have different carbon emissions. If an MDI is required for the patient, for instance because a DPI is not indicated, prescribing a lower carbon salbutamol MDI will reduce overall carbon emissions from salbutamol inhalers without compromising patient safety or disease control. A table providing the manufacturer-reported or estimated whole lifecycle carbon emissions from each type of salbutamol inhaler is provided below. This table will be used to calculate the numerator of this indicator and can therefore be used by PCNs as a guide to what they can do to reduce the carbon intensity of their salbutamol prescribing.
Indicator type	Standard Quantitative
Running period	1 October 2021 – 31 March 2022
Denominator	Number of salbutamol inhalers prescribed on or after 1 October
Numerator	Total carbon emissions from all inhalers in the denominator (kg CO_2e)

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e) [suspended]	
Prevalence numerator	Number of patients prescribed salbutamol inhalers on or after 1 October 2021
Exclusions	None
Personalised care adjustments	None
Desired direction	Downward
Thresholds	25.1 kg CO_2e (LT), 22.1 kg CO_2e (UT)
Points	0 (was 27)
Data source	Business Services Authority (BSA) prescribing data, combined with manufacturer-reported or estimated carbon emissions from each type of salbutamol inhaler, compiled by a manufacturer survey and literature review conducted by PrescQIPP.
Subject to declaration?	No – PCNs who believe that ES-02 data collected in respect of them is incorrect are advised to consult the following link, which provides further information about how they may pursue any queries or concerns they have about BSA prescribing data collected in respect of them (see final paragraph of webpage): • https://www.nhsbsa.nhs.uk/prescription-data/understanding-our-data/prescription-requests
Additional information	The numerator of this indicator will be calculated by multiplying the number of each inhaler type prescribed, by the carbon emissions per inhaler for that inhaler type. For example, if a PCN only prescribes two inhaler types, A and B, then Numerator = Count of inhaler A × Emissions per inhaler A + Count of inhaler B × Emissions per inhaler B The following table shows the variation in estimated life cycle carbon emissions for different salbutamol inhaler types, based on a manufacturer survey and literature review conducted by PrescQIPP, and commissioned by NHS England and NHS Improvement. Life cycle inhaler emissions include propellant emissions as well as emissions from all other stages in the

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e) [suspended]

product life cycle (e.g. transportation, energy and water use, and waste disposal). These estimates are based on manufacturer survey responses where available, and on information in the literature where survey responses were not provided – see below links for further information. These estimated inhaler carbon emissions values will be combined with BSA prescribing data to calculate the ES-02 indicator numerator.

Prescribing term	Carbon emissions per inhaler (kg CO_2e)
Airomir 100 microgram	9.72
Airomir Autohaler 100 microgram	9.72
Easyhaler Salbutamol 100 microgram	0.62
Easyhaler Salbutamol 200 microgram	0.62
Salbutamol CFC free breath actuated inhaler 100 microgram (GENERIC)	11.79
Salbutamol CFC free Inhaler 100 microgram (GENERIC)	25.24
Salamol CFC-Free Inhaler 100 microgram	11.95
Salamol Easi-Breathe 100 microgram	12.08
Salbulin Novolizer 100 microgram	3.75
Ventolin Accuhaler 200 microgram	0.58
Ventolin Evohaler 100 microgram	28.26

This table contains two entries for generic salbutamol MDI prescribing – one for a breath-actuated MDI (BAI) ("Salbutamol CFC free breath actuated inhaler 100 microgram"), and the other for a conventional pressurised MDI (pMDI) ("Salbutamol CFC free Inhaler 100 microgram").

As it is not currently possible to know which inhaler is dispensed each time a generic salbutamol inhaler is prescribed, carbon emissions associated with generic salbutamol prescribing have been inferred based on IQVIA data which indicates that:

- When a generic salbutamol pMDI is prescribed ("Salbutamol CFC free Inhaler 100 microgram"):

ES-02: Mean carbon emissions per salbutamol inhaler prescribed on or after 1 October (kg CO_2e) [suspended]	
	• Ventolin Evohaler 100 microgram is dispensed 81.5% of the time. • Salamol CFC-Free Inhaler 100 microgram is dispensed 18.4% of the time. • Airomir 100 microgram is dispensed 0.1% of the time. • When a generic salbutamol BAI is prescribed ("Salbutamol CFC free breath actuated inhaler 100 microgram"): • Airomir Autohaler 100 microgram is dispensed 12.5% of the time. • Salamol Easi-Breathe 100 microgram is dispensed 87.5% of the time. We use this information to impute a carbon intensity to generic salbutamol MDI prescribing, as a weighted average of the carbon intensities of the inhalers that tend to be dispensed when generic salbutamol MDI is prescribed, i.e. • Carbon intensity of generic salbutamol pMDI prescribing = . (28.26 × 81.5%) + (11.95 × 18.4%) + (9.72 × 0.1%) = 25.24 kg • Carbon intensity of generic salbutamol BAI prescribing = . (12.08 × 87.5%) + (9.72 × 12.5%) = 11.79 kg The calculation of these weighted averages will be reviewed annually. **Further information** Click here for further PrescQIPP respiratory care resources and materials. Click here for a direct link to the PrescQIPP inhaler carbon emissions data and resources to support lowering the inhaler carbon footprint.

Annex A: Prevalence adjustment and list size adjustment

A.1 This annex explains why a prevalence adjustment (for Quantitative indicators) and list size adjustment are applied when calculating IIF achievement payments, as well as explaining how they are calculated. Further details about calculation of these adjustments are provided in Annex C of the 2021/22 Network Contract DES specification.

Prevalence adjustment

A.2 Prevalence refers to the percentage of a population affected by a given disease or condition. We use this concept to define a generalised 'prevalence' concept for every Quantitative IIF indicator, equal to a prevalence numerator divided by the number of registered patients at the PCN. The prevalence numerator will usually, but not always, be equal to the indicator denominator (the denominator may be a count of eligible patients or a count of interventions e.g. medications delivered to a set of eligible patients). For instance, for indicator VI-01 prevalence is equal to the percentage of a PCN's patients who are aged 65 and over.

A.3 Consider two PCNs that are identical other than one has twice as many patients aged 65 and over. This would mean that PCN has to deliver twice as many seasonal influenza vaccinations to earn the same number of points. Applying a prevalence adjustment compensates that PCN for the extra effort required to earn a given number of points (i.e. achieve a given percentage point improvement in performance).

A.4 An example where the prevalence numerator is not equal to the indicator denominator is ES-02. For ES-02, the indicator denominator is a count of salbutamol inhalers prescribed, whereas the prevalence numerator is a count of the number of patients prescribed salbutamol inhalers. If ES-02 prevalence had been defined using the indicator denominator, this would have made earnings ability proportional to the number of salbutamol inhalers prescribed, which would be contrary to the clinical and environmental policy objectives of reducing unnecessary salbutamol prescribing.

A.5 The prevalence adjustment for an indicator is equal to PCN prevalence divided by national prevalence. For instance, if 20% of the residents of

England registered at practices signed up to the Network Contract DES are aged 65 and over, then a PCN with 30% of registered patients aged 65 and over would have a prevalence adjustment of 1.5 – that is, it would be paid 50% more for each additional achievement point than an otherwise identical PCN with a prevalence equal to the national average prevalence.

A.6 The target cohort for some indicators is the total number of patients registered in the PCN e.g. PC-01. In this case, the denominator equals the PCN list size, and when prevalence is defined as being equal to the indicator denominator, prevalence (denominator divided by PCN list size) is equal to one for all PCNs. As prevalence is equal to one for all PCNs, national average prevalence for this indicator is also equal to one. Therefore, effectively there is no prevalence adjustment for these indicators.

A.7 As well as making payments more proportional to effort, applying a prevalence adjustment also encourages appropriate case finding for indicators whose denominator is under the control of the PCN. Consider indicator HI-01, the denominator for which is the number of patients on the learning disability register aged 14 and over. PCNs and their constituent practices are responsible for adding patients to this register. The prevalence adjustment encourages efforts to identify patients with a Learning Disability and to add them to the register, as case finding increases earnings ability.

List size adjustment

A.8 The list size adjustment is based on a similar principle to the prevalence adjustment. If two PCNs are identical (including having identical prevalence for every IIF indicator) other than one has double the list size, that PCN would have to change its treatment of twice as many patients to earn the same number of points. The list size adjustment compensates larger PCNs for this situation by making the payment per achievement point proportional to list size.

A.9 Formally, the list size adjustment for a PCN is equal to the PCN list size divided by the national average PCN list size (i.e. the total number of patients registered that are a Core Network Practices that are part of a PCN, divided by the total number of PCNs). Thus, if the national average PCN list size is 47,000 and a PCN has 94,000 patients, that PCN's list size adjustment would be 2. In other words, that PCN would be paid twice as

much for each additional achievement point as an otherwise identical PCN with a list size equal to the national average.

Summary

A.10 The net effect of applying a prevalence adjustment (for Quantitative indicators) and a list size adjustment is to make payment proportional to the amount of activity undertaken (e.g. number of patients treated). The effort required to deliver one unit of activity is not fixed, but may vary according to patient demographics, socio-economic status and other characteristics. Likewise, there may be economies of scale, so that treating 200 patients does not require twice as much effort as treating 100 patients. Thus, applying a prevalence adjustment and a list size adjustment does not ensure an exact correspondence between effort and reward, but does bring the two closer together.

Annex B: The IIF in 2022/23

B.1 To provide clarity on the onward trajectory of the Investment and Impact Fund and wider Network Contract DES after 2021/22, NHS England and NHS Improvement has published details of the thresholds and valuations for the IIF indicators expected to run in 2022/23.

B.2 The addition of new indicators to the scheme, and the increase in value of many indicators rolled over from April 2022, brings total funding for the IIF to £225 million in 2022/23. This will increase further to at least £300 million in 2023/24.

B.3 The following table summarises details of the scheme in 2022/23.

Objective 1: Improve prevention and tackle health inequalities			
Indicator	Thresholds	Value	Source
HI-01: Percentage of patients on the Learning Disability register aged 14 years or over, who received an annual Learning Disability Health Check and have a completed Health Action Plan	60% (LT), 80% (UT)	£8.1m / 36 pts	GPES
VI-01: Percentage of patients aged 65 years or over who received a seasonal influenza vaccination between 1 September and 31 March	80% (LT), 86% (UT)	£9.0m / 40 pts	GPES
VI-02: Percentage of at-risk patients aged 18 to 64 years inclusive who received a seasonal influenza vaccination between 1 September and 31 March[4]	57% (LT), 90% (UT)	£19.8m / 88 pts	GPES
VI-03: Percentage of patients aged two or three years on 31 August of the relevant financial year who received a seasonal influenza vaccination between 1 September and 31 March	45% (LT), 82% (UT)	£3.2m 14 pts	GPES

[4] Including the following at-risk groups eligible for a free influenza vaccination:
Chronic respiratory disease; Chronic heart disease; Chronic kidney disease; Chronic liver disease; Chronic neurological disease; Learning disabilities (as captured by being on the QOF Learning Disability register); Diabetes; Immunosuppression; Asplenia or dysfunction of the spleen; Morbidly obese; People in long stay residential or homes.
Excluding the following at-risk groups eligible for a free influenza vaccination, on the basis that membership of these groups is not reliably recorded in GP systems:
Pregnant women; Household contact of immunocompromised individual; Household contact of person on NHS shielded patient list; Social care worker; Hospice worker.

CVD-01: Percentage of patients aged 18 or over with an elevated blood pressure reading (≥ 140/90mmHg)[5] and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up[6] to confirm or exclude a diagnosis of hypertension	25% (LT), 50% (UT)	£16.0m / 71 pts	GPES
CVD-02: Percentage of registered patients on the QOF Hypertension Register	Increase 0.6pp (LT), Increase 1.2pp (UT)	£7.9m / 35 pts	GPES
CVD-03: Percentage of patients aged between 25 and 84 years inclusive and with a CVD risk score (QRISK2 or 3) greater than 20 percent, who are currently treated with statins	48% (LT), 58% (UT)	£7.0m / 31pts	GPES
CVD-04: Percentage of patients aged 29 and under with a total cholesterol greater than 7.5 OR aged 30 and over with a total cholesterol greater than 9.0 who have been referred for assessment for familial hypercholesterolaemia	20% (LT), 48% (UT)	£4.1m / 18 pts	GPES

Objective 2: Support better patient outcomes in the community through proactive primary care			
Indicator	Thresholds	Value	Source
PC-01: Percentage of registered patients referred to a social prescribing service	1.2% (LT), 1.6% (UT)	£4.5m / 20 pts	GPES
EHCH-02: Percentage of care home residents aged 18 years or over, who had a Personalised Care and Support Plan (PCSP) agreed or reviewed	80% (LT), 98% (UT)	£4.1m / 18 pts	GPES
EHCH-04: Mean number of patient contacts as part of weekly care home round per care home resident aged 18 years or over	6 (LT), 8 (UT)	£2.9m / 13 pts	GPAD/ GPES
EHCH-06: Standardised number of emergency admissions per 100 care home residents aged 18 years or over	Improvement: Reduction of 0 (LT), 4 (UT)	£6.1m / 27 pts	HES-SUS APC / GPES

[5] Either (i) a last recorded blood pressure reading in the two years prior to 1 April 2022 ≥ 140/90mmHg, or (ii) a blood pressure reading ≥ 140/90mmHg on or after 1 April 2022.
[6] Occurrence of one of the following within six months of 1 April 2022 (cohort (i)) or the first elevated blood pressure reading after 1 April 2022 (cohort (ii)): Ambulatory Blood Pressure Monitoring; Home Blood Pressure Monitoring; Change of medication followed by subsequent non-elevated reading; Same-day referral for treatment; Commencement of anti-hypertensive therapy.

	Absolute: 30 (LT), 20 (UT)		
AC-02: Standardised number of emergency admissions for specified Ambulatory Care Sensitive Conditions[7] per 1000 registered patients	Improvement: Reduction of 0 (LT), 1 (UT) Absolute: 10 (LT), 8 (UT)	£25.0m / 111 pts	HES-SUS APC / GPES

Objective 3: Support improved patient access to primary care services			
Indicator	Thresholds	Value	Source
ACC-06: Standardised percentage of survey respondents indicating that it was "easy" or "very easy" for them to make a general practice appointment, or to seek medical care or advice from their general practice	35th (LT), 65th (UT) percentile of performance from piloting	£25.0m / 111 pts	Patient experience survey
ACC-02: Number of online consultation submissions received by the PCN per 1000 registered patients	**TBC**	£4.1m / 18 pts	OCVC Extended Collection / GPES
ACC-07: Specialist Advice utilisation rate (number of Specialist Advice requests per 100 outpatient first attendances) across twelve specialties[8] identified for accelerated delivery	6.6 (LT), 19 (UT)	£9.9m / 44 pts	System Elective Recovery Outpatient Collection / HES-SUS OP
ACC-08: Percentage of patients who had to wait two weeks or less for a general practice appointment	90% (LT), 98% (UT)	£16.0m / 71 pts	GPAD
ACC-09: Number of referrals to the Community Pharmacist Consultation Service per 1000 registered patients	34 (single threshold)	£6.1m / 27 pts	GPES

[7] ACSCs in scope: COPD, Diabetes complications, Convulsions and Epilepsy, Asthma, Congestive Heart Failure, Hypertension, Influenza and Pneumonia, Ear Nose and Throat Infections, Pyelonephritis, Cellulitis.
[8] Cardiology, Dermatology, Gastroenterology, Gynaecology, Neurology, Urology, Paediatrics, Endocrinology, Haematology, Rheumatology, Respiratory, Ear, Nose and Throat.

Objective 4: Deliver better outcomes for patients on medication			
Indicator	Thresholds	Value	Source
SMR-01: Percentage of patients eligible to receive a Structured Medication Review who received a Structured Medication Review	**TBC**	£12.0m / 53 pts	GPES
SMR-02A: Percentage of patients aged 18 years or over prescribed both a Non-Steroidal Anti-Inflammatory Drug (NSAID) and an oral anticoagulant in the 3 months to 1 April 2022, who in the 3 months to 1 April 2023 were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to both an NSAID and an oral anticoagulant.	85% (LT), 90% (UT)	£0.9m / 4 pts	GPES
SMR-02B: Percentage of patients aged 65 years or over prescribed a Non-Steroidal Anti-Inflammatory Drug (NSAID) and not an oral anticoagulant in the 3 months to 1 April 2022, who in the 3 months to 1 April 2023 were either (i) no longer prescribed an NSAID or (ii) prescribed a gastroprotective in addition to an NSAID.	85% (LT), 90% (UT)	£0.9m / 4 pts	GPES
SMR-02C: Percentage of patients aged 18 years or over prescribed both an oral anticoagulant and an anti-platelet in the 3 months to 1 April 2022, who in the 3 months to 1 April 2023 were either (i) no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both an oral anticoagulant and an anti-platelet.	75% (LT), 90% (UT)	£0.9m / 4 pts	GPES
SMR-02D: Percentage of patients aged 18 years or over prescribed aspirin and another anti-platelet in the 3 months to 1 April 2022, who in the 3 months to 1 April 2023 were either (i) no longer prescribed aspirin and/or no longer prescribed an anti-platelet or (ii) prescribed a gastroprotective in addition to both aspirin and another anti-platelet.	75% (LT), 90% (UT)	£0.9m / 4 pts	GPES
SMR-03: Percentage of patients prescribed a direct oral anti-coagulant, who received a renal function test and a recording of their weight	50% (LT), 75% (UT)	£2.9m / 13 pts	GPES

and Creatinine Clearance Rate, along with a change or confirmation of their medication dose.			
RESP-01: Percentage of patients on the QOF Asthma Register who were regularly prescribed* an inhaled corticosteroid over the previous 12 months * 22/23: 3 or more ICS prescriptions; 23/24 onwards: 5 or more ICS inhalers.	71% (LT), 90% (UT)	£7.0m/ 31 pts	GPES
RESP-02: Percentage of patients on the QOF Asthma Register who received six or more SABA inhaler prescriptions* over the previous 12 months * From 23/24: who were prescribed 6 or more SABA inhalers	25% (LT), 15% (UT)	£5.0m/ 22 pts	GPES

Objective 5: Help create a more sustainable NHS;			
Indicator	Thresholds	Value	Source
ES-01: Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 or over	44% (LT), 35% (UT) intended 23/24 trajectory: 35%/25%	£6.1m / 27 pts	GPES
ES-02: Mean carbon emissions per salbutamol inhaler prescribed (kg CO2e)	22.1kg (LT), 18.0kg (UT) intended 23/24 trajectory: 18.0kg/ 13.4kg	£9.9m / 44 pts	BSA prescribing data

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 January 2022

WINTER ACCESS FUNDING - PRIMARY CARE INVESTMENTS

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		*Approval*		*Assurance*	x	*Information*	

2. PURPOSE

This paper provides an update to the decision made at the Extraordinary PCCC on the 16 December 2021 regarding Winter Access Funds

In addition, it outlines how other funding available to invest in Primary Care will be utilised before 31st March 2022.

3. REPORT OF

	Name	Designation
Executive Lead	Chris Edwards	Chief Officer
Author	Louise Dodson	Primary Care Transformation Manager

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
Extraordinary PCCC	16th December 2021	Winter Access Funding - Agreed
Finance & Performance Committee	6th January 2022	GPIT - Agreed

5. EXECUTIVE SUMMARY

Winter Access Funding

Following the discussion at the Extraordinary Primary Care Commissioning Meeting on 16th December, and agreement by a further Extraordinary Primary Care Commissioning email on 31st December 2021 to the principles for use of the WAF Funding in Barnsley, a letter was sent to all practices in December 2021 outlining the funding available and how to access.

To avoid undue burden on GP practice teams as a result of claims processes, the proposal taken to and agreed by PCCC and further communicated by email on 31st December was to make available a sum of £3 per head of the GP registered population as at October 2021 for practices to use over the remainder of this financial year to fund activity linked the areas of the SYB Winter Access Fund Plan – This was intended to cover all associated costs.

£1 per head of population was confirmed to be used to fund additional activity over the remainder of the year in i-HEART extended access, Out of Hours, Home Visiting and COVID Clinics.

In total this equates to around £1.2m across Barnsley available to support access to and resilience of General Practice. Given the amount of funding being deployed and to meet the requirements of the Winter Access Fund, it was agreed we need to have an audit trail and be able to demonstrate that additional capacity/improvements to access have been delivered.

To access the funding available each practice has been asked to submit a brief plan, describing how they will spend the allocated funding up to 31 March 2022, and what benefit this will deliver. Practices have been asked to return this to the Primary Care team by the 21 January so the allocation of funds can be distributed at pace for immediate impact.

The Primary Care Team and Finance Team will also establish a process to ensure checks are in place to monitor delivery of the plans. Practices have been asked to include in plans how they will demonstrate the funding has been used to improve access to Primary Care which will support this process. Practices are aware any significant changes to plans or spend will require prior agreement through the CCG Primary Care Team.

Practices have been supported to develop their plans by the Primary Care Team and have been asked to consider their clinical priorities and known pressure points or backlogs and the workforce available in doing so.

Additional Funding

It has been identified during the month 9 forecast position that there is funding available within the GP IT budgets to support Primary Care with practice resilience and the increased need for home working.

The Primary Care Team have written to all practices asking them to outline the need for additional IT equipment, or the need to replace existing equipment which may now not be working effectively.

Practices have been asked to outline which staff group additional IT equipment would be required to support the CCG to understand the current situation within Primary Care better.

Additionally, through the month 9 financial review funding has been identified for additional medical equipment to support practices with increasing access to treatments and reducing waiting times for equipment to be borrowed from practice for home use.

	Practices have been asked to identify the need for the following: • Thermometers • Otoscopes • Adult Pulse Oximeters • BP Monitors (for practice clinical rooms) • BP Monitors (for patient home monitoring) • BP Self-Monitoring Device (for waiting rooms) • 24 Hour BP Monitors • FENO Testing Kits • Spirometer • ECG Machines This is in addition to Paediatric Pulse Oximeters whereby practice need has already been established previously due to available funding from NHSE. Practices will be expected to fund ongoing maintenance of the medical equipment. Establishing the need across Barnsley practices will support the CCG in addressing variation, support long term sustainability and support good practice. A process will be established if the need for equipment – medical or IT – is higher than anticipated to ensure funding is distributed equitably across practices.
6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	Note - There is funding available for Primary Care to increase access, support resilience, support homeworking and improve patient care. Processes have been put into place to ensure this is distributed in the most beneficial manner for patients based upon practice need.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	N/A

Agenda time allocation for report:	*10 minutes.*

PCCC 22/01/08

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1.	**Links to Corporate Priorities, GBAF and Risk Register**

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework:

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	**x**	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
3.2 Maximising Elective Activity		9.1 Digital and Technology	
4.1 Mental Health		10.1 Compliance with statutory duties	
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2.	**Links to statutory duties**

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act :

Management of conflicts of interest (s14O)	**See 3.2**	Duties as to reducing inequalities (s14T)	**See 3.5**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.3**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.4**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.4**	Public involvement and consultation (s14Z2)	**See 3.6**

2A.	**PCCC ONLY - PLEASE DELETE IF NOT APPLICABLE** **Links to delegated primary care commissioning functions**

This report is relevant to the following responsibilities for primary care commissioning delegated to the CCG :

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts (inc breach notices etc)		Decisions in relation to the management of poorly performing GP Practices	
Planning the primary medical services provider landscape in Barnsley (inc closures, mergers, dispersals)		Decisions in relation to the Premises Costs Directions Functions	
Planning the Commissioning of Primary Medical Services in Barnsley		Co-ordinating a common approach to the commissioning of primary care services	
Manage the delegated allocation for commissioning of primary medical care services in Barnsley			

3.	**Governance Considerations Checklist** *(these will be especially relevant*

	where a proposal or policy is brought for decision or approval)
3.1	**Clinical Leadership**

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***Y***

3.2	**Management of Conflicts of Interest (s14O)**

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***N***

3.3	**Discharging functions effectively, efficiently, & economically (s14Q)**

Have any financial implications been considered & discussed with the Finance Team?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***Y***

3.4	**Improving quality (s14R, s14S)**

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***

3.5	**Reducing inequalities (s14T)**

Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***

3.6	**Public Involvement & Consultation (s14Z2)**

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***N/A***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***

3.7	**Data Protection and Data Security**

Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***

3.8	**Procurement considerations**

Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***

3.9	**Human Resources**

Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***

3.10	**Environmental Sustainability**

Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 January 2022

FINANCE UPDATE

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		*Approval*		*Assurance*		*Information*	

2. PURPOSE

This report provides an update of the forecast financial position as at 30 November 2021 (Month 8).

3. REPORT OF

	Name	Designation
Executive / Clinical Lead	Roxanna Naylor	Chief Finance Officer
Author	Ruth Simms	Finance Manager

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome

5. EXECUTIVE SUMMARY

5.1 **<u>Forecast Position 2021/22</u>**

The forecast position as at Month 8 reflects a £1,112k overspend, which includes an overspend of £1,341k against the Additional Roles Reimbursement Scheme (ARRS), funding is held nationally and reimbursed to CCGs based on actual costs, and an underspend against the CCG core allocation of £229k which relates in the main to the underutilisation of 2020/21 accruals. A full breakdown is included in Appendix A.

Although there is a £1,341k funding requirement against the National NHS England 40% there is an overall an underspend on the total ARRS funding available. The forecast underspend against the maximum funding is £183k. The CCG are currently working with the Primary Care Network (PCN) to try and fully utilise this funding however unfortunately an element of this funding is likely to be lost due to delays in recruitment and staff turnover.

	Further updates on the 2021/22 Financial position will be presented to Committee in March 2022. Updates on the financial position are reported on a monthly basis through the Integrated Performance Report which is a standing agenda item at the Finance and Performance Committee and Governing Body.
5.2	**<u>Primary Medical Care Services (PMCS) Finance Audit</u>** At the end of November 2021 360 Assurance, concluded their PMCS Finance Audit. The final report can be seen in Appendix B. The audit opinion given was Full Assurance, with the auditors providing full assurance that the controls in place adequately address the risks to the successful achievement of objectives; and controls tested operate effectively. This final assurance report is provided for the committee to note.
6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	• Note the financial position as at Month 8 • Note the level of funding being utilised against Additional Roles Reimbursement and work being undertaken with the PCN to maximise funding. • Note the Primary Medical Care Services Finance Audit report and internal audit full assurance opinion on controls in place to address risks.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix A – Finance Monitoring Statement for 2021/22 • Appendix B – Primary Medical Care Services Finance Audit Report

Agenda time allocation for report:	10 minutes

PCCC 22/01/09
PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (*place ✓ beside all that apply*):

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
3.2 Maximising Elective Activity		9.1 Digital and Technology	
4.1 Mental Health		10.1 Compliance with statutory duties	
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (place ✓ beside all that are relevant):

Management of conflicts of interest (s14O)	**See 3.2**	Duties as to reducing inequalities (s14T)	**See 3.5**
Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.3**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.4**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.4**	Public involvement and consultation (s14Z2)	**See 3.6**

2A. Links to delegated primary care commissioning functions

This report is relevant to the following responsibilities for primary care commissioning delegated to the CCG (place ✓ beside all that are relevant):

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts (inc breach notices etc)		Decisions in relation to the management of poorly performing GP Practices	
Planning the primary medical services provider landscape in Barnsley (inc closures, mergers, dispersals)		Decisions in relation to the Premises Costs Directions Functions	
Planning the Commissioning of Primary Medical Services in Barnsley		Co-ordinating a common approach to the commissioning of primary care services	

	Manage the delegated allocation for commissioning of primary medical care services in Barnsley	✓		

3.	**Governance Considerations Checklist** *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***Y***

3.4 Improving quality (s14R, s14S)

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***

3.5 Reducing inequalities (s14T)

Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***

3.6 Public Involvement & Consultation (s14Z2)

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***

3.7 Data Protection and Data Security

Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***

3.8 Procurement considerations

Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***

3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

APPENDIX A

NHS Barnsley Clinical Commissioning Group

NHS BARNSLEY CLINICAL COMMISSIONING GROUP

Finance Monitoring Statement - Primary Care Commissioning (Delegated budgets) - Month 8

FOR THE PERIOD ENDING 30th November 2021

PRIMARY MEDICAL SERVICES	TOTAL ANNUAL BUDGET (£)			FORECAST OUTTURN (£)			
(CO-COMMISSIONING - DELEGATED BUDGETS)	RECURRENT	NON RECURRENT	TOTAL BUDGET (£'000)	FORECAST OUTTURN	VARIANCE OVER / (UNDER)	VARIANCE AS % OF TOTAL BUDGET	Forecast Outturn Variance Explanation
ENHANCED SERVICES	569,227		569,227	613,043	43,816	7.70%	Overspend over a number of areas - **Specialist Allocation Scheme** - FOT (£23k) under for 21/22 actuals lower than expected. **Minor Surgery** - overspend relating to 20/21 of £15k and FOT (£24k) under for 21/22 actual activity lower than expected. **Learning Disability** - underspend relating to 20/21 (£2k) due to actuals lower than expected and FOT £78k overspend for 21/22 actuals higher than expected.
GENERAL PRACTICE - APMS	1,287,770		1,287,770	1,246,953	(40,817)	-3.17%	Primary Care Co Commissioning outturn for GMS, APMS and PMS contracts are based on up to date list sizes (October 2021). List sizes are adjusted quarterly and payments are updated in line with this. Underspend on APMS contracts (£41k), overspend of £42k on PMS Contracts and an underspend of (£16k) on GMS contracts. Both FOT and actuals for 21/22 includes the impact of the national increase in the GP Contract.
GENERAL PRACTICE - GMS	12,829,258		12,829,258	12,813,445	(15,813)	-0.12%	
GENERAL PRACTICE - PMS	13,415,160		13,415,160	13,456,675	41,515	0.31%	
OTHER GP SERVICES	1,750,673	(455,355)	1,295,318	1,136,148	(159,170)	-12.29%	Underspend over a number of areas - **Prescribing & Dispensing** - overspend of £8k relating to 20/21 due to actuals higher than expected and FOT overspend of £34k actuals higher than expected. **Interpreting Services** - FOT overspend of £20k actuals higher than expected. **Telephone Costs** - FOT underspend for 21/22 of (£65k) actuals lower than expected. **Locums** - underspend of (£71k) realting to underutilised accruals from 20/21. Other underutlised accruals from 20/21 of (£85k).
OTHER PREMISES	32,750		32,750	10,630	(22,120)	-67.54%	Underspend due to underutilised accruals from 20/21 and actuals for 21/22 lower than expected
PREMISES COST REIMBURSEMENT	5,778,779	(281,620)	5,497,159	5,266,600	(230,559)	-4.19%	Underspend of (£57k) due to underutilised accruals from 20/21 and a FOT underspend for 21/22 of (£174k) relating to actuals lower than expected for Healthcentre Rents, NDR Rates, Water Rates and Clinical Waste
QOF	3,954,746	(265,609)	3,689,137	3,899,968	210,831	5.71%	FOT overspend due to increase in the value of QOF points for 21/22
Primary Care Network DES	1,799,880	648,000	2,447,880	2,390,743	(57,137)	-2.33%	Underspend of (£19k) due to underutilised accruals from 20/21 in relation to Investment and Impact achievement and (£9k) for 20/21 extended hours not delivered. 21/22 FOT underspend of (£13k) on Care Homes Premium, overspend of £2k in relation to weight management and (£18k) underspend on the leadership and management.
Additional Roles Reimbursement Scheme	1,912,000		1,912,000	3,253,025	1,341,025	70.14%	FOT overspend of £1,341k relates to 21/22 requirement against NHS England central funding
TOTAL PRIMARY MEDICAL SERVICES	**43,330,243**	**(354,584)**	**42,975,659**	**44,087,230**	**1,111,571**	-5.79%	

Primary Medical Care Services (PMCS) - Finance

NHS Barnsley Clinical Commissioning Group

November 2021

2122/BCCG/04

Final Report

Contents

Distribution

Name, Job Title	For action	For information
Roxanna Naylor, Chief Finance Officer	✓	
Julie Frampton, Head of Primary Care		✓
Ruth Simms, Finance Manager		✓
Chris Millington, Lay Member – Chair of Primary Care Commissioning Committee		✓

The report has also been shared with the organisation's standard distribution list for internal audit reports.

Executive summary

Introduction and background

Your 2021/22 Internal Audit Plan includes an allocation of time to undertake a review of primary medical care commissioning and contracting in accordance with an Internal Audit Framework issued by NHS England (NHSE). This framework sets out the requirement for independent assessments to be undertaken across four domains, on a cyclical basis, by March 2022, the four domains being as follows:

- Commissioning and Procurement of Services
- Contract Oversight and Management Functions
- Primary Care Finance
- Governance (common to each of the above areas).

It was agreed with the CCG that the internal audit focus for 2021/22 would be on primary care finance.

Audit objective

The objective of our review was to determine whether a robust, efficient and effective control environment is in place in relation to primary care finance, as detailed within the Delegation Agreement between the CCG and NHSE.

In accordance with the Internal Audit Framework this included:

- overall management and reporting of delegated funds, reviewing processes for forecasting, monitoring and reporting
- review of financial controls and processes for approving payments to practices
- review of compliance with coding guidance on a sample basis
- processes to approve and decisions regarding 'discretionary' payments, e.g. Section 96 funding arrangements (as per NHSE's Primary Medical Care Policy and Guidance Manual, page 268) and Local Incentive Schemes
- implementation of the Premises Costs Directions (as per the Policy and Guidance Manual, page 287).

Further detail regarding the scope of the work we completed during the review can be found in Appendix A.

Audit Opinion

Full assurance	The controls in place adequately address the risks to the successful achievement of objectives; and the controls tested operate effectively.

Executive summary

	Our opinion is limited to the controls examined and samples tested as part of this review.

Summary findings and actions

The CCG has appropriate arrangements in place for setting budgets and forecasts for delegated co-commissioning. Financial reports are presented to each public meeting of the Primary Care Commissioning Committee (PCCC) and evidence of questions/discussions of these reports is recorded within the minutes. We confirmed that finance staff meet regularly with the Head of Primary Care.

We also confirmed that appropriate arrangements are in place for the PCCC to approve leases or premises costs directions and to notify NHSE who will make payments to practices. None had been processed in the period of our review.

We have not made any recommendations.

Management of delegated funds

The terms of reference (ToR) for the Primary Care Commissioning Committee (PCCC) were approved by the Governing Body in March 2021. The ToR for the PCCC are consistent with the Delegation Agreement between the CCG and NHSE and include a specific responsibility to manage delegated funds and Premises Costs Directions.

We confirmed that a financial report is presented to each public meeting of the PCCC (see also the section 'Finance Reporting' below). We also confirmed that there is a process to highlight 'Items for escalating to the Governing Body' which is a standing item on the agenda of PCCC meetings.

We confirmed that finance staff meet regularly with the Head of Primary Care in accordance with the Budgetary Control Policy.

The CCG Primary Care Finance Team have a number of documented procedure notes for the production of primary care financial forecasts and other financial activity required for primary care finance.

Financial controls and processes

The Finance Manager responsible for primary care confirmed that the majority of transactions for delegated funds are managed by NHSE who process payments to practices and upload entries onto the CCG ledger after appropriate approval by a CCG approver. Activity is managed on the General Practitioners Payments System (GPPS). The CCG receives a separate assurance in respect of the operation of the GPPS via a Service Auditor Report. At its meeting in June 2021, the Audit Committee received an assurance reports summary which included the exceptions noted within the NHS Digital Report for GPPS for the period 1 April 2020 to 31 October 2020 and Extraction and Processing of GP Data services for the period 1 November 2020 to 31 March 2021.

In accordance with our agreed terms of reference, we did not undertake any testing on controls in place outside of the CCG. We confirmed that there are local payments which are processed by the Finance Team at the CCG. This includes the Practice Delivery Agreement (PDA) which is a form of a Local Incentive Scheme for practices. This scheme was approved by the Governing Body and the PCCC in May and July 2021 respectively. In addition, payments are also processed internally for Additional Roles Reimbursements (ARRs) to Primary Care Networks (PCNs). Through provision of the manual payment runs, we were able to see evidence that these payments were made for the PDA in August 2021 and at the mid-year point in October 2021. We were also provided with evidence to demonstrate the Chief Finance Officer's approval of the payments that were made for the PDA in these two months. We also reviewed a sample of invoices relating to ARRs. The invoices received related to PCN Salary Recharge for two months in August and September 2021.

We confirmed that the payment runs are sent to the Finance Manager, Head of Finance: Statutory Accounts and Financial Reporting and the Chief Finance Officer. The Finance Manager carries out a number of checks for the Delegated Primary Care payments prior to senior approval. We also confirmed that there are two approvers at the CCG as a contingency arrangement and that these are the Chief Finance Officer and the Head of Finance: Statutory Accounts and Financial Reporting who formally approve the payments runs. We confirmed through sample testing that supporting documentation had been maintained by the CCG for local payment runs and that these had been approved by either the Chief Finance Officer or the Head of Finance: Statutory Accounts and Financial Reporting. As far as variations to contracts are concerned, we confirmed that these can only be signed by the Chief Finance Officer.

The Primary Care Finance Team operate to the CCG Policy for Budget Management for setting budgets and forecasts, monitoring them, and generating financial reports.

Coding guidance

NHSE issue coding guidance to CCGs and the latest version (2020) was shared with us. We were able to confirm from our review of transactions for April to August 2021 that subjective codes used were correct for GMS, PMS and APMS (contracts with practices for the provision of care to patients).

Discretionary payments and Local Incentive Schemes

GP Practices can request financial assistance, but an appropriate claim must be made, and the CCG must assess claims against the NHSE Policy Guidance Manual.

We reviewed the PCCC papers and minutes from September 2020 to November 2021. We confirmed that no claims for discretionary payments had been made.

We identified that the CCG operates an agreement with practices known as the Practice Delivery Agreement (PDA) to improve services and performance. This was initially approved by the Governing Body in 2014 and different iterations of the PDA have been in place since then. The most recent iteration was approved by the Governing Body and the PCCC in May and July 2021 respectively. We undertook a review of the local incentive schemes in 2018/19 and issued report 1819/BCCG/02 (Contract Management for Primary Care) with a significant assurance opinion. See the section on financial controls and processes above for testing undertaken.

Implementing Premises Cost Directions

The CCG has adopted the Policy Guidance Manual (PGM). This specifies what support the CCG can provide to practices for premises costs and how claims must be made and what must be considered for eligibility. Governance arrangements are:

Copies of the PCCC minutes are shared with NHSE to confirm actions approved by PCCC. During the period of our review no new premises costs claims had been made/approved by the PCCC.

Finance reporting

We were able to confirm from our review of papers and minutes of the PCCC that there was a report at each meeting on delegated funds and that this contained budget, actual and variances as well as forecast positions. It is the responsibility of the Primary Care Finance Team, managed by the Finance Manager to prepare the financial forecasts.

For 2021/22, the PCCC has received reports on the actual budgets for delegated primary care as compared with the delegation resource limit for delegation co-commissioning notified by NHSE at the PCCC meeting in May 2021.

Based on our sample testing to month 4 for 2021/22 (which was reported to the PCCC in September 2021), we confirmed that the amounts reported to the PCCC reflected the allocation for delegated funds on primary care co-commissioning notified by NHSE to the CCG. The 2021/22 allocation for primary care co-commissioning for H1(covering April to September 2021) was £20.672 million against a requirement of £21.529 million so an under allocation of £857k which would need to be managed by the CCG. The actual forecast position at month 4 was an underspend of £127k.

A further update was presented to the PCCC in November 2021. The annual allocation from NHSE (covering H1 and H2) was £42.231 million against a required budget of £43.215 million which equates to an under resource of £984k.

Appendix A: Audit scope

Scope area	Audit testing
Overall management and reporting of delegated funds	We interviewed officers in the Finance department and reviewed sample forecast reports for the period September 2020 to November 2021. We reviewed agendas, papers and minutes from the Primary Care Commissioning Committee (PCCC) between September 2020 to November 2021 and assessed the level of reporting on primary care finance.
Review of financial controls and process for approving payments	We interviewed officers in the Finance department to understand any control in place and where relevant we undertook walk through testing. We obtained the latest Service Auditor Report for Primary Care Support England (PCSE) as a source of assurance on the controls in place at NHSE for the approval of payments to GP practices. We selected a sample of payments made to GP practices for which we sought evidence of approval.
Compliance with the Coding Guidance	We compared for the period April to August 2021 all the subjective codes used on the CCG transaction list for the cost centre on primary care co-commissioning to the notification of codes from NHSE. Our sample covered the main GP contract payments (GMS, PMS and APMS) and premises cost directions.

Appendix A: Audit scope

Processes to approve and decisions for discretionary payments (section 96 funding arrangements from NHSE Policy Guidance) and Local Incentive Schemes	We reviewed agendas, papers and minutes for the PCCC between September 2020 and November 2021 and assessed whether there were any requests to make discretionary payments and Local Incentive Schemes (LIS). If payments had been made, we confirmed that the papers to the PCCC provided assurance that the NHSE Policy Manual had been applied and for LIS that payments were based on confirmation of activity to confirm accurate payments were made.
Implementation of the Premises Costs Directions in accordance with the NHSE Policy Guidance Manual	We reviewed agendas, papers and minutes for the PCCC between September 2020 and November 2021 and assessed whether there were any requests to make premises costs payments. If payments had been made, we confirmed that the papers to the PCCC provided assurance that the NHSE Policy Guidance Manual had been applied.
Limitations of scope: *The scope of our work was limited to the areas identified in the Terms of Reference. Excluded from scope was the management of conflicts of interests which was subject to a separate mandated internal audit framework.* *We have not provided assurance on the controls in place within any outsourced arrangements that may be in place.*	

Appendix B: 360 Assurance standing information

Risk matrix and opinion levels

Risks contained within this report have been assessed using a standard 5x5 risk matrix. The score has been determined by consideration of the impact the risk may have, and its likelihood of occurrence, in relation to the system's objectives. The two scores have then been multiplied in order to identify the risk classification of low, medium, high or extreme.

The audit opinion has been determined in relation to the objectives of the system being reviewed. It takes into consideration the volume and classification of the risks identified during the review.

Our risk matrix can be viewed in full on our website. For this review, we are required to apply an opinion in accordance with the following definitions provided by NHSE:

Assurance level	Evaluation and testing conclusion
Full	The controls in place adequately address the risks to the successful achievement of objectives; and the controls tested operate effectively.
Substantial	The controls in place do not adequately address one or more risks to the successful achievement of objectives; and/ or one or more of the controls tested are not operating effectively, resulting in unnecessary exposure to risk.
Limited	The controls in place do not adequately address multiple significant risks to the successful achievement of objectives; and /or a number of controls are not operating effectively, resulting in exposure to a high level of risk.
No assurance	The controls in place do not adequately address several significant risks leaving the system open to significant error or abuse; and/or the controls tested are wholly ineffective, resulting in an unacceptably high level of risk to the successful achievement of objectives.

Appendix B: 360 Assurance standing information

Contact details

Leanne Hawkes, Director	
leanne.hawkes@nhs.net	07545 423040
Ruth Vernon, Deputy Director	
ruth.vernon@nhs.net	07775 007153
Kay Meats, Assistant Director	
kay.meats@nhs.net	07816 272663
Usman Niazi, Client Manager	
u.niazi@nhs.net	07557 566793
Joel Fantom, Internal Auditor	
joel.fantom@nhs.net	07342 079845

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 January 2022

CQC REPORT

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		Approval		Assurance	X	Information	X

2. PURPOSE

The purpose of the report is to provide members with an update on the current CQC position in relation our GP Practices and for Barnsley Healthcare Federation i-Heart contracts.

3. REPORT OF

	Name	Designation
Executive Lead	Chris Edwards	Chief Officer
Authors	Terry Hague	Primary Care Transformation Manager

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
Quality and Patient Safety Committee	21/10/2021	Noted

5. EXECUTIVE SUMMARY

CQC Inspections

Lakeside Surgery

Lakeside Surgery was inspected on the 11 November 2021. In the report published on the 14 December 2021 the practice received a rating of Good overall and in all domains.

This was the first rating of this practice with the current contract holders.

You can read the report in full on the CQC's website at:
Lakeside Surgery (cqc.org.uk)

	The CCG will write to the practices to congratulate all staff on receiving the 'Good' rating and commendable CQC report and thanking the practice for their continued efforts to provide high quality services for the people of Barnsley.
	CQC Monitoring The CQC criteria definitions are detailed within this report at Appendix A which includes the five key lines of enquiry domains of Safe, Effective, Caring, Responsive and Well led and provides a list of the indicators review by the CQC when completing an inspection. The Primary Care Team maintain a database of each inspection completed and the outcome of each indicator to identify where an indicator is not met, or partially met to assist with supporting practices if a theme is identified. The CQC will also consider additional holistic information such as complaints received regarding an organisation and other data available within the public domain such as prescribing and other service related quality indicators. This assist in the continuous monitoring of service providers to assist in prioritising inspections and action required. Further information can be found by accessing the link below: How we monitor, inspect and regulate GP practices | Care Quality Commission (cqc.org.uk)
6.	**THE PRIMARY CARE COMMISSIONING COMMITTEE IS ASKED TO:**
	1. Note the CQC's inspection rating of good for Lakeside Surgery 2. Note the CQC monitoring process and the criteria definitions and indicators included within the five CQC domains.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	N/A

Agenda time allocation for report:	*5* mins

PCCC 22/01/10
PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (*place ✓ beside all that apply*):

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
4.1 Mental Health		9.1 Digital and Technology	
5.1 Integrated Care @ System		10.1 Compliance with statutory duties	
5.2 Integrated Care @ Place			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*Provide ref(s) or state N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (place ✓ beside all that are relevant):

Management of conflicts of interest (s14O)	**See 3.1**	Duties as to reducing inequalities (s14T)	**See 3.4**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.2**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.3**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.3**	Public involvement and consultation (s14Z2)	**See 3.5**

2A. Links to delegated primary care commissioning functions

This report is relevant to the following responsibilities for primary care commissioning delegated to the CCG (place ✓ beside all that are relevant):

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts (inc breach notices etc)	✓	Decisions in relation to the management of poorly performing GP Practices	
Planning the primary medical services provider landscape in Barnsley (inc closures, mergers, dispersals)		Decisions in relation to the Premises Costs Directions Functions	
Planning the Commissioning of Primary Medical Services in Barnsley		Co-ordinating a common approach to the commissioning of primary care services	
Manage the delegated allocation for commissioning of primary medical care services in Barnsley			

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.2	**Management of Conflicts of Interest (s14O)**	
	Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.3	**Discharging functions effectively, efficiently, & economically (s14Q)**	
	Have any financial implications been considered & discussed with the Finance Team?	***Y***
	Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.4	**Improving quality (s14R, s14S)**	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

Appendix A

CQC Monitoring Domain Indicators

The table below includes the five domains of Safe, Effective, Caring, Responsive and Well led and provides a list of the indicators review by the CQC when completing an inspection.

Safe Domain	
Safeguarding	There was a lead member of staff for safeguarding processes and procedures.
Safeguarding	Safeguarding systems, processes and practices were developed, implemented, and communicated to staff.
Safeguarding	There were policies covering adult and child safeguarding.
Safeguarding	Policies took account of patients accessing any online services.
Safeguarding	Policies and procedures were monitored, reviewed, and updated.
Safeguarding	Policies were accessible to all staff.
Safeguarding	Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).
Safeguarding	There was active and appropriate engagement in local safeguarding processes.
Safeguarding	The Out of Hours service was informed of relevant safeguarding information.
Safeguarding	There were systems to identify vulnerable patients on record.
Safeguarding	There was a risk register of specific patients.
Safeguarding	Disclosure and Barring Service (DBS) checks were undertaken where required.
Safeguarding	Staff who acted as chaperones were trained for their role.
Safeguarding	There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.
Recruitment Systems	Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).
Recruitment Systems	Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.
Recruitment Systems	There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.
Recruitment Systems	Staff had any necessary medical indemnity insurance.
Safety systems and records	There was a record of portable appliance testing or visual inspection by a competent person.
Safety systems and records	There was a record of equipment calibration.
Safety systems and records	There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.
Safety systems and records	There was a fire procedure.
Safety systems and records	There was a record of fire extinguisher checks.

Safety systems and records	There was a log of fire drills.
Safety systems and records	There was a record of fire alarm checks.
Safety systems and records	There was a record of fire training for staff.
Safety systems and records	There were fire marshals.
Safety systems and records	A fire risk assessment had been completed.
Safety systems and records	Actions from fire risk assessment were identified and completed.
Health and Safety	Premises/security risk assessment had been carried out.
Health and Safety	Health and safety risk assessments had been carried out and appropriate actions taken.
Infection prevention and control	There was an infection risk assessment and policy.
Infection prevention and control	Staff had received effective training on infection prevention and control.
Infection prevention and control	Date of last infection prevention and control audit
Infection prevention and control	The practice had acted on any issues identified in infection prevention and control audits.
Infection prevention and control	The arrangements for managing waste and clinical specimens kept people safe.
Risks to patients	There was an effective approach to managing staff absences and busy periods.
Risks to patients	There was an effective induction system for temporary staff tailored to their role.
Risks to patients	Comprehensive risk assessments were carried out for patients.
Risks to patients	Risk management plans for patients were developed in line with national guidance.
Risks to patients	Panic alarms were fitted, and administrative staff understood how to respond to the alarm and the location of emergency equipment.
Risks to patients	Clinicians knew how to identify and manage patients with severe infections including sepsis.
Risks to patients	Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.
Risks to patients	There was a process in the practice for urgent clinical review of such patients.
Risks to patients	There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.
Risks to patients	There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.
Risks to patients	When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment	Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.
Information to deliver safe care and treatment	There was a system for processing information relating to new patients including the summarising of new patient notes.
Information to deliver safe care and treatment	There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
Information to deliver safe care and treatment	Referral letters contained specific information to allow appropriate and timely referrals.
Information to deliver safe care and treatment	Referrals to specialist services were documented.
Information to deliver safe care and treatment	There was a system to monitor delays in referrals.
Information to deliver safe care and treatment	There was a documented approach to the management of test results and this was managed in a timely manner.
Information to deliver safe care and treatment	The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.
Medicines management	The practice ensured medicines were stored safely and securely with access restricted to authorised staff.
Medicines management	Blank prescriptions were kept securely, and their use monitored in line with national guidance.
Medicines management	Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).
Medicines management	The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.
Medicines management	There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.
Medicines management	The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.
Medicines management	There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate, and lithium) with appropriate monitoring and clinical review prior to prescribing.
Medicines management	The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations, and strength).
Medicines management	There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.

Medicines management	If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.
Medicines management	The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.
Medicines management	For remote or online prescribing there were effective protocols for verifying patient identity.
Medicines management	The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.
Medicines management	The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.
Medicines management	The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.
Medicines management	There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.
Medicines management	Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.
Track record on safety and lessons learned and improvements made	The practice monitored and reviewed safety using information from a variety of sources.
Track record on safety and lessons learned and improvements made	Staff knew how to identify and report concerns, safety incidents and near misses.
Track record on safety and lessons learned and improvements made	There was a system for recording and acting on significant events.
Track record on safety and lessons learned and improvements made	Staff understood how to raise concerns and report incidents both internally and externally.
Track record on safety and lessons learned and improvements made	There was evidence of learning and dissemination of information.
Safety alerts	There was a system for recording and acting on safety alerts.
Safety alerts	Staff understood how to deal with alerts.
Effective Domain	
Effective needs assessment, care, and treatment	The practice had systems and processes to keep clinicians up to date with current evidence-based practice.

Effective needs assessment, care, and treatment	Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
Effective needs assessment, care, and treatment	We saw no evidence of discrimination when staff made care and treatment decisions.
Effective needs assessment, care, and treatment	Patients' treatment was regularly reviewed and updated.
Effective needs assessment, care, and treatment	There were appropriate referral pathways were in place to make sure that patients' needs were addressed.
Effective needs assessment, care, and treatment	Patients were told when they needed to seek further help and what to do if their condition deteriorated.
Older People population group (examples)	The practice identified older patients who were living with moderate or severe frailty and referred to them to other services for a full assessment of their physical, mental, and social needs. The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
People with Long-term conditions Population group (examples)	Patients with long-term conditions were reviewed opportunistically when they visited the practice as well as attending a planned appointment. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. Staff who were responsible for reviews of patients with long-term conditions had received specific training. The practice could demonstrate how they identified patients with commonly undiagnosed conditions. For example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with suspected hypertension were offered ambulatory blood pressure monitoring. Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
Families, children, and young people Population group (examples)	The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines and referred them to midwifery services. The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary. Young people could access services for sexual health and contraception.

Working age people (including those recently retired and students) Population group (examples)	The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Patients had access to appropriate health assessments and checks, external to the practice, including NHS checks for patients aged 40 to 74. Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. 30% of the practice population had registered to use online services.
People whose circumstances make them vulnerable Population group (examples)	End of life care was delivered in a coordinated way, with other care providers, which considered the needs of those whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. The practice had identified people who misused substances The practice reviewed young patients at local residential homes.
People experiencing poor mental health (including people with dementia) Population group (examples)	Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. All staff had received dementia training in the last 12 months.
Monitoring care and treatment	Clinicians took part in national and local quality improvement initiatives.
Monitoring care and treatment	The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.
Effective staffing	Staff had the skills, knowledge, and experience to deliver effective care, support, and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.
Effective staffing	The learning and development needs of staff were assessed.
Effective staffing	The practice had a programme of learning and development.
Effective staffing	Staff had protected time for learning and development.
Effective staffing	There was an induction programme for new staff.
Effective staffing	Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.
Effective staffing	Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision, and revalidation. They were supported to meet the requirements of professional revalidation.
Effective staffing	The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists, and physician associates.
Effective staffing	There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment	The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed
Coordinating care and treatment	We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning, and delivering care and treatment.
Coordinating care and treatment	Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.
Coordinating care and treatment	Patients received consistent, coordinated, person-centred care when they moved between services.
Coordinating care and treatment	For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.
Helping patients to live healthier lives	The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
Helping patients to live healthier lives	Staff encouraged and supported patients to be involved in monitoring and managing their own health.
Helping patients to live healthier lives	Staff discussed changes to care or treatment with patients and their careers as necessary.
Helping patients to live healthier lives	The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.
Consent to care and treatment	Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.
Consent to care and treatment	Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
Consent to care and treatment	Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.
Consent to care and treatment	The practice monitored the process for seeking consent appropriately.
Caring Domain	
Kindness, respect, and compassion	Staff understood and respected the personal, cultural, social, and religious needs of patients.
Kindness, respect, and compassion	Patients were given appropriate and timely information to cope emotionally with their care, treatment, or condition.
Kindness, respect, and compassion	Includes CQC comment cards, NHS choices, GP pateint survey results
Kindness, respect, and compassion	Patients were given appropriate and timely information to cope emotionally with their care, treatment, or condition.
Kindness, respect, and compassion	The practice carries out its own patient survey/patient feedback exercises.
Involvement in decisions about care and treatment	Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.

Involvement in decisions about care and treatment	Staff helped patients and their carers find further information and access community and advocacy services.
Involvement in decisions about care and treatment	Interpretation services were available for patients who did not have English as a first language.
Involvement in decisions about care and treatment	Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.
Involvement in decisions about care and treatment	Information leaflets were available in other languages and in easy read format.
Involvement in decisions about care and treatment	Information about support groups was available on the practice website.
Privacy and dignity	Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations, and treatments.
Privacy and dignity	Consultation and treatment room doors were closed during consultations.
Privacy and dignity	A private room was available if patients were distressed or wanted to discuss sensitive issues.
Privacy and dignity	There were arrangements to ensure confidentiality at the reception desk.
Responsive Domain	
Responding to and meeting people's needs	The practice understood the needs of its local population and had developed services in response to those needs.
Responding to and meeting people's needs	The importance of flexibility, informed choice and continuity of care was reflected in the services provided.
Responding to and meeting people's needs	The facilities and premises were appropriate for the services being delivered.
Responding to and meeting people's needs	The practice made reasonable adjustments when patients found it hard to access services.
Responding to and meeting people's needs	The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
Responding to and meeting people's needs	Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
Responding to and meeting people's needs	The practice complied with the Accessible Information Standard.
Access to the service	There was information available for patients to support them to understand how to access services (including on websites and telephone messages).
Access to the service	Patients were able to make appointments in a way which met their needs.

Access to the service	The practice offered a range of appointment types to suit different needs (e.g., face to face, telephone, online).
Access to the service	There were systems in place to support patients who face communication barriers to access treatment.
Timely access to the service	Patients with urgent needs had their care prioritised.
Timely access to the service	The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.
Timely access to the service	Appointments, care, and treatment were only cancelled or delayed when absolutely necessary.
Listening and learning from concerns and complaints	Information about how to complain was readily available.
Listening and learning from concerns and complaints	There was evidence that complaints were used to drive continuous improvement.
Well-led Domain	
Leadership capacity and capability	Leaders demonstrated that they understood the challenges to quality and sustainability.
Leadership capacity and capability	They had identified the actions necessary to address these challenges.
Leadership capacity and capability	Staff reported that leaders were visible and approachable.
Leadership capacity and capability	There was a leadership development programme, including a succession plan.
Vision and strategy	The practice had a clear vision and set of values that prioritised quality and sustainability.
Vision and strategy	There was a realistic strategy to achieve their priorities.
Vision and strategy	The vision, values and strategy were developed in collaboration with staff, patients, and external partners.
Vision and strategy	Staff knew and understood the vision, values and strategy and their role in achieving them.
Vision and strategy	Progress against delivery of the strategy was monitored.
Culture	There were arrangements to deal with any behaviour inconsistent with the vision and values.
Culture	Staff reported that they felt able to raise concerns without fear of retribution.
Culture	There was a strong emphasis on the safety and well-being of staff.
Culture	There were systems to ensure compliance with the requirements of the duty of candour.
Culture	The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.
Culture	The practice had access to a Freedom to Speak Up Guardian.
Culture	Staff had undertaken equality and diversity training.
Governance arrangements	There were governance structures and systems which were regularly reviewed.

Governance arrangements	Staff were clear about their roles and responsibilities.
Governance arrangements	There were appropriate governance arrangements with third parties.
Managing risks, issues, and performance	There were comprehensive assurance systems which were regularly reviewed and improved.
Managing risks, issues, and performance	There were processes to manage performance.
Managing risks, issues, and performance	There was a systematic programme of clinical and internal audit.
Managing risks, issues, and performance	There were effective arrangements for identifying, managing, and mitigating risks.
Managing risks, issues, and performance	A major incident plan was in place.
Managing risks, issues, and performance	Staff were trained in preparation for major incidents.
Managing risks, issues, and performance	When considering service developments or changes, the impact on quality and sustainability was assessed.
Managing risks, issues, and performance	The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.
Managing risks, issues, and performance	The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.
Managing risks, issues, and performance	There were systems in place to identify and manage patients who needed a face-to-face appointment.
Managing risks, issues, and performance	The practice actively monitored the quality of access and made improvements in response to findings.
Managing risks, issues, and performance	There were recovery plans in place to manage backlogs of activity and delays to treatment.
Managing risks, issues, and performance	Changes had been made to infection control arrangements to protect staff and patients using the service.
Appropriate and accurate information	Staff used data to adjust and improve performance.
Appropriate and accurate information	Performance information was used to hold staff and management to account.
Appropriate and accurate information	Our inspection indicated that information was accurate, valid, reliable, and timely.
Appropriate and accurate information	There were effective arrangements for identifying, managing, and mitigating risks.

Appropriate and accurate information	Staff whose responsibilities included making statutory notifications understood what this entails.
Governance and oversight of remote services	The practice used digital services securely and effectively and conformed to relevant digital and information security standards.
Governance and oversight of remote services	The provider was registered as a data controller with the Information Commissioner's Office.
Governance and oversight of remote services	Patient records were held in line with guidance and requirements.
Governance and oversight of remote services	Patients were informed and consent obtained if interactions were recorded.
Governance and oversight of remote services	The practice ensured patients were informed how their records were stored and managed.
Governance and oversight of remote services	Patients were made aware of the information sharing protocol before online services were delivered.
Governance and oversight of remote services	The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. Nothing recorded at present but have GDPR policy in place
Governance and oversight of remote services	Online consultations took place in appropriate environments to ensure confidentiality.
Governance and oversight of remote services	The practice advised patients on how to protect their online information.
Engagement with patients, the public, staff, and external partners	Patient views were acted on to improve services and culture.
Engagement with patients, the public, staff, and external partners	Staff views were reflected in the planning and delivery of services.
Engagement with patients, the public, staff, and external partners	The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.
Feedback from Patient Participation Group.	The practice had an active Patient Participation Group.
Continuous improvement and innovation	There was a strong focus on continuous learning and improvement.

Continuous improvement and innovation	Learning was shared effectively and used to make improvements.

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 January 2021

CONTRACTUAL ISSUES REPORT

PART 1A – SUMMARY REPORT

1.	**THIS PAPER IS FOR**						
	Decision		*Approval*	X	*Assurance*	X	*Information*	
2.	**PURPOSE**						
	The purpose of the report is to provide members with an update on the current contractual issues in relation to our primary care contracts.						
3.	**REPORT OF**						

	Name	Designation
Executive / Clinical Lead	Chris Edwards	Chief Officer
Author	Terry Hague Louise Darwin	Primary Care Transformation Manager Primary Care Transformation Manager

4.	**SUMMARY OF PREVIOUS GOVERNANCE**

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
N/A		

5.	**EXECUTIVE SUMMARY**

<u>Social Prescribing Update</u>

Currently, South Yorkshire Housing Association (SYHA) provides a Social Prescribing High Intensity User Service (HIUS) in Barnsley. The funding for this service expires on 31 March 2022 and therefore the CCG has been exploring options for the future of the service.

On 14 January 2022 the CCG's Senior Management Team considered a number of options and approved Option One; To work with Barnsley Healthcare Federation (BHF) to develop alternative ways of delivering the High Intensity

	User Service, such as utilising the Additional Roles Reimbursement Scheme (AARS) to deliver the HIUS within the Core Social Prescribing Service envelope. Therefore, from April 2022 both the Core Social Prescribing Service and the HIUS will be provided by BHF. The CCG, SYHA and BHF are working together to ensure that the transition of this service is as smooth as possible for both staff and service users. The contract between the CCG and BHF will include both the core service and the HIUS and will be for a term of 1 year, however provision will be reviewed in line with the National PCN DES requirements.
	<u>E-Declaration Update</u> General Practices are required to complete an electronic Annual Practice Declaration (eDec) which forms an integral part of the NHS England Policy and Guidance Manual book of Primary Medical Services. Submissions are made in December each year. All 32 practices within Barnsley have submitted their responses as required which includes information regarding practice staff, premises and equipment, opening hours, practice services, practice procedures, governance, catchment area, CQC and general practice IT. This is notable given that nationally the deadline has been extended to enable practices who have not yet completed their submission additional team. The Primary Care team included an article within the GP Practice Newsletter to thank practices for completing their submissions prior to the deadline. Analysis of responses will be undertaken when data regarding the submissions has been released and an update provided to the committee.
6.	**THE GOVERNING BODY / COMMITTEE IS ASKED TO:**
	1) Note update regarding the Social Prescribing High Intensity User Service. 2) Note the update regarding practices submission of their annual eDeclaration for assurance.
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	None

Agenda time allocation for report:	*10 minutes*

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework (*place ✓ beside all that apply*):

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
3.2 Maximising Elective Activity		9.1 Digital and Technology	
4.1 Mental Health		10.1 Compliance with statutory duties	
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*Provide ref(s) or state N/A*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act (place ✓ beside all that are relevant):

Management of conflicts of interest (s14O)	**See 3.2**	Duties as to reducing inequalities (s14T)	**See 3.5**
Duty to promote the NHS Constitution (s14P)		Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)	**See 3.3**	Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)	**See 3.4**	Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)	**See 3.4**	Public involvement and consultation (s14Z2)	**See 3.6**

2A. Links to delegated primary care commissioning functions

This report is relevant to the following responsibilities for primary care commissioning delegated to the CCG (place ✓ beside all that are relevant):

Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contracts (inc breach notices etc)	✓	Decisions in relation to the management of poorly performing GP Practices	
Planning the primary medical services provider landscape in Barnsley (inc closures, mergers, dispersals)		Decisions in relation to the Premises Costs Directions Functions	
Planning the Commissioning of Primary Medical Services in Barnsley		Co-ordinating a common approach to the commissioning of primary care services	
Manage the delegated allocation for commissioning of primary medical care services in Barnsley			

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1	**Clinical Leadership**

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.2	**Management of Conflicts of Interest (s14O)**

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***Y***
If relevant provide brief details here OR cross refer to detailed report if used	

3.3	**Discharging functions effectively, efficiently, & economically (s14Q)**

Have any financial implications been considered & discussed with the Finance Team?	***Y***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.4	**Improving quality (s14R, s14S)**

Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.5	**Reducing inequalities (s14T)**

Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.6	**Public Involvement & Consultation (s14Z2)**

Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.7	**Data Protection and Data Security**

Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.8	**Procurement considerations**

Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
Has a Single Tender Waiver form been completed if appropriate?	***NA***
Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
If relevant provide brief details here OR cross refer to detailed report if used	

3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***
	If relevant provide brief details here OR cross refer to detailed report if used	

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 January 2022

RISK AND GOVERNANCE REPORT

PART 1A – SUMMARY REPORT

1. THIS PAPER IS FOR

Decision		*Approval*		*Assurance*	✓	*Information*	

2. PURPOSE

- To assure the Primary Care Commissioning Committee members re the delivery of the CCG's annual strategic objectives.
- To assure the Primary Care Commissioning Committee of current risks to the organisation are being effectively managed and monitored appropriately.

3. REPORT OF

	Name	Designation
Executive Lead	Richard Walker	Head of Governance & Assurance
Author	Paige Dawson	Governance, Risk & Assurance Facilitator

4. SUMMARY OF PREVIOUS GOVERNANCE

The matters raised in this paper have been subject to prior consideration in the following forums:

Group / Committee	Date	Outcome
N/A		

5. EXECUTIVE SUMMARY

Introduction

In common with all committees of the CCG, the Primary Care Commissioning Committee receives and reviews at every meeting extracts of the Governing Body Assurance Framework (GBAF) and Corporate Risk Register providing details of the risks allocated to the Committee for monitoring and updating.

Assurance Framework

The Governing Body Assurance Framework (GBAF) facilitates the Governing Body in assuring the delivery of the CCG's annual strategic objectives. The GBAF is refreshed at the start of each financial year then reported to every meeting of the Governing Body as part of the Risk & Governance Exception Report.

Appendix 1 of this report provides the Committee with an extract from the GBAF of the two risks for which the Primary Care Commissioning Committee is the assurance provider. Two risks are scored as 'Amber' High Risk:

- Risk ref 2.1 Primary Care - There is a risk to the delivery of Primary Care priorities if the following threat(s) are not successfully managed and mitigated by the CCG:
    - Engagement with primary care providers and workforce
    - Workforce and capacity shortage, recruitment, and retention
    - Under development of opportunities of primary care at scale, including new models of care
    - Primary Care Networks do not embed and support delivery of Primary Care at place
    - Not having quality monitoring arrangements embedded in practice
    - Inadequate investment in primary care
    - Independent contractor status of General Practice

- Risk ref 9.1 Digital Technology - There is a risk that the key deliverables will not be achieved if the following threats to delivery are not appropriately managed and mitigated:
    - Lack of IT technical expertise locally for input into projects and programmes of work / lack of technical support to ensure deliverables are robust
    - Primary Care colleagues fatigued with the amount of IT work scheduled
    - Short timelines to deliver projects
    - Supplier and equipment delays
    - constructive and timely engagement by system partners to deliver a SCR by 20/21
    - system wide strategic digital strategy and planning currently under-resourced with no dedicated Barnsley resource available to progress this work
    - Incomplete information available from NHS Futures regarding future work.

Risk Register

The Risk Register is an important governance document that facilitates the effective management of the CCG's strategic and operational risks. The Risk Register is a repository of current risks to the organisation, including risk ratings and the controls in place to mitigate the risk. The full risk register is submitted to the Committee on a six monthly basis, (March and September), the red and amber rated risks are considered at each meeting of the Committee. In line with reporting timescales, Members' attention is drawn to Appendix 1 of this report which provides the Committee with an exception risk register report associated with the Primary Care Commissioning Committee.

	There are currently five risks on the Corporate Risk Register allocated to the PCCC for which the Committee is responsible for managing. Of the five risks, there is one red (extreme) rated risk, one amber risk (high), one yellow risk (moderate) and two green (low) risks. Members are asked to review the risks detailed on Appendix 1 to ensure that the risks are being appropriately managed and scored. Members are asked to review the risk detailed on Appendix 1 to ensure that the risk is being appropriately managed and scored.
6.	**THE COMMITTEE IS ASKED TO:**
	• Review and agree that the risks are being appropriately managed and scored
7.	**APPENDICES / LINKS TO FURTHER INFORMATION**
	• Appendix 1 - GBAF • Appendix 2 – Risk Register

Agenda time allocation for report:	5 minutes

PART 1B – SUPPORTING INFORMATION & ASSURANCE

1. Links to Corporate Priorities, GBAF and Risk Register

This report provides assurance against the following corporate priorities on the Governing Body Assurance Framework

1.1 Urgent & Emergency Care		6.1 Efficiency Plans	
2.1 Primary Care	✓	7.1 Transforming Care for people with LD	
3.1 Cancer		8.1 Maternity	
3.2 Maximising Elective Activity		9.1 Digital and Technology	✓
4.1 Mental Health		10.1 Compliance with statutory duties	
5.1 Integrated Care @ System		11.1 Delivery of Enhanced Health in Care Homes	
5.2 Integrated Care @ Place		12.1 Delivering The Covid Vaccination Programme & Meeting The Needs of Patients with Covid-19	
5.3 Implementing Population Health Management And Personalised Care			

The report also provides assurance against the following red or amber risks on the Corporate Risk Register:	*ALL*

2. Links to statutory duties

This report has been prepared with regard to the following CCG statutory duties set out in Chapter A2 of the NHS Act

Management of conflicts of interest (s14O)		Duties as to reducing inequalities (s14T)	
Duty to promote the NHS Constitution (s14P)	✓	Duty to promote the involvement of each patient (s14U)	
Duty to exercise its functions effectively, efficiently and economically (s14Q)		Duty as to patient choice (s14V)	
Duty as to improvement in quality of services (s14R)		Duty as to promoting integration (s14Z1)	
Duty in relation to quality of primary medical services (s14S)		Public involvement and consultation (s14Z2)	

3. Governance Considerations Checklist *(these will be especially relevant where a proposal or policy is brought for decision or approval)*

3.1 Clinical Leadership

Have GB GPs and / or other appropriate clinicians provided input and leadership?	***NA***

3.2 Management of Conflicts of Interest (s14O)

Have any potential conflicts of interest been identified and managed appropriately, having taken advice from the Head of Governance & Assurance and / or the Conflicts of Interest Guardian if appropriate?	***NA***

3.3 Discharging functions effectively, efficiently, & economically (s14Q)

Have any financial implications been considered & discussed with the Finance Team?	***NA***
Where relevant has authority to commit expenditure been sought from Management Team (<£100k) or Governing Body (>£100k)?	***NA***

3.4	**Improving quality (s14R, s14S)**	
	Has a Quality Impact Assessment (QIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Chief Nurse (or Deputy) if appropriate?	***NA***
3.5	**Reducing inequalities (s14T)**	
	Has an Equality Impact Assessment (EIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from Equality Diversity & Inclusion Lead if appropriate?	***NA***
3.6	**Public Involvement & Consultation (s14Z2)**	
	Has a s14Z2: Patient and Public Participation Form been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the Head of Comms & Engagement if appropriate?	***NA***
3.7	**Data Protection and Data Security**	
	Has a Data Protection Impact Assessment (DPIA) been completed if relevant?	***NA***
	Have any issues or risks identified been appropriately addressed having taken advice from the SIRO, IG Lead and / or DPO if appropriate?	***NA***
3.8	**Procurement considerations**	
	Have any issues or risks identified been appropriately addressed having taken advice from the procurement Shared Service if appropriate?	***NA***
	Has a Single Tender Waiver form been completed if appropriate?	***NA***
	Has a Primary Care Procurement Checklist been completed where GPs, networks or Federations may be a bidder for a procurement opportunity?	***NA***
3.9	**Human Resources**	
	Have any significant HR implications been identified and managed appropriately, having taken advice from the HR Lead if appropriate?	***NA***
3.10	**Environmental Sustainability**	
	Have any significant (positive or negative) impacts on the environment or the CCG's carbon footprint been identified?	***NA***

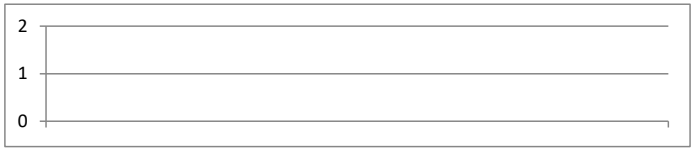
21/01/2022

NHS Barnsley CCG Governing Body Assurance Framework 2021-22

PRIORITY AREA 9: DIGITAL AND TECHNOLOGY	*Delivery supports these CCG objectives:*		PRINCIPAL THREATS TO DELIVERY
1. Development of a system wide shared care record 2. Ensure the delivery of the GP IT Futures Model to: - Comply with mandatory core standards re: interoperability and cyber security - Ensure HSCN supports effective and fast connectivity - Support the identification of equipment that poses a threat to cyber security e.g. pre Windows 10 software - Support the implementation and roll out of the GPIT refresh of IT equipment - Support the wider use of digital technology as described within the Long Term Plan - Working closely with the SY&B digital and IT workstream to deliver the digital road map - Delivery of O365 across Barnsley - Support the transition of video and online consultation software as the Doctorlink contract ends - Support the delivery of the Digital Primary Care First projects - Support the development of the Digital Citizen project in collaboration across "place" - Support the GP practices with digitisation of the Lloyd George records when confirmed by NHSEI - Support the roll out of the corporate Wi-Fi solution - Support the resilience work at Hillder House with the servers and CCG corporate IT needs - Support the upgrade to utilise digital technology for telephony resilience across GP practices and Hillder House 3. Development of a Barnsley "place" Digital Strategy that reflects the "system" digital strategy and aligns with the emerging Eststes strategy	Highest quality governance		There is a risk that the key deliverables will not be achieved if the following threats to delivery are not appropriately managed and mitigated: - Lack of IT technical expertise locally for input into projects and programmes of work / lack of technical support to ensure deliverables are robust - Primary Care colleagues fatigued with the amount of IT work scheduled - Short timelines to deliver projects - Supplier and equipment delays - constructive and timely engagement by system partners to deliver a SCR by 20/21 - system wide strategic digital strategy and planning currently under-resourced with no dedicated Barnsley resource available to progress this work - Incomplete information available from NHS Futures regarding future work.
	High quality health care	✓	
	Care closer to home	✓	
	Safe & sustainable local services	✓	
	Strong partnerships, effective use of £	✓	
	Links to NHSE/I Planning Guidance		
	F3 - Develop the underpinning digital and data capability to support population-based approaches		

Committees providing assurance	**PCCC & SMT**	*Executive Lead*	**JB**	*Clinical Lead*	**JH**

Risk rating	Likelihood	Consequence	**Total**
Initial	3	4	12
Current	3	4	12
Appetite	3	4	12
Approach	**Tolerate**		



Date reviewed	**Dec-21**

Rationale: Likelihood has been scored at 3 as transition to new provider has been successfully completed but will be kept under review. Consequence has been scored at 4 given the major impact on the CCG and the system if digital and It technology is not safeguarded and fully exploited.

Key controls to mitigate threat:	**Sources of assurance**	**Rec'd?**
Barnsley IT Strategy Group	Monthly meetings to review SCR progress and refresh Digitial Roadmap. Minutes to GB	Ongoing
BBS IT Delivery Group and BBS Digital Strategy Group established	Monthly meetings to review progress of the delivery of key projects and programmes. Updates to SMT, GB and PCCC	Ongoing
GP IT and Corporate IT service commissioned from BBS IT Services, the successor to eMBED. The new shared service is now establishing working protocols. Shared staffing allows for technical and network experience to be available to the CCG. Additional staffing to be secured if Digital First EOIs are successful as bids include resource.	CCG representatives attend the BBS IT Delivery Group and BBS Digital Strategy Group. KPIs and other performance monitoring data is provided and reviewed. Isses would be escalated to SMT in first instance.	Ongoing
SYB has led a procurement leading to the identification of Doctorlink as the preferred local provider of online consultation services. Contact in place until Oct 2021 with another 2 year option.	Every Barnsley practice has Doctorlink installed for use within their practice.	Complete
Redcentric become the commissioned service to maintain HSCN	Transition to new HSCN network now complete across the Barnsley CCG & primary care estate	Complete

Gaps in assurance	Positive assurances received
Governance process to be established for the IT groups eg link with the IT Strategy group and the CCG Operational Group	
Gaps in control	**Actions being taken to address gaps in control / assurance**

RISK REGISTER – January 2022

Domains
1. Adverse publicity/ reputation
2. Business Objectives/ Projects
3. Finance including claims
4. Human Resources/ Organisational Development/ Staffing/ Competence
5. Impact on the safety of patients, staff or public (phys/psych)
6. Quality/ Complaints/ Audit
7. Service/Business Interruption/ Environmental Impact
8. Statutory Duties/ Inspections

Likelihood		Consequence		Scoring Description			Current Risk No's	Review
Almost Certain	5	Catastrophic	5	Red	Extreme Risk	(15-25)	11	Monthly
Likely	4	Major	4	Amber	High Risk	(8- 12)	20	3 mthly
Possible	3	Moderate	3	Yellow	Moderate Risk	(4 -6)	6	6 mthly
Unlikely	2	Minor	2	Green	Low Risk	(1-3)	3	Yearly
Rare	1	Negligible	1					
				Total = Likelihood x Consequence				

The initial risk rating is what the risk would score if no mitigation was in place. The residual/current risk score is the likelihood/consequence (impact) of the risk sits when mitigation plans are in place

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
CCG 14/10	2, 5, 6	If the Barnsley area is not able to attract & retain a suitable & sufficient Primary Care clinical workforce e.g. due to delays in recruiting into the ARRS roles there is a risk that: (a)Primary Medical Services for patients are inconsistent (b)The people of Barnsley will receive a poorer quality of healthcare services (c)Patients services could be further away from their home.	**3**	**3**	**9**	The Long Term Plan includes a section on workforce planning and Network Contract DES includes provision for a number of Primary Care specific roles that will support the delivery of services. The Network Contract DES has several deliverables that will support existing service delivery, utilise roles under the Additional Roles Scheme, support reduction in healthcare inequalities, and that will work towards achieving sustainable service delivery in Barnsley. The Primary Care Strategy Group has a workforce	Head of Primary Care. (Primary Care Commissioning Committee)	Governing Body	**4**	**4**	**16**	12/21	**Dec 2021** Workforce Plan has been submitted for ARRS to fully utilise available additional roles. Good progress is being made on recruitment but there are still risks associated with turnover. The ARRS has supported increase in primary care workforce numbers and roles.	01/22

			Initial Risk Score						Residual Risk Score					
Ref	**Domain**	**Risk Description**	**Likelihood**	**Consequence**	**Score**	**Mitigation/Treatment**	**Lead Owner of the risk**	**Source of Risk**	**Likelihood**	**Consequence**	**Score**	**Date Risk Assessed**	**Progress/ Update**	**Date for re-assessment**
						element included within its transformation plans and will support the Barnsley "Place" Workforce Plan. The Primary Care Strategy Group will incorporate the SYB ICS Primary Care Strategy to support consistent service delivery across the ICS reflecting the needs of Barnsley as a "place". NHS England has published an Interim People Plan to support the workforce challenge. Links have been developed with the Medical School to enhance attractiveness of Barnsley to students.							**Nov 2021** There was an October submission from PCN to CCG, this has not yet gone to NHSE (Deadline end of November for CCG to submit). This has any changes to recruitment since last submission and forward projections for 2022/23 & 2023/24 - the same risks of retention and unable to recruit are there, and ongoing discussions being held between CCG and PCN.	

CCG 15/03		If the CCG does not effectively discharge its delegated responsibility for contract performance management there is a risk that the CCG's reputation and relationship with its membership could be damaged.	**3**	**4**	**12**	The CCG has access to existing primary care commissioning resource within the Area Team under the RASCI agreement. The CCG has an open channel of communication with the Membership Council regarding commissioning and contracting arrangements (e.g. equalisation).	Head of Primary Care (Primary Care Commissioning Committee)	Risk Assessment	2	4	**8**	11/21	**Nov 2021** No further update. **August 2021** TOR have been submitted for the 360 Audit. This year it is Primary Care Finances that are to be audited.	02/22

NHS
Barnsley
Clinical Commissioning Group

PRIMARY CARE COMMISSIONING COMMITTEE

27 January 2022

PUBLIC WORK PLAN/AGENDA TIMETABLE MARCH 2022 TO JULY 2022

AGENDA ITEMS	MARCH 22	MAY 22	JULY 22
Apologies	✓	✓	✓
Quoracy	✓	✓	✓
Declaration of Interest	✓	✓	✓
Minutes of previous Public PCCC meeting	✓	✓	✓
Matters Arising Report	✓	✓	✓
STRATEGY, PLANNING, NEEDS ASSESSMENT & COORDINATION OF PRIMARY CARE			
Primary Care Networks Update	✓		✓
Primary Care Strategy/Updates		✓ tbc	
GP IT	**AS REQUIRED**		
Procurement Updates	**AS REQUIRED**		
Primary Care Estate			✓
Review of Primary Care business cases and investments	**AS REQUIRED**		
QUALITY & FINANCE			
Finance Update	✓	✓	✓
CQC Updates	✓	✓	✓
CONTRACT MANAGEMENT			
e-Declarations		✓	
PDA Sign Up 21/22		✓	
PDA 20/21 End of Year Report		✓	

PCCC 22/01/12.3

AGENDA ITEMS	MARCH 22	MAY 22	JULY 22
Contractual Issues	✓	✓	✓
LES, DES, Local Incentive Schemes	**AS REQUIRED**		
GOVERNANCE, RISK & ASSURANCE			
Risk & Governance Report	✓	✓	✓
Assurance Framework & Risk Register	✓	✓	✓
Internal Audit Report	**AS REQUIRED**		
Annual Assurance Report	✓		
Work Plan Update	✓		
OTHER			
Questions from the public	✓	✓	✓
Items for escalating to the Governing Body	✓	✓	✓