

Network Contract Directed Enhanced Service

Contract specification 2020/21 - PCN
Requirements and Entitlements

17 September 2020

NHS England and NHS Improvement



Network Contract Directed Enhanced Service

Contract Specification 2020/21 – PCN Requirements and Entitlements

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Equalities and health inequalities statement

"Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities."

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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 2019¹.
- 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 2020 to 31 March 2021.
- 1.7. This document has been 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 2020 and ending on 31 March 2021 unless expressly stated otherwise;
- 2.2.2. a “**practice**” refers to a primary medical services contractor;
- 2.2.3. a “**New Practice**” refers to a practice that is newly formed following the taking effect of a new primary medical services contract;
- 2.2.4. 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;
- 2.2.5. 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 agreement² in accordance with section 5.1.2.d;
- 2.2.6. 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;
- 2.2.7. an “**Previously Approved PCN**” refers to a PCN that was approved in the period commencing 1 July 2019 and ending on 31 March 2020;
- 2.2.8. 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;
- 2.2.9. the “**Network Area**” refers to the area of a PCN as described in section 5.1.3;
- 2.2.10. 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;
- 2.2.11. the “**PCN’s Patients**” refers collectively to the persons on a PCN’s Core Network Practices’ lists of patients;
- 2.2.12. the “**practice list size**” refers to the number of persons on the list of patients of the practice;

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 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;

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. Context

- 4.1.1. A practice wishing to participate in the Network Contract DES for the period from 1 April 2020 to 31 March 2021 must follow the participation process set out in this section 4.
- 4.1.2. A practice participating in this Network Contract DES acknowledges that it will automatically participate in subsequent years’ Network Contract DES unless the practice follows the opt-out process set out in section 4.13 of this Network Contract DES Specification.
- 4.1.3. A commissioner must ensure that any patients of a practice that is not participating in the Network Contract DES are covered by a PCN (for example through commissioning a local incentive scheme). Further information on commissioning PCN services for patients of non-participating practices is available in the Network Contract DES Guidance.

4.2. Eligibility

- 4.2.1. 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.

4.3. Participation

- 4.3.1. By 1 April 2020 the commissioner must indicate to each practice the method the practice must use to provide the information necessary for that practice to participate in the Network Contract DES. The information must be provided by using the form set out at Annex A of this Network Contract DES Specification.
- 4.3.2. Where a practice wishes to participate in the Network Contract DES, one of the situations below will apply. The practice must identify the relevant situation and act in accordance with the appropriate section:
- a. If the practice is a Core Network Practice under the Network Agreement of a Previously Approved PCN and there have been no changes to the following information:
 - i. identity of the Core Network Practices,
 - ii. the Nominated Payee,
 - iii. the Clinical Director;
 - iv. Network Area,the practice must act in accordance with section 4.4;
 - b. If the practice is a Core Network Practice under the Network Agreement of a Previously Approved PCN and there have been changes to the information listed in sections a.i to a.iv above, the practice must act in accordance with section 4.5;
 - c. If the practice has not previously participated in a Network Contract DES but wishes to be a Core Network Practice of a Previously Approved PCN, the practice must act in accordance with section 4.6;
 - d. If the practice is a New Practice and wishes to be a Core Network Practice of a Previously Approved PCN, the practice must act in accordance with section 4.7;

- e. 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 4.8; or
- f. 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 4.9.

4.4. Previously Approved PCNs with no change

- 4.4.1. Where this section applies, the practice must notify the commissioner of no change on or before 31 May 2020. Where the PCN wants to ensure there is no interruption to payments made to the PCN as the PCN transitions to this new Network Contract DES Specification, the Core Network Practices of that PCN must have completed the process for participating in the Network Contract DES prior to the next local payment deadline. Commissioners should liaise with Core Network Practices to confirm timescales.
- 4.4.2. On receipt of the notification, 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 whether its participation in the Network Contract DES is confirmed.
- 4.4.3. Where the commissioner notifies a practice that its participation in the Network Contract DES:
 - a. is not confirmed, section 4.10 applies;
 - b. is confirmed, section 4.11 applies.

4.5. Previously Approved PCNs with change

- 4.5.1. Where this section applies, the practice must notify the commissioner of the relevant change on or before 31 May 2020. Where the PCN wants to ensure there is no interruption to payments made to the PCN as the PCN transitions to this new Network Contract DES Specification, the Core Network Practices of that PCN must have completed the process for participating in the Network Contract DES prior to the next local payment deadline. Core Network Practices should liaise with the commissioner to confirm timescales.
- 4.5.2. The practice must include in the notification:
 - a. the change that has occurred;
 - b. the reasons for the change.

- 4.5.3. The practice must promptly provide to the commissioner any information the commissioner requests in relation to the change.
- 4.5.4. 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 whether its participation in the Network Contract DES is confirmed.
- 4.5.5. Where the commissioner consents to a change in the details of the Previously Approved PCN, the commissioner must complete the PCN ODS Change Instruction Notice³, to indicate any changes to a PCN's membership and/or Nominated Payee. 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 ensure that the latest it submits the notice by 12 June 2020.
- 4.5.6. Where the commissioner notifies a practice that its participation in the Network Contract DES:
 - a. is not confirmed, section 4.10 applies;
 - b. is confirmed, section 4.11 applies.

4.6. Previously non-participating practice joining a Previously Approved PCN

- 4.6.1. Where this section applies, the practice must provide the following information to the commissioner on or before 31 May 2020:
 - 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, prior to the start of any service delivery under the Network Contract DES.

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

- 4.6.2. Where the commissioner is satisfied that it has all relevant 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 whether its participation in the Network Contract DES is confirmed.
- 4.6.3. Where, as a result of the commissioner's decision, there is a change in the details of the Previously Approved PCN, the commissioner must complete the PCN ODS Change Instruction Notice⁴, to indicate any changes to a PCN's membership and/or Nominated Payee. 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 ensure that the latest it submits the notice is by 12 June 2020.
- 4.6.4. Where the commissioner notifies a practice that its participation in the Network Contract DES:
- a. is not confirmed, section 4.10 applies;
 - b. is confirmed, section 4.11 applies.

4.7. New Practice joining a Previously Approved PCN

- 4.7.1. Where this section applies, the New Practice must provide the information set out in sections 4.6.1.a to 4.6.1.d to the commissioner.
- 4.7.2. A New Practice may provide the information to the commissioner at any time during the financial year.
- 4.7.3. Where the commissioner is satisfied that it has all relevant 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, notify the practice whether its participation in the Network Contract DES is confirmed.
- 4.7.4. Where, as a result of the commissioner's decision, there is a change in the details of the Previously Approved PCN, the commissioner must complete the PCN ODS Change Instruction Notice⁵, to indicate any changes to a PCN's membership and/or Nominated Payee. The commissioner must submit the notice by the last working day on or before the 14th day of a month for the change to take effect by the end of that month.

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

⁵ The PCN ODS Change Instruction Notice is available [here](#).

- 4.7.5. Where the commissioner notifies a practice that its participation in the Network Contract DES:
- a. is not confirmed, section 4.10 applies;
 - b. is confirmed, section 4.11 applies.

4.8. New Practice or existing practice forms a new PCN

- 4.8.1. Where this section applies, the practice must provide the following information to the commissioner on or before 31 May 2020:
- a. the names and ODS codes⁶ of the proposed PCN's Core Network Practices⁷;
 - b. the number of the PCN's Patients as at 1 January 2020⁸;
 - 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 Payee⁹ 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.
- 4.8.2. The information must be provided by using the form set out at Annex A of this Network Contract DES Specification.
- 4.8.3. The practice must promptly provide to the commissioner any further information the commissioner requests in relation to the proposed PCN.
- 4.8.4. 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

⁶ <https://digital.nhs.uk/services/organisation-data-service>

⁷ This may be a single super practice.

⁸ 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.

⁹ Payment nomination would only apply where there is more than one primary medical care contractor in the PCN.

receipt of the notification, notify the practice whether its participation in the Network Contract DES is confirmed and whether the proposed PCN is approved.

- 4.8.5. Where the commissioner approves the PCN, the commissioner must complete the PCN ODS Change Instruction Notice¹⁰ to indicate the details of the PCN. The commissioners 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 ensure that the latest it submits the notice by 12 June 2020. The commissioner must also indicate to the PCN and its Core Network Practices when they are required to commence delivery of the Network Contract DES and the date payments will be made, taking into account local payment arrangements.
- 4.8.6. Where the commissioner notifies a practice that its participation in the Network Contract DES:
 - a. is not confirmed, section 4.10 applies;
 - b. is confirmed, section 4.11 applies.

4.9. PCNs unwilling to accept a practice

- 4.9.1. Where this section applies, the practice must notify the commissioner by 31 May 2020 that no Previously Approved PCN or proposed PCN is willing to enable the practice to be a Core Network Practice of the PCN.
- 4.9.2. On receipt of the notification, the commissioner will liaise with the relevant LMC to facilitate discussions between the practice wishing to sign-up to the Network Contract DES and the appropriate PCN(s) taking all reasonable steps to reach agreement on the terms for the inclusion of the practice in a PCN.
- 4.9.3. Where the commissioner determines that there is no agreement on the terms for the inclusion of the practice in a PCN, the commissioner may require a PCN to include the practice as a Core Network Practice of that PCN.
- 4.9.4. Where the commissioner is minded to require a PCN to include the practice as a Core Network Practice of that PCN, 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

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

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.

- 4.9.5. Where the commissioner requires a PCN to include the practice as a Core Network Practice of that PCN pursuant to section 4.9.3:
- a. the commissioner must inform that PCN on or before 30 June 2020;
 - b. the commissioner must inform any other PCN with whom the commissioner has been liaising with pursuant to section 4.9.2 of its determination; and
 - c. 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.
- 4.9.6. As soon as practicable after the PCN has taken the necessary steps pursuant to section 4.9.5.c, 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 preferences¹¹, prior to the start of any service delivery under the Network Contract DES.
- 4.9.7. 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

¹¹ <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>

the practice in the PCN, notify the practice whether its participation in the Network Contract DES is confirmed.

- 4.9.8. 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 Notice¹². 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.
- 4.9.9. Where the commissioner notifies a practice that its participation in the Network Contract DES:
- a. is not confirmed, section 4.10 applies;
 - b. is confirmed, section 4.11 applies.

4.10. Participation not confirmed

- 4.10.1. 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.
- 4.10.2. 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.
- 4.10.3. If the commissioner notifies the practice that its participation in the Network Contract DES is confirmed, section 4.11 applies;

4.11. Confirmation of participation

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

¹² The PCN ODS Change Instruction Notice is available [here](#).

- 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.

4.12. Auto-enrolment in the subsequent Network Contract DES or in-year variation

4.12.1. A practice participating in this Network Contract DES acknowledges that it will automatically participate in:

- a. the subsequent Network Contract DES (which means the Network Contract DES commencing on 1 April 2021); and
- b. any variation to the Network Contract DES Specification that is to take effect prior to 31 March 2021,

unless it chooses not to continue to participate in the Network Contract DES in accordance with section 4.13.

4.12.2. The PCN acknowledges that to automatically participate in the subsequent Network Contract DES and the associated specification or the varied Network Contract DES Specification (as relevant), this particular Network Contract DES Specification must end on either 31 March 2021 or, where the Network Contract DES Specification has been varied, the date determined in accordance with section 4.13, to be replaced with the new specification. Subject to section 4.12.3 therefore, where a practice participates in the Network Contract DES, the practice and the commissioner agree that immediately after the 31 March 2021 or the date determined in accordance with section 4.13, as relevant, provided that the practice’s participation has not ceased at an earlier date:

- a. this Network Contract DES Specification will cease to have effect; and
- b. the practice’s primary medical services contract will be deemed to have been varied to remove the incorporation of this Network Contract DES Specification.

4.12.3. Unless expressly stated otherwise or by necessary implication, no term of this Network Contract DES Specification shall survive beyond 31 March 2021 or earlier termination (as relevant).

4.13. Opting out of auto-enrolment in the subsequent Network Contract DES and opting out of the Network Contract DES where there is an in-year variation

- 4.13.1. A Core Network Practice of a PCN may choose not to participate in:
- a. the subsequent Network Contract DES (which means the Network Contract DES commencing on 1 April 2021); or
 - b. the Network Contract DES where there is any variation to the Network Contract DES Specification that is to take effect prior to 31 March 2021, in which case that Core Network Practice must notify the commissioner within one calendar month of the publication by NHS England and NHS Improvement of the specification for the subsequent Network Contract DES or the varied Network Contract DES Specification (as relevant).
- 4.13.2. The PCN, of which the practice providing notice under section 4.13.1 was a Core Network Practice, must act in accordance with any provisions set out in the specification for the subsequent Network Contract DES or the varied Network Contract DES Specification that relate to changes to the PCN.
- 4.13.3. For the avoidance of doubt, a practice choosing not to participate in the subsequent Network Contract DES or any variation is required to act in accordance with this Network Contract DES Specification until 31 March 2021 unless section 4.14 applies.

4.14. Ending participation in this Network Contract DES

- 4.14.1. A practice participating in the Network Contract DES acknowledges that it will participate in the Network Contract DES until 31 March 2021 unless:
- a. the practice chooses to end its participation in this Network Contract DES by notifying the commissioner prior to 31 May 2020, in which case section 4.14.2 applies;
 - b. the practice provides notice under section 4.13.1 that it no longer wishes to participate in the Network Contract DES where there is any variation to the Network Contract DES Specification that is to take effect prior to the 31 March 2021, in which case section 4.14.2 applies; or
 - c. any of the following events occur:
 - i. expiry or termination of the Core Network Practice's primary medical services contract, in which case section 5.13 applies;
 - ii. there has been an irreparable breakdown in relationship or an expulsion, in which case section 5.14 applies;

- iii. the commissioner consents to a merger or split of the Core Network Practice, in which case section 5.15 applies; or
- iv. the commissioner determines that the Core Network Practices' participation in the Network Contract DES should cease in accordance with section 8.

4.14.2. Where a practice notifies the commissioner:

- a. prior to 31 May 2020 that it chooses to cease its participation in the Network Contract DES; or
- b. that it no longer wishes to participate in the Network Contract DES where there is any variation to the Network Contract DES Specification that is to take effect prior to 31 March 2021,

the same process applies as where there is a change in the Core Network Practice members due to expiry or termination of a Core Network Practice's primary medical services contract (and the applicable sections are sections 5.13.1.b to 5.13.4.c).

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 providers¹³) 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 2020 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

¹³ 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 agreement¹⁴¹⁵.
- 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 preferences¹⁶¹⁷.

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;
- c. cover a boundary that makes sense to:

¹⁴ 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.

¹⁵ 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/>

¹⁶ <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>

¹⁷ A template data controller/data processor agreement and a template data controller/data controller agreement can be found at <https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-data-templates/>

- 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.
- 5.2.2. A PCN must ensure its Network Agreement reflects the requirements of this Network Contract DES Specification.
- 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 arrangements¹⁸, that are compliant with data protection legislation to:

¹⁸ 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/>

- a. support the delivery of extended hours access service requirement from 1 April 2020; and
 - b. support the delivery of all other 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:
- a. provide the Extended Hours Access service under this Network Contract DES Specification from 1 April 2020; and
 - b. to take such steps as are necessary to provide the service requirements under this Network Contract DES Specification other than the Extended Hours Access service in the timescales set out in this Network Contract DES Specification.
- 5.2.5. The PCN acknowledges that confirmation of the Core Network Practices' participation in this Network Contract DES may not be received until after 1 April 2020. The PCN acknowledges that it must act in accordance with section 5.2.4 but the PCN acknowledges that section 9 sets out backdating of certain elements of the financial entitlements.
- 5.2.6. A commissioner and a PCN must not vary this Network Contract DES Specification. For the avoidance of doubt, the 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**")¹⁹, 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 local incentive scheme.

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;

¹⁹ 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 requirements²⁰:
- 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 6.5;
 - d. supporting PCN implementation of agreed service changes and pathways and work closely with Core Network Practices and the commissioner and other PCNs to develop, support and deliver local improvement programmes aligned to national priorities;
 - e. developing local initiatives that enable delivery of the PCN's agenda, working with commissioners and other networks to reflect local needs and ensuring initiatives are coordinated;
 - f. developing relationships and work closely with other Clinical Directors, clinical leaders of other primary care, health and social care providers, local commissioners and LMCs;

²⁰ 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.

- 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/STP, contributing to the strategy and wider work of the ICS/STP.
- 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 and analytics

- 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 a GP 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 data²¹ 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 to support data collections for the indicators related to the Network Contract DES some of which will be included in the Network Dashboard²².

5.5. Patient engagement

- 5.5.1. A PCN must act in accordance with the requirements relating to patient engagement under the PCN's Core Network Practice's primary medical services contracts by:
 - a. engaging, liaising and communicating with the PCN's Patients in the most appropriate way;
 - b. informing and/or involving them in developing new services and changes related to service delivery; and
 - c. engaging with a range of communities, including 'seldom heard' groups.
- 5.5.2. A PCN must provide reasonable support and assistance to the commissioner in the performance of its duties²³ 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

²¹ 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).

²² The Network Dashboard will be 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.

²³ Section 14Z2 of the 2006 NHS Act.

before the date on which the sub-contracting arrangement is intended to begin.

- 5.6.3. A PCN (and its members that are practices) must make available on request from the commissioner any information relating to sub-contracting arrangements and reporting information relating to either the delivery of network services or the engagement of PCN staff, for which reimbursement is being claimed under the Network Contract DES.
- 5.6.4. Notwithstanding any provision to the contrary of a PCN Core Network Practices' primary medical services contract, a Core Network Practice may sub-contract any of its rights or duties under the Network Contract DES in relation to non-clinical matters provided that the Core Network Practice obtains prior written approval from the commissioner (such approval to not be unreasonably withheld or delayed).
- 5.6.5. Where a Core Network Practice of a PCN has sub-contracted a non-clinical matter that relates to the Network Contract DES, the sub-contract may allow the sub-contractor to sub-contract the non-clinical matter provided that the Core Network Practice obtains prior written approval from the commissioner (and such approval will not be unreasonably withheld or delayed).

5.7. Collaboration with non-GP providers

- 5.7.1. A PCN must agree with local community services providers, mental health providers and community pharmacy providers how they will work together.
- 5.7.2. A PCN must ensure that compliance with this requirement is evidenced through setting out in Schedule 7 of the Network Agreement:
 - a. the specifics of how, where required by this Network Contract DES Specification or otherwise deemed appropriate, the service requirements will be delivered through integrated working arrangements between the PCN and other providers; and
 - b. how providers will work together, including agreed communication channels, agreed representatives, and how any joint decisions will be taken.
- 5.7.3. A PCN must detail the arrangements with its local community services provider(s) in Schedule 7 of the Network Agreement by 30 September 2020. 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 by 31 March 2021.

5.8. Changes to a PCN

- 5.8.1. 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.
- 5.8.2. Where a PCN is minded to change that information, it must act in accordance with the appropriate section of this Network Contract DES Specification.

5.9. Clinical Director change

- 5.9.1. 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.

5.10. Nominated Payee change

- 5.10.1. A PCN must obtain the prior written consent of the commissioner to any change in the identity of its Nominated Payee.
- 5.10.2. 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.
- 5.10.3. 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 Notice²⁴.
- 5.10.4. The commissioner must also ensure this information aligns to the information contained within the relevant GP payment systems.
- 5.10.5. 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

²⁴ 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.

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.

5.11. Change in non-Core Network Practice members

5.11.1. 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.

5.12. Change in Core Network Practice members

5.12.1. 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 4.14. The process for changing Core Network Practice members is separate from the process of a practice ending its participation in the Network Contract DES but there may be situations in which a change is a result of a practice ending its participation.

5.12.2. Once a PCN has been approved in line with the process set out in this Network Contract DES Specification, changes to Core Network Practices of the PCN will only be allowed in the exceptional circumstances set out in sections 5.13 to 5.16.

5.12.3. 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 5.13 to 5.16, 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.

5.12.4. 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.

5.12.5. 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 Sum²⁵. 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.

²⁵ Refer to section 6.2 for details of baselines.

- 5.12.6. A PCN must promptly provide any information required by the commissioner in relation to the change in Core Network Practice membership.
- 5.12.7. The commissioner will record a PCN's Core Network Practices 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 Notice²⁶. 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.
- 5.12.8. 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 Notice²⁷ 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.
- 5.12.9. The PCN must ensure the Network Agreement is updated as soon as reasonably practicable following the change taking effect.

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

- 5.13.1. Where the primary medical services contract of a Core Network Practice of a PCN expires or terminates for any reason prior to 31 March 2021, 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 – i.e. whether a new primary medical services contract will be

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

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

entered into which takes over the former practice's list of patients, whether the list of patients of the previous practice are dispersed between existing practices in the area or any other likely consequences;

- ii. the impact of any consequences on the financial entitlements set out in this Network Contract DES Specification including consideration of the fact that for payments based on practice list size or PCN list size, the consequence of a practice no longer being a Core Network Practice of a PCN could result in a reduction in the level of payments made to a PCN; and
- iii. any other relevant matters.

5.13.2. The commissioner will, depending on the likely consequences and following any discussion with the LMC, determine the outcome of such matters including any changes to the information of the PCN such as changes to the Network Area and/or level of payments due to the PCN under this Network Contract DES specification.

5.13.3. 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 2020.

5.13.4. 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 Notice²⁸.

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

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

- 5.14.1. 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.
- 5.14.2. The commissioner will consider the matter, including holding discussions with all practices within the PCN.
- 5.14.3. The commissioner will consider the consequences of the practice being expelled from the PCN. This will include:
 - a. the likely consequences for the registered patients of the practice of that practice being expelled the PCN, i.e. whether that practice can join another PCN;
 - b. the impact of any consequences on the financial entitlements of the Network Contract DES of the PCN which the practice would be expelled from and that of any PCN the practice may seek to join. It is acknowledged that for payments based on practice list size or PCN list size, the consequence of a practice being expelled from a PCN is likely to be a reduction in the level of payments made to a PCN;
 - c. the viability of the PCN including reference to the criteria of a PCN set out in section 5.1.2; and
 - d. any other relevant matters.
- 5.14.4. 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.
- 5.14.5. 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 Notice²⁹.

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

5.15.1. 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.

5.15.2. 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.

5.15.3. The commissioner may require any New Practice formed from a merger/split to provide the information set out in sections 4.6.1.a to 4.6.1.d before indicating to the New Practice whether its participation in the Network Contract DES is confirmed.

5.15.4. Where the commissioner consents to the type of change set out in section 5.15.1 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.

5.15.5. Where the commissioner consents to the type of change set out in section 5.15.1, the commissioner must, before the end of the month in which it gives consent, complete the PCN ODS Change Instruction Notice³⁰. 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.

5.15.6. 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

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

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

- 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.

5.15.7. 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.

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

- a. the likely consequences for the registered patients of the practice(s);
- b. the impact of any consequences on a PCN's financial entitlements due under this Network Contract DES Specification given that the consequence of a practice leaving a PCN is likely to be a reduction in the level of payments made to the PCN;
- 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; and
- d. any other relevant matters.

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

- a. the application of sections 5.15.1 to 5.15.8 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 5.15.1 to 5.15.8 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.

5.15.10. Where the commissioner consents to any changes to the details of a PCN as a result of sections 5.15.8 or 5.15.9, the commissioner must complete the PCN ODS Change Instruction Notice³¹. 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.

³¹ The PCN ODS Change Instruction Notice is available [here](#).

5.16. Change in Core Network Practice membership due to New Practice joining

- 5.16.1. Where a New Practice wishes to join a Previously Approved PCN, section 4.7 applies.
- 5.16.2. Where a commissioner has confirmed the New Practice's participation in the Network Contract DES, the PCN must ensure that its Network Agreement reflects the arrangements for delivery of the Network Contract DES.

6. Additional Roles Reimbursement Scheme

6.1. General

- 6.1.1. 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.
- 6.1.2. The new additional staff recruited by a PCN 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**”.

6.2. Principle of additionality

- 6.2.1. 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 6.2.2 to 6.2.11 below set out how additionality is measured.
- 6.2.2. 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 established³² 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.

³² See [Network Contract DES: Additional Roles Reimbursement Scheme Guidance](#) 2019/20 for further information.

- 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 - funded³³ 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.
- 6.2.3. Subject to section 6.2.4 below, a PCN's Core Network Practices are required to maintain the declared PCN baseline in order to meet the additionality rules under the Network Contract DES Additional Roles Reimbursement Scheme. In the event the PCN baseline reduces (meaning a vacancy arises in a Core Network Practices' 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 9.
- 6.2.4. 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 and physician associates 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.
- 6.2.5. 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.
- 6.2.6. A PCN baseline will not be established for health and wellbeing coaches, care coordinators, dieticians, podiatrists or occupational therapists. While the PCN baseline will not include these five 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 five roles, the PCN is confirming that:

³³ The six reimbursable roles funded include those directly employed by the CCG.

- 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.
- 6.2.6A. Section 6.2.6 above will also apply to the two new roles being introduced from 1 October 2020 – Nursing Associate and Trainee Nursing Associate – which from this date will also be considered Additional Roles.
- 6.2.7. 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 1.9.10. 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.
- 6.2.8. Staff employed or engaged via a sub-contract within the reimbursable roles after 31 March 2019 (i.e. above the baseline set) will be eligible for reimbursement under the Network Contract DES, if those staff are employed or engaged to deliver services across the PCN and if the PCN meets the requirements set out in this Network Contract DES specification.
- 6.2.9. 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**”)³⁴ transferred to become PCN staff will be exempt from the additionality principles.
- a. For this exception to apply to clinical pharmacists previously employed via the national *Clinical Pharmacist in General Practice Scheme* the employee must have 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 Specification³⁵.
- 6.2.10. For all clinical pharmacists and pharmacy technicians employed under the MOCH Scheme, transfer must take place by no later than 31 March 2021 under the relevant requirements for clinical pharmacists or pharmacy technicians within this Network Contract DES Specification. PCNs will be required to support any pharmacists who transfer from the MOCH Scheme prior to 31 March 2021 to complete their training. Where the transfer is agreed

³⁴ This will include some pharmacy technicians currently funded by CCGs.

³⁵ Full details on the transfer arrangements for clinical pharmacists is available in the 2019/20 [Network Contract DES Guidance](#).

before 31 March 2021 then PCNs will be expected to make operational use of the pharmacist's experience in relation to Care Homes as outlined in the Network Contract DES Guidance. Any MOCH pharmacy technicians transferred will count towards a PCN's eligible limit as outlined in Table 1 in section 6.3.3. Where MOCH pharmacists do not transfer before 31 March 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.

- 6.2.11. The Additional Roles may be employed by a member of the PCN, or another body (e.g. GP Federation, voluntary sector provider, Local Authority or Trust). If the PCN chooses to commission the health services provided by the Additional Roles from another body, outside of the PCN, which therefore employs the staff, this does not change the general position that the PCN and its Core Network Practices are responsible for ensuring that the requirements of the Network Contract DES are delivered. The employer remains responsible for all costs (including taxes and where applicable VAT) and liabilities relating to the employment of staff or sub-contracting of services. A PCN should set out within the Network Agreement if and how any costs and liabilities will be shared.

6.3. Additional Roles Reimbursement Sum

- 6.3.1. A PCN must act in accordance with the requirements set out in this section 6 in respect of the Additional Roles and the arrangements in section 9 to receive reimbursement for employing or engaging the Additional Roles from within a maximum allocated sum. This sum is referred to in this Network Contract DES Specification as the "Additional Roles Reimbursement Sum".
- 6.3.2. From within the allocated Additional Roles Reimbursement Sum, a PCN may claim reimbursement for staff across ten eligible roles in accordance with the terms set out in this section 6.3, section 9 and Table 1.
- 6.3.2A. From 1 October 2020, a PCN may also claim reimbursement for staff across two further roles - Nursing Associate and Trainee Nursing Associate. Such reimbursement is from within the allocated Additional Roles Reimbursement Sum and must be in accordance with the terms set out in this section 6.3, section 9 and Table 1A.
- 6.3.3. A PCN may employ or engage any one or more of the roles set out in Table 1 below subject to any limits on the number of any specific role.
- 6.3.3A. From 1 October 2020, a PCN may also employ or engage any one or more of the roles set out in Table 1A below subject to any limits on the number of any specific role.

Table 1: Workforce roles eligible for reimbursement under the Network Contract DES with applicable limits

| Roles | Limit on number eligible for reimbursement |
|---------------------------------|--|
| Clinical Pharmacists | No limit |
| Pharmacy Technicians | One individual pharmacy technician per PCN where the PCN's Patients number 99,999 or less. Two individual pharmacy technicians per PCN where the PCN's Patients number 100,000 or over. |
| Social Prescribing Link Workers | No limit |
| Health and Wellbeing Coaches | No limit |
| Care Co-ordinators | No limit |
| Physician Associates | No limit |
| First Contact Physiotherapists | One WTE per PCN where the PCN's Patients number 99,999 or less. Two WTE per PCN where the PCN's Patients number 100,000 or over. |
| Dieticians | No limit |
| Podiatrists | No limit |
| Occupational Therapists | No limit |

Table 1A: Additional workforce roles eligible for reimbursement from 1 October 2020 under the Network Contract DES with applicable limits

| Roles | Limit on number eligible for reimbursement |
|---------------------------|---|
| Nursing Associate | No limit |
| Trainee Nursing Associate | No limit |

6.3.4. The commissioner may waive any limits in Table 1 where this is agreed by the PCN, the commissioner, and the relevant Integrated Care System (ICS).

6.4. Additional Role requirements

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

- a. Additional Roles employed or engaged via a sub-contract 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.
- b. Liaising with any employing organisation if relevant, the PCN must consider the appropriateness of, and if considered appropriate, the PCN must carry out, a review and appraisal process for Additional Roles whether they are employed directly by the PCN or a PCN member or engaged via a sub-contract.
- c. The PCN must ensure that 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 description.
- d. The PCN must ensure the PCN's approach to deploying the Additional Roles is set out in the Network Agreement.

6.4.2. 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).

6.4.3. 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.

6.4.4. The commissioner must complete and return the six-monthly workforce report to england.primarycareworkforce@nhs.net³⁷.

6.5. PCN Additional Roles planning and redistribution of Additional Roles Reimbursement Scheme funding

6.5.1. A PCN must complete and return to the commissioner a workforce plan, using the agreed national workforce planning template³⁸, providing details of its recruitment plans for 2020/21 by 31 August 2020 and indicative intentions through to 2023/24 by 31 October 2020.

6.5.2. 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 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.

6.5.3. The commissioner must:

- a. have shared with the PCN and relevant LMCs; and
- b. have agreed with the PCN,

by 30 September 2020 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 2021. This amount is referred to in this Network Contract DES Specification as the “**Unclaimed Funding**”.

6.5.4. 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 2020.

6.5.5. 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

³⁶ Further information is available in the [Network Contract DES Guidance](#).

³⁷ Further information is available in the [Network Contract DES Guidance](#).

³⁸ The workforce planning template is available at <https://www.england.nhs.uk/publication/pcn-workforce-planning-template-2020-21/>

commissioner may give other PCNs within the commissioner's boundary the opportunity to bid for the Unclaimed Funding.

- 6.5.6. 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.
- 6.5.7. 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 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.
- 6.5.8. 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 recruitment process ready to begin for the Additional Roles to which the Unclaimed Funding relates;
 - b. evidence that a bidding PCN has the resources and capability to undertake further recruitment; 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; and
 - ii. evidences that it is able to meet sections 6.5.8.a and 6.5.8.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 deprivation³⁹; and
 - f. any other factor that the commissioner, acting reasonably, considers is relevant to its decision.
- 6.5.9. 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

³⁹ 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>

- b. the commissioner will give preference to a bid which satisfies the criteria in section 6.5.8.c. over all other bids.
- 6.5.10. 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.
- 6.5.11. 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.
- 6.5.12. 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 2021 and that there is no right for the PCN to require a commissioner to continue paying the additional funding after 31 March 2021.
- 6.5.13. 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.

7. Service Requirements

7.1. Extended Hours Access

- 7.1.1. 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 2020/21 (which are referred to in this Network Contract DES Specification as “**CCG Extended Access Services**”).
- 7.1.2. 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 8. If a commissioner determines to withhold payment⁴⁰, the amount withheld will

⁴⁰ 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.

be an appropriate proportion of the extended hours access payment and the Core PCN funding payment.

- 7.1.3. 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 contracts⁴¹ 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 these would not be additional hours appointments) but could be provided at the other practice's premises; and
 - ii. a proportion of the additional clinical appointments must be provided after 8pm;
 - e. are demonstrably in addition to any appointments provided by the PCN's practices under the CCG Extended Access Services;
 - f. are held at times having taken into account the PCN's patient's expressed preferences, based on available data at practice or PCN level and evidenced by patient engagement;
 - g. equate to a minimum of 30 minutes per 1,000 registered patients per week, calculated using the following formula:

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

⁴¹ 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.

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

**this is the total number of person on the lists of patients of all Core Network Practices of the PCN as at 1 January 2020

- 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.
- 7.1.4. A PCN must set out how the extended hours access appointments will be delivered in the Network Agreement.
- 7.1.5. A PCN must ensure that all practices in the PCN member actively engage in planning of the provision of the extended hours access requirements and acknowledges that nothing in this Network Contract DES Specification require 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 7.1.3.g.
- 7.1.6. 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 Choices website, the practice leaflet, the practice website, on a waiting room poster, by writing to patients and active offers by staff booking appointments.
- 7.1.7. 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. 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 7.1.3.g. The PCN must

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

- 7.1.8. A commissioner must publicise information to help patients to identify which practices are offering appointments at given times.
- 7.1.9. 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.
- 7.1.10. 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.
- 7.1.11. 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.
- 7.1.12. 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.
- 7.1.13. The term "prior written approval" in section 7.1.11.a means an explicit agreement between the practice and the commissioner that specifically includes written approval to close for half a day on a weekly basis for the purposes of the Network Contract DES Specification. The agreement must take the form of either:
 - a. a new agreement which expressly states that:
 - i. it is pursuant to the Network Contract DES Specification; and
 - ii. it will expire no later than 31 March 2021; or
 - b. an existing agreement with the commissioner to close for half a day on a weekly basis, which, instead of referring to the Network Contract DES, explicitly references the GP Extended Hours Access Scheme Directed Enhanced Service which came to an end on 30 June 2019. For the purposes of the Network Contract DES, existing agreements will be considered to expire no later than 31 March 2021.

- 7.1.14. 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 (10) and (11) of the GMS Regulations⁴² or Schedule 2, Part 5 para 43 (5) and (6) of the PMS Regulations⁴³, as applicable - so that patients continue to have access to essential services which meet their reasonable⁴⁴ needs during core hours.

7.2. Structured Medication Review and Medicines Optimisation

7.2.1. From the 1 October 2020, 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 homes⁴⁵;
 - ii. with complex and problematic polypharmacy, specifically those on 10 or more medications;
 - iii. on medicines commonly associated with medication errors⁴⁶;
 - iv. with severe frailty⁴⁷, who are particularly isolated or housebound patients, or who have had recent hospital admissions and/or falls; and

⁴³ National Health Service (Personal Medical Services Agreements) Regulations 2015

⁴⁴ 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.

⁴⁵ 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).

⁴⁶ 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.

⁴⁷ Based on the validation of the eFI, on average around 3 per cent of over 65s will be identified as potentially living with severe frailty. However, in some practices this number may be significantly higher. 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/>

- v. using potentially addictive pain management medication;
- 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;⁴⁸
- 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 7.2, have due regard to NHS England and NHS Improvement guidance on Structured Medication Reviews and Medicines Optimisation⁴⁹.

7.3. Enhanced Health in Care Homes

7.3.1. By 31 July 2020, 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

⁴⁸ 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>

⁴⁹ [NHS England and NHS Improvement guidance on Structured Medication Reviews and Medicines Optimisation](#)

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.
- 7.3.1A. 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.
- 7.3.2. By 30 September 2020, 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.
- 7.3.3. As soon as is practicable, and by no later than 31 March 2021, a PCN must establish protocols between the care home and with system partners for information sharing, shared care planning, use of shared care records, and clear clinical governance.
- 7.3.4. From 1 October 2020, 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 7.3.2 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 Assessment⁵⁰ 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 27⁵¹.
- 7.3.5. For the purposes of this section 7.3, a 'care home' is defined as a CQC-registered care home service, with or without nursing.⁵²

⁵⁰ https://www.bgs.org.uk/sites/default/files/content/resources/files/2019-03-12/CGA%20Toolkit%20for%20Primary%20Care%20Practitioners_0.pdf

⁵¹ <https://www.nice.org.uk/guidance/ng27>

⁵² 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>

7.4. Early Cancer Diagnosis

7.4.1. From 1 October 2020, 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 12⁵³ and make use of:
 - a. clinical decision support tools;
 - b. practice-level data to explore local patterns in presentation and diagnosis of cancer; and
 - c. where available the Rapid Diagnostic Centre pathway for people with serious but non-specific symptoms⁵⁴;
 - ii. build on current practice to ensure a consistent approach to monitoring patients who have been referred urgently with suspected cancer or for further investigations to exclude the possibility of cancer ('safety netting'), in line with NICE Guideline 12; and
 - iii. ensure that all patients are signposted to or receive information on their referral including why they are being referred, the importance of attending appointments and where they can access further support;
- b. contribute to improving local uptake of National Cancer Screening Programmes. To fulfil this requirement, a PCN must:
 - i. work with local system partners – including the Public Health Commissioning team and Cancer Alliance – to agree the PCN's contribution to local efforts to improve uptake which should build on any existing actions across the PCN's Core Network Practices and must include at least one specific action to engage with a group with low-participation locally; and
 - ii. provide the contribution agreed pursuant to section 7.4.1.b.i within timescales agreed with local system partners; and
- c. establish a community of practice between practice-level clinical staff to support delivery of the requirements set out in sections 7.4.1.a to 7.4.1.b. A PCN must, through the community of practice:

⁵³ <https://www.nice.org.uk/guidance/ng12>

⁵⁴ 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/>

- 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; and
- ii. engage with local system partners, including Patient Participation Groups, secondary care, the relevant Cancer Alliance, and Public Health Commissioning teams.

7.5. Social Prescribing Service

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

7.5.2. 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.

7.5.3. Where a PCN directly employs Social Prescribing Link Workers to provide the service, the PCN will be considered to have provided the service where the PCN's Social Prescribing Link Workers comply with the provisions of paragraph 3 of Annex B of this Network Contract DES Specification.

7.5.4. Where a PCN sub-contracts provision of the service to another provider, the PCN will be considered to have provided the service where the persons employed or engaged by the sub-contracted provider to deliver the service comply with the provisions of paragraph 3 of Annex B of this Network Contract DES Specification. Where this applies, references to the Social Prescribing Link Worker or Workers in paragraph 3 of Annex B are to be read as references to the persons employed or engaged by the sub-contracted provider to deliver the service.

8. Contract management

8.1. General

8.1.1. 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.

8.1.2. A PCN acknowledges that, where a requirement or obligation of a PCN is not carried out, each Core Network Contract will be in breach of this Network Contract DES Specification.

- 8.1.3. 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.
- 8.1.4. 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.
- 8.1.5. 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 8.1.4.
- 8.1.6. 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.
- 8.1.7. 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 5.13 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.

9. Network financial entitlements

9.1. General

- 9.1.1. 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.
- 9.1.2. A PCN acknowledges that confirmation of participation in the Network Contract DES may not occur until June 2020 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 2020. Any such backdating is set out in the relevant sections of this section 9.
- 9.1.3. Where information relating to a new proposed PCN is submitted to the commissioner between 1 April 2020 and 31 March 2021, the commissioner will, where a PCN is approved, indicate when payments of the financial entitlements will be made.
- 9.1.4. Where the financial entitlements refers to a payment being based on practice list size or PCN list size, the relevant figure will be taken from the registration system (approved by NHS England) as at 1 January 2020 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 Practice's lists of patients such that the figure derived from the later date is more appropriate.

- 9.1.5. 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.
- 9.1.5A. If there is a change to the Nominated Payee that takes effect in accordance with section 5.10 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 2021 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.
- 9.1.6. 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 9.3 to 1.9.10.
- 9.1.7. 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.
- 9.1.8. If a practice is allocated to a PCN in accordance with section 4.9, 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 9.1.7, 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 4.9.7.

- 9.1.9. The adjustment referred to in section 9.1.8 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 (or six for the PCN Support Payment) 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 9.1.7, 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.

9.2. Administrative provisions relating to payment

- 9.2.1. 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.
- 9.2.2. 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.
- 9.2.3. 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.
- 9.2.4. 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.

9.2.5. 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 9 must be accurate.

9.2.6. 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 PCN⁵⁵ or relevant Core Network Practice as relevant must pay to the commissioner that equivalent amount.

9.2.7. 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 9, it

⁵⁵ 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.

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.

9.3. Network Participation Payment

9.3.1. 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 2020 to support practice engagement.

9.3.2. 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.

9.3.3. 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.

9.3.4. 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.

9.3.5. The NPP for the period 1 April 2020 to 31 March 2021 is calculated as £1.761 multiplied by the practice’s “**weighted patient population**” where weighted patient population means the practice’s Contractor Registered Population (as calculated in accordance with the SFE regardless of whether the SFE applies to that practice) as at 1 January 2020 and as adjusted by the Global Sum Allocation Formula set out in Part 1 of Annex B of the SFE.

9.3.6. Subject to sections 9.3.7 and 9.3.8, 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.

- 9.3.7. The commissioner will make the first payment of the relevant NPP amount to a Core Network Practice of a Previously Approved PCN 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 subject to section 9.1.7 and local payment arrangements. Where the first payment is paid after April 2020, the first payment will include payment of instalments backdated to April 2020.
- 9.3.8. Where a new proposed PCN is approved after 1 April 2020, the Core Network Practices of that PCN acknowledges that the NPP will be calculated as set out in section 9.3.4 and split into 12 monthly instalments but the PCN's 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. As indicated in section 4.8 the commissioner will, when the PCN is approved, indicate to the PCN the relevant service delivery commencement date and payment dates.
- 9.3.9. A Core Network Practice will no longer be eligible to receive the NPP if under exceptional circumstances it leaves the PCN after 31 May 2020. The change will take effect from the month following the month in which the Core Network Practice leaves the PCN.

9.4. Clinical Director Payment

- 9.4.1. A PCN is entitled to a population-based payment to facilitate the delivery of the requirements of the Clinical Director role.
- 9.4.2. The clinical director payment for the period 1 April 2020 to 31 March 2021 is calculated using a baseline equivalent of 0.25 WTE (1 WTE is £139,469 in 2020/21) per 50,000 PCN Patients (as at 1 January 2020)⁵⁶. This equates to a payment of £0.722⁵⁷ per registered patient per annum (which equates to £0.060 per patient per month).
- 9.4.3. Subject to sections 9.4.4 and 9.4.5, the amount calculated as the clinical director payment is payable in 12 equal monthly instalments and the commissioner must arrange for 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.
- 9.4.4. The commissioner will make the first payment of the relevant clinical director payment amount to a Previously Approved PCN no later than the end of the month in which the participation of all Core Network Practices of that PCN has been confirmed subject to section 9.1.7 and local payment arrangements.

⁵⁶ <https://digital.nhs.uk/services/organisation-data-service>

⁵⁷ The additional 6 per cent employer's superannuation will be met centrally.

Where the first payment is paid after April 2020, the first payment will include payment of instalments backdated to April 2020.

- 9.4.5. Where a new proposed PCN is approved after 1 April 2020, the PCN acknowledges that the clinical director payment will be calculated as set out in section 9.4.2 and split into 12 monthly instalments but the PCN will only be entitled to receive the monthly instalments for the months it delivers the service requirements of the Network Contract DES. As indicated in section 4.8 the commissioner will indicate to the PCN the relevant service delivery commencement date and payment dates when the PCN is approved.

9.5. Core PCN funding

- 9.5.1. A PCN is entitled to a payment of Core PCN Funding for use by the PCN as it sees fit.
- 9.5.2. The Core PCN Funding for the period 1 April 2020 to 31 March 2021 is calculated as £1.50 multiplied by the PCN list size (equating to £0.125 per patient per month).
- 9.5.3. Subject to sections 9.5.4 and 9.5.5, the amount calculated as the Core PCN Funding is payable in 12 equal monthly instalments and the commissioner must arrange for 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.
- 9.5.4. The commissioner will make the first payment of the relevant Core PCN Funding amount to an Approved PCN no later than the end of the month in which the participation of all Core Network Practices of that PCN has been confirmed subject to section 9.1.7 and local payment arrangements. Where the first payment is paid after April 2020, the first payment will include payment of instalments backdated to April 2020.
- 9.5.5. Where a new proposed PCN is approved after 1 April 2020, the PCN acknowledges that the Core PCN Funding will be calculated as set out in section 9.5.2 and split into 12 monthly instalments but the PCN will only be entitled to receive the monthly instalments for the months it delivers the service requirements of the Network Contract DES. As indicated in section 4.8 the commissioner will indicate to the PCN the relevant service delivery commencement date and payment dates when the PCN is approved.

9.5.6. The Commissioner must provide the Core PCN Funding from its CCG core allocations⁵⁸ as per the NHS Operational Planning and Contracting Guidance 2020/21⁵⁹.

9.6. Extended hours access payment

9.6.1. A PCN is entitled to a payment to facilitate the delivery of the requirements of the Extended Hours Access service requirement.

9.6.2. The extended hours access payment for the period 1 April 2020 to 31 March 2021 is calculated as £1.45 multiplied by the PCN list size (equating to £0.121 per patient per month).

9.6.3. Subject to sections 9.6.4 and 9.6.5, the amount calculated as the extended hours access payment is payable in 12 equal monthly instalments and the commissioner must arrange for 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.

9.6.4. The commissioner will make the first payment of the relevant extended hours access payment amount to an Approved PCN no later than the end of the month in which the participation of all Core Network Practices of that PCN has been confirmed subject to section 9.1.7 and local payment arrangements. Where the first payment is paid after April 2020, the first payment will include payment of instalments backdated to April 2020.

9.6.5. Where a new proposed PCN is approved after 1 April 2020, the PCN acknowledges that the extended hours access payment will be calculated as set out in section 9.6.2 and split into 12 monthly instalments but the PCN will only be entitled to receive the monthly instalments for the months it delivers the service requirements of the Network Contract DES. As indicated in section 4.8 the commissioner will indicate to the PCN the relevant service delivery commencement date and payment dates when the PCN is approved.

9.7. Care home premium

9.7.1. A PCN is entitled to a payment to facilitate delivery of services to patients in care homes.

9.7.2. The payment is calculated on the basis of £60 per bed for the period 1 August 2020 to 31 March 2021. The number of beds will be based on Care Quality Commission (CQC) data on beds within services that are registered as care

⁵⁸ Rather than specific primary medical care allocations.

⁵⁹ <https://www.england.nhs.uk/publication/nhs-operational-planning-and-contracting-guidance-2020-21/>

home services with nursing (CHN) and care home services without nursing (CHS) in England⁶⁰.

- 9.7.3. The commissioner must arrange for payment to be made to the PCN on a monthly basis from 1 August 2020 at a rate of £7.50 per bed per month for the period 1 August 2020 to 31 March 2021 based on the number of relevant beds in the PCN's Aligned Care Homes.
- 9.7.4. Subject to sections 9.7.5 to 9.7.7 the amount calculated as the care home premium payment is payable in eight equal monthly instalments and the commissioner must arrange for 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.
- 9.7.5. Where a new proposed PCN is approved after 1 August 2020, the PCN acknowledges that the care home premium payment will be calculated as set out in section 9.7.3 and split into eight monthly instalments but the PCN will only be entitled to receive the monthly instalments for the months it delivers the service requirements⁶¹ of the Network Contract DES. As indicated in section 4.8 the commissioner will indicate to the PCN the relevant service delivery commencement date and payment dates when the PCN is approved.
- 9.7.6. 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 Directory⁶².
- 9.7.7. Payment will only be made where the commissioner is satisfied that the PCN or its Core Network Practices have comprehensively coded care home residents using appropriate clinical codes as follows and as set out in section 10:
 - a. 160734000 – Lives in a nursing home; and
 - b. 394923006 – Live in a residential home.

9.8. PCN Support Payment

- 9.8.1. A PCN is entitled to the PCN Support Payment for the period 1 April 2020 to 30 September 2020. This payment is calculated as £0.27 multiplied by the PCNs "**weighted patient population**" where weighted patient population means the PCN's Core Network Practice's Contractor Registered Population (as calculated in accordance with the SFE regardless of whether the SFE

⁶⁰ 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.

⁶¹ Monthly payments will be paid in full regardless of whether the new proposed PCN was established mid-month.

⁶² 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.

applies to that practice) as at 1 January 2020 and as adjusted by the Global Sum Allocation Formula set out in Part 1 of Annex B of the SFE. This equates to £0.045 per weighted patient per month.

- 9.8.2. Subject to sections 9.8.3 and 9.8.4, the amount calculated as the PCN Support Payment is payable in six equal monthly instalments and the commissioner must arrange for 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.
- 9.8.3. The commissioner will make the first payment of the relevant PCN Support Payment amount to an Approved PCN no later than the end of the month in which the participation of all Core Network Practices of that PCN has been confirmed subject to section 9.1.7 and local payment arrangements. Where the first payment is paid after April 2020, the first payment will include payment of instalments backdated to April 2020.
- 9.8.4. Where a new proposed PCN is approved after 1 April 2020, the PCN acknowledges that the PCN Support Payment will be calculated as set out in section 9.8.1 and split into six monthly instalments but the PCN will only be entitled to receive the monthly instalments for the months it delivers the service requirements of the Network Contract DES. As indicated in section 4.8 the commissioner will indicate to the PCN the relevant service delivery commencement date and payment dates when the PCN is approved.

9.9. Additional funding from October 2020

- 9.9.1. A PCN and the commissioner acknowledge that:
 - a. additional funding will be made available to practices in the six months prior to 31 March 2021;
 - b. to receive the funding, a PCN may be required to carry out certain actions or activities;
 - c. NHS England and NHS Improvement will publish in a separate document prior to 1 October 2020 details of the level of funding, how to claim the funding and any actions or activities required to be eligible for the funding which will be agreed with the BMA's GPCE;
 - d. Where a PCN is required to carry out certain actions or activities to receive the funding and a PCN carries out those actions or activities, then the terms of the document published by NHS England and Improvement relating to those actions or activity and associated arrangements for funding will apply for the period specified in that document;

- e. Where a PCN does not carry out those actions or activities then the PCN will not be entitled to the funding and the terms of the document published by NHS England and NHS Improvement will not apply; and
- f. The existing provisions of this Network Contract DES Specification will not change as a result of the additional funding and therefore section 4.13.1.b will not apply in respect of the additional funding.

9.9A. Investment and Impact Fund

9.9A.1. From 1 October 2020, a PCN is entitled to additional funding by virtue of the Investment and Impact Fund (“IIF”). Consequently, from 1 October 2020:

- a. section 9.9 ceases to apply; and
- b. this section 9.9A applies.

9.9A.2. Subject to adherence to the provisions of this section 9.9A, a PCN is entitled to an achievement payment (the “Total Achievement Payment”) in relation to the IIF.

9.9A.3. A PCN acknowledges that:

- a. it will earn points based on its performance in relation to the IIF indicators (the “Indicators”)⁶³;
- 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 194 points across all Indicators; and
- e. each point is worth £111.00.

9.9A.4. In relation to the Indicators, a PCN acknowledges that:

- a. Each Indicator consists of:
 - i. a numerator (N);
 - ii. a denominator (D);
 - iii. a lower performance threshold (L);
 - iv. an upper performance threshold (U); 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 ($X=N/D$).

⁶³ IIF Indicators are set out in Annex D.

- c. The number of points that can be earned for each Indicator 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.

9.9A.5. In relation to the Indicators' thresholds, 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 earn 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.

9.9A.6. The commissioner will calculate a PCN's Total Achievement Payment in accordance with the five steps listed below, each of which is set out in more detail in Annex C:

- a. Step 1: For each 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.
- 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 Total Achievement Payment for the PCN (the sum of Achievement Payments across all Indicators) will be calculated.
- 9.9A.7. The commissioner will calculate the Total Achievement Payment in respect of a PCN after 31 March 2021.
- 9.9A.8. The commissioner will, in a timely manner after 31 March 2021, make available to a PCN a summary of the data in relation to it – whether from GP clinical systems or from other sources, which will be used to calculate performance, Achievement Points and Achievement Payments.
- 9.9A.9. To be eligible for payment, a PCN must review and validate the data provided under section 9.9A.8 and extracted from GP clinical systems by 30 April 2021, or within 14 calendar days of the data being made available, if the data is made available after 16 April 2021. For the avoidance of doubt, validation means that the PCN must confirm that the data extracted from GP clinical systems is an accurate summary of its performance in relation to the Indicators. The PCN will have the opportunity to resubmit data where the extracted data is incorrect, before final performance and achievement is calculated.
- 9.9A.10. PCNs will not have the opportunity to validate and resubmit data provided under section 9.9A.8 that comes from sources other than the GP clinical systems, but will instead be referred to existing routes for querying and correcting errors in such data.
- 9.9A.11. The data extracted from GP clinical systems and provided under section 9.9A.8 must be validated on a PCN’s behalf by the Core Network Practices of that PCN. Each Core Network Practice of the PCN will have made available to it a summary of its contribution to PCN-level performance for each Indicator, and each Core Network Practice will validate these data as accurate before any payment is made to the PCN.
- 9.9A.12. Where a payment in respect of IIF is due to a PCN, the commissioner will make that payment by 31 July 2021. 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 9.1.5A.
- 9.9A.13. To be eligible to receive the Total Achievement Payment, a PCN must:
- a. commit in writing to the commissioner to reinvest the Total Achievement Payment into additional workforce and/or additional primary medical services;

- 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 Rules⁶⁴. 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. validate any data extracted from GP clinical systems that is made available to it concerning its performance in relation to the Indicators;
- g. ensure that it is able to provide to the commissioner any information that may reasonably be requested to demonstrate that it is entitled to each Achievement Point to which it says it is entitled, and make that information available to the commissioner on request. In verifying that information has been correctly recorded, the commissioner may choose to inspect the output from a computer search that has been used to provide information on the indicator, or a sample of patient records relevant to the indicator;
- h. co-operate fully with any reasonable inspection or review that the commissioner or another relevant statutory authority wishes to undertake in respect of the Achievement Points to which it says it is entitled; and
- i. ensure that all information supplied pursuant to or in accordance with this paragraph is accurate.

⁶⁴ Network Contract DES Service Business rules: <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/quality-and-outcomes-framework-qof/quality-and-outcome-framework-qof-business-rules/enhanced-services-es-vaccination-and-immunisation-vi-and-core-contract-components-2019--2020#primary-care-networks>

9.9A.14. If the conditions set out in section 9.9A.13 are not met, the commissioner may withhold payment of all or part of the Total Achievement Payment that is otherwise payable.

9.10. Workforce

- 9.10.1. Subject to sections 9.10.4 to 9.10.8, a PCN is entitled to claim 100 per cent reimbursement of the aggregate WTE actual⁶⁵ salary (including employer on-costs⁶⁶) 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.
- 9.10.2. A PCN's Additional Roles Reimbursement Sum equates to £7.131 per PCN weighted list size as at 1 January 2020. The explanation of PCN's weighted list size and the calculation used to determine a PCN's Additional Roles Reimbursement Sum is set out in the Network Contract DES Guidance.
- 9.10.3. A PCN must use the mandatory claim form⁶⁷, or subsequent electronic replacement, to submit the monthly workforce claim.
- 9.10.4. The following conditions apply to any claim made pursuant to section 9.10.1:
- 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 engagement via a service sub-contract. The commissioner will only make payments following the start of the employment or engagement.
 - 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 2020 is to be made on or by the end May 2020).
 - d. The claim must relate to reimbursement of costs referred to in section 9.10.1 from within the ten roles covered by the Additional Roles Reimbursement Scheme in accordance with section 6.
 - e. A PCN must demonstrate that claims being made are for additional staff roles beyond the baseline (including in future years, replacement as a

⁶⁵ If relevant the percentage will be appropriately apportioned to PCN related activity.

⁶⁶ This does not include the additional 6 per cent employer contributions.

⁶⁷ The claim form available at <https://www.england.nhs.uk/publication/des-additional-roles-reimbursement-scheme-claim-form-2020-21/>. Further information regarding the electronic replacement is available in the [Network Contract DES Guidance 2020/21](#).

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 6.

- 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 and pharmacy technicians, reimbursed under the national [Medicines Optimisation in Care Homes Scheme](#) and that have been transferred⁶⁸ so that they 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 pharmacist or pharmacy technician work across the PCN and carry out the relevant duties pursuant to section 6 in the delivery of health services.
 - i. The commissioner will make any payments due under this section 9.10 to the Nominated Payee.
- 9.10.5. For the purposes of this section 9.10, “**WTE**” is defined as 37.5 hours in line with Agenda for Change (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.
- 9.10.6. If the workforce delivering the health services is employed by a non-PCN body, the contribution will be the relevant percentage of the actual WTE equivalent salary and employer on-costs costs, that have been appropriately apportioned to PCN-related activity.
- 9.10.7. In addition to the reimbursement of 100 per cent of actual WTE equivalent salary and employer on costs (pension and national insurance contributions), where a PCN does not employ a Social Prescriber Link Worker and sub-contracts the delivery of the social prescribing service, a PCN may claim a contribution towards additional costs charged by the sub-contracted provider for the provision of the social prescribing service. A PCN may claim a contribution of up to £200 per month (£2,400 per year) for each whole WTE

⁶⁸ Information regarding the transition arrangements is available in the [Network Contract DES guidance](#).

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. 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 2020/21

| Role | AfC band | Annual maximum reimbursable amount per role ⁶⁹ |
|--------------------------------|----------|---|
| | | £ |
| Clinical pharmacist | 7-8a | 55,670 |
| Pharmacy technician | 5 | 35,389 |
| Social prescribing link worker | Up to 5 | 35,389 |
| Health and wellbeing coach | Up to 5 | 35,389 |
| Care coordinator | 4 | 29,135 |
| Physician associate | 7 | 53,724 |
| First contact physiotherapist | 7-8a | 55,670 |
| Dietician | 7 | 53,724 |
| Podiatrist | 7 | 53,724 |
| Occupational therapist | 7 | 53,724 |
| Trainee Nursing Associate | 3 | 25,671 |
| Nursing Associate | 4 | 29,135 |

⁶⁹ 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.

9.10.8. 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 6 for the relevant roles against which payment is being claimed.
- b. The employing organisation (whether this is a PCN member or a third party) 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;
- ci. 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;
- d. The PCN makes any returns required of it and does so promptly and fully; and
- e. All information supplied pursuant to or in accordance with this Network Contract DES Specification is complete and accurate.

10. Monitoring

10.1. The commissioner will monitor services and calculate payments under the Network Contract DES using CQRS and/or NHAIS or any subsequent replacement system.

10.2. A PCN's Core Network Practices will be required to manually input data into CQRS, until General Practice Extraction Service ("**GPES**") (or any subsequent replacement system) is available to conduct electronic data collections. The data input⁷⁰ will be in relation to both management and payment counts.

10.3. Details as to when automated collections will be available to support this Network Contract DES will be communicated via NHS Digital⁷¹.

⁷⁰ For information on how to manually enter data into CQRS, see NHS Digital's website

⁷¹ <https://digital.nhs.uk/search/publicationStatus/false?area=data&sort=date>

- 10.4. A PCN's Core Network Practices will be required to use the relevant SNOMED codes, as published in the supporting Business Rules on the NHS Digital website (<http://www.hscic.gov.uk/qofesextractspecs>) to record:

| Activity to be coded | Code type ⁷² | Available from ⁷³ |
|--|-------------------------|------------------------------|
| Patient Activation Measure (PAM) completed | Existing | Apr 2020 |
| Patients whose care has been discussed as part of shared decision-making | Existing | Apr 2020 |
| Workforce | | |
| Referrals to social prescribing services (carried over from 2019/20). | Existing | Oct 2019 |
| Patients who have declined a referral to a social prescribing service (carried over from 2019/20). | Existing | Oct 2019 |
| Medication reviews by clinical pharmacists (carried over from 2019/20). | Existing | Oct 2019 |
| Consultations by clinical pharmacists (carried over from 2019/20). | Existing | Oct 2019 |
| Care home visits by a clinical pharmacist (carried over from 2019/20). | Existing | Oct 2019 |
| Consultations by a First Contact Physiotherapist. | New | Oct 2020 |
| Consultations by a Physician Associate | New | Oct 2020 |
| Consultations by a Health and Wellbeing Coach | New | Apr 2021 |
| Consultations by a Care Coordinator | New | Apr 2021 |
| Consultations by a Dietician | Existing | Apr 2020 |
| Consultations by an Occupational Therapist | Existing | Apr 2020 |
| Consultations by a Podiatrist | Existing | Apr 2020 |
| Consultations by a Pharmacy Technician | Existing | Apr 2020 |

⁷² Those codes indicated as being 'new' have either been requested or are being requested and will be available in clinical systems in due course.

⁷³ Proposed availability but may be subject to change.

| Structured Medication Reviews | | |
|--|----------|----------|
| Delivery of structured medication reviews. | New | Oct 2020 |
| Enhanced Health in Care Homes | | |
| Patients living in a residential home or nursing home | Existing | Apr 2020 |
| Patients living temporarily in a residential home or nursing home. | New | Oct 2020 |
| Delivery of personalised care and support plans | New | Oct 2020 |
| Reviews of personalised care and support plans | New | Oct 2020 |
| Falls risk assessments for patients recorded as living in a residential home or nursing home | Existing | Apr 2020 |
| Patients with acute confusion recorded as living in a residential home or nursing home | Existing | Apr 2020 |
| Delirium assessments for patients experiencing acute confusion, who are recorded as living in a residential home or nursing home | Existing | Apr 2020 |
| Psychosocial assessments for patients recorded as living in a residential or nursing home | Existing | Apr 2020 |
| Supporting Early Cancer Diagnosis | | |
| Patients placed on an urgent referral pathway for suspected cancer | Existing | Apr 2020 |
| Delivery of safety netting for patients on urgent referral pathway for suspected cancer | New | Oct 2020 |
| Investment and Impact Fund (IIF) | | |
| Patients on the learning disability register | Existing | Apr 2020 |
| Learning disability annual health checks for patients on the learning disability register | Existing | Apr 2020 |
| Seasonal flu vaccinations for patients aged 65+ | Existing | Apr 2020 |
| Patients referred to social prescribing | Existing | Apr 2020 |

10.5. A PCN's Core Network Practices must ensure the coding of care home residence is accurately recorded on a continuous basis.

- 10.6. The SNOMED codes outlined in section 10.4 will be used as the basis for the GPES data collection, which will allow CQRS to calculate aggregated numbers to support the management information counts. Core Network Practices must use the relevant codes, outlined above, within their clinical systems as only those included in this document and 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.

Annex A - Network Contract DES Participation Form

The Network Contract DES Participation Form is available at <https://www.england.nhs.uk/publication/des-participation-form-2020-21/>.

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^{74,75}); and
 - b. deliver the key responsibilities outlined in section B1.2.
- B1.2. 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;
 - 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

⁷⁴ <https://www.cppe.ac.uk/career/clinical-pharmacists-in-general-practice-education#navTop>

⁷⁵ <https://www.cppe.ac.uk/wizard/files/general-practice/clinical-pharmacists-in-general-practice-education-brochure.pdf>

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 pharmacist⁷⁶;
 - ii. the senior clinical pharmacist must receive a minimum of one supervision session every three months by a GP clinical supervisor;
 - iii. each clinical pharmacist will have access to an assigned GP clinical supervisor for support and development; and
 - iv. a ratio of one senior clinical pharmacist to no more than five junior clinical pharmacists, with appropriate peer support and supervision in place.

B.2. Pharmacy Technicians

B2.1. Where a PCN employs or engages a Pharmacy Technician under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Pharmacy Technician:

- a. is registered with the General Pharmaceutical Council (GPhC);

⁷⁶ 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.

- b. meets the specific qualification and training requirements as specified by the GPhC criteria⁷⁷ 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;
- 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;

⁷⁷ 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>

- 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 Workers; 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 programme⁷⁸
- b. is enrolled in, undertaking or qualified from appropriate training as set out by the Personalised Care Institute⁷⁹; and
- c. attends the peer support networks run by NHS England and NHS Improvement at ICS and/or STP 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 agencies⁸⁰ 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 needs⁸¹;
- 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';

⁷⁸ <https://www.e-lfh.org.uk/programmes/social-prescribing/>

⁷⁹ <https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/>

⁸⁰ 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.

⁸¹ Including considering if the persons needs are met (for example, reasonable adjustments, interpreter etc).

- g. take a holistic approach, based on the patient's priorities and the wider determinants of health;
 - 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.
- 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 6.4.1 and 10).
- 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 Guide⁸², with the training delivered by a training organisation listed by the Personalised Care Institute⁸³;
 - 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

⁸² <https://www.england.nhs.uk/publication/health-coaching-summary-guide-and-technical-annexes/>

⁸³ <https://www.england.nhs.uk/personalisedcare/supporting-health-and-care-staff-to-deliver-personalised-care/personalised-care-institute/>

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:
 - d. 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;
 - e. providing interventions such as self-management education and peer support;
 - f. supporting patients to establish and attain goals that are important to the patient;
 - g. 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;
 - h. 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;
 - i. increasing patient motivation to self-manage and adopt healthy behaviours;
 - j. work with patients with lower activation scores to understand their level of knowledge, skills and confidence (their “**Activation**” level), when engaging with their health and well-being and subsequently supporting them in shared decision-making conversations;
 - k. utilise health coaching skills to support people with lower levels of activation 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

- I. 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 wellbeing, 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 Institute⁸⁴; 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;
 - e. support people to take up training and employment, and to access appropriate benefits where eligible;
 - f. support people to understand their level of knowledge, skills and confidence (their "**Activation**" level) when engaging with their health and wellbeing, including through the use of the Patient Activation Measure;
 - g. assist people to access self-management education courses, peer support or interventions that support them in their health and wellbeing and increase their activation level;

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

- h. explore and assist people to access personal health budgets where appropriate;
 - i. 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
 - j. 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); and
 - c. has passed the UK Physician Associate (PA) National Re-Certification Exam, which needs to be retaken every six years;
 - d. participates in continuing professional development opportunities by keeping up to date with evidence-based knowledge and competence in all aspects of their role, meeting clinical governance guidelines for continuing professional development (CPD), and
 - e. is working under supervision of a doctor as part of the medical team, in order to deliver the key responsibilities outlined in section B6.2.
- B6.2. Where a PCN employs or engages one or more Physician Associates under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Physician Associate has the following key responsibilities, in delivering health services:
- a. provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems by utilising history-taking, physical examinations and clinical decision-making skills to establish a working diagnosis and management plan in partnership with the patient (and their carers where applicable);
 - b. support the management of patient's conditions through offering specialised clinics following appropriate training including (but not limited to) family planning, baby checks, COPD, asthma, diabetes, and anticoagulation;
 - c. provide health/disease promotion and prevention advice, alongside analysing and actioning diagnostic test results;
 - d. develop integrated patient-centred care through appropriate working with the wider primary care multi-disciplinary team and social care networks;

- e. utilise clinical guidelines and promote evidence-based practice and partake in clinical audits, significant event reviews and other research and analysis tasks;
 - f. participate in duty rotas; undertaking face-to-face, telephone, and online consultations for emergency or routine problems as determined by the PCN, including management of patients with long-term conditions;
 - g. undertake home visits when required; and
 - h. develop and agree a personal development plan (PDP) utilising a reflective approach to practice, operating under appropriate clinical supervision.
- B6.3. A PCN's Core Network practices must identify a suitable named GP supervisor for each physician associate, to enable them to work under appropriate clinical supervision.

B.7. First Contact Physiotherapists

- B7.1. Where a PCN employs or engages a First Contact Physiotherapist under the Additional Roles Reimbursement Scheme, the PCN must ensure that the First Contact Physiotherapist:
- a. has completed an undergraduate degree in physiotherapy;
 - b. is registered with the Health and Care Professional Council;
 - c. holds the relevant public liability insurance;
 - d. has a Masters Level qualification or the equivalent specialist knowledge, skills and experience;
 - e. can demonstrate working at Level 7 capability in MSK related areas of practice or equivalent (such as advanced assessment diagnosis and treatment);
 - f. can demonstrate ability to operate at an advanced level of practice, in order to deliver the key responsibilities outlined in section B7.2.
- B7.2. Where a PCN employs or engages one or more First Contact Physiotherapists under the Additional Roles Reimbursement Scheme, the PCN must ensure that each First Contact Physiotherapist has the following key responsibilities, in delivering health services:
- a. work independently, without day to day supervision, to assess, diagnose, triage, and manage patients, taking responsibility for prioritising and managing a caseload of the PCN's Registered Patients;

- b. receive patients who self-refer (where systems permit) or from a clinical professional within the PCN, and where required refer to other health professionals within the PCN;
- c. work as part of a multi-disciplinary team in a patient facing role, using their expert knowledge of movement and function issues, to create stronger links for wider services through clinical leadership, teaching and evaluation;
- d. develop integrated and tailored care programmes in partnership with patients, providing a range of first line treatment options including self-management, referral to rehabilitation focussed services and social prescribing;
- e. make use of their full scope of practice, developing skills relating to independent prescribing, injection therapy and investigation to make professional judgements and decisions in unpredictable situations, including when provided with incomplete or contradictory information. They will take responsibility for making and justifying these decisions;
- f. manage complex interactions, including working with patients with psychosocial and mental health needs, referring onwards as required and including social prescribing when appropriate;
- g. communicate effectively with patients, and their carers where applicable, complex and sensitive information regarding diagnoses, pathology, prognosis and treatment choices supporting personalised care;
- h. implement all aspects of effective clinical governance for own practice, including undertaking regular audit and evaluation, supervision and training;
- i. develop integrated and tailored care programmes in partnership with patients through:
 - i. effective shared decision-making with a range of first line management options (appropriate for a patient's level of activation);
 - ii. assessing levels of patient activation to support a patient's own level of knowledge, skills and confidence to self-manage their conditions, ensuring they are able to evaluate and improve the effectiveness of self-management interventions, particularly for those at low levels of activation;
 - iii. agreeing with patient's appropriate support for self-management through referral to rehabilitation focussed services and wider social prescribing as appropriate; and

- iv. designing and implementing plans that facilitate behavioural change, optimise patient's physical activity and mobility, support fulfilment of personal goals and independence, and reduce the need for pharmacological interventions;
 - j. request and progress investigations (such as x-rays and blood tests) and referrals to facilitate the diagnosis and choice of treatment regime including, considering the limitations of these investigations, interpret and act on results and feedback to aid patients' diagnoses and management plans; and
 - k. be accountable for decisions and actions via Health and Care Professions Council (HCPC) registration, supported by a professional culture of peer networking/review and engagement in evidence-based practice.
- B7.3. The following sets out the key wider responsibilities of First Contact Physiotherapists:
- a. work across the multi-disciplinary team to create and evaluate effective and streamlined clinical pathways and services;
 - b. provide leadership and support on MSK clinical and service development across the PCN, alongside learning opportunities for the whole multi-disciplinary team within primary care;
 - c. develop relationships and a collaborative working approach across the PCN, supporting the integration of pathways in primary care;
 - d. encourage collaborative working across the wider health economy and be a key contributor to supporting the development of physiotherapy clinical services across the PCN;
 - e. liaising with secondary and community care services, and secondary and community MSK services where required, using local social and community interventions as required to support the management of patients within the PCN; and
 - f. support regional and national research and audit programmes to evaluate and improve the effectiveness of the First Contact Practitioner (FCP) programme. This will include communicating outcomes and integrating findings into own and wider service practice and pathway development.

B.8. Dieticians

- B8.1. Where a PCN employs or engages a Dietician under the Additional Roles Reimbursement Scheme, the PCN must ensure that the Dietician:

- 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 Dieticians under the Additional Roles Reimbursement Scheme, the PCN must ensure that each Dietician 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 Dieticians:
- 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 supervision⁸⁵;
- b. improve safety and quality of care at every opportunity;
- c. contribute to the delivery of integrated care;
- d. work with the PCN MDT to ensure delivery of nursing associate duties complement existing workforce;
- e. provide support and supervision to training nursing associates, healthcare assistants, apprentices, and those on learning assignments/placements as required;
- f. support registered nurses to enable them to be able to focus on the more complex clinical care;
- g. develop relationships across the MDT to support integration of the role across health and social care including primary care, secondary care, and mental health;
- h. perform and record clinical observations such as blood pressure, temperature, respirations, and pulse;

⁸⁵ For example, as set out in the [NMC Standards for Nursing Associates](#)

- 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. The PCN must ensure that each TNA undertakes the following key responsibilities, when 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
 - 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.

Annex C - Investment and Impact Fund Calculation of Achievement⁸⁶

C1. Step 1: Aggregate practice-level numerators and denominators to PCN level

- C1.1. For each 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.
- For all Indicators, the 'size of the target cohort' will be a count of eligible patients.
 - For Indicators eligible for Personalised Care Adjustments (defined in Annex C, section C6 below), the size of the target cohort will be calculated by excluding any patient eligible for a Personalised Care Adjustment.
- C1.2. For each 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 Indicator, a numerator will be collected at for each Core Network Practice in the PCN.
- For Indicators with a desired direction of upwards, the numerator will capture the extent to which a desired intervention is provided to the target cohort.
 - For Indicators with a desired direction of downwards, the numerator will capture the extent to which an undesired intervention is provided to the target cohort.
 - For all Indicators, the numerator will be a count of the number of patients receiving a desired or undesired intervention.
- C1.4. For each Indicator, a PCN-level numerator (N) will be calculated by adding up all the numerators for the Core Network Practices of the PCN.

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

- C2.1. For each Indicator, the performance of the PCN (X) will be calculated by dividing the PCN-level numerator (N) by the PCN-level denominator (D):

⁸⁶ 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.

$X=N/D$. For all Indicators, performance will be equal to the percentage of patients receiving an intervention.

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

C3.1. For each Indicator, 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).

C3.2. Where the desired direction of the indicator 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: $Q = A$.

C3.3. Where the desired direction of the indicator 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: $V = L - X$.
 - iv. Subtract the upper performance threshold from the lower performance threshold, and call this number W: $W = L - U$.
 - v. 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 Prevalence Adjustment and a List Size 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 an indicator is defined as the size of the target cohort, or denominator (D), divided by registered unweighted PCN list size (S): $C = D/S$.
 - a. For all Indicators, prevalence captures the percentage of the PCN's Patients that are in the target cohort. Thus, prevalence will by definition be between 0 and 1 inclusive.
 - b. For Indicator PC01, the size of the target cohort is equal to the PCN's registered unweighted list size. Therefore, for indicator PC01, prevalence will be equal to 1 for all PCNs.
- C4.3. For each Indicator, national average prevalence (K) is defined as the sum of all PCN-level target cohorts, or denominators (D), divided by the sum of all registered unweighted PCN list sizes (S).
- C4.4. For each Indicator, the Prevalence Adjustment for a PCN will be equal to PCN-level prevalence (C) divided by national average prevalence (K).
 - a. For Indicator PC01, the Prevalence Adjustment will be equal to 1 for all PCNs. For the avoidance of doubt, this means there will not be any Prevalence Adjustment for these indicators.
- 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 Indicator, payments earned by the PCN (M) will be calculated by multiplying points earned (Q), by the value of an IIF point (P), by the Prevalence Adjustment (C/K), by the List Size Adjustment (S/T): $M = Q * P * (C/K) * (S/T)$.

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

C5.1. For the PCN the Total Achievement Payment is equal to the sum of Achievement Payments for each Indicator.

C6. Personalised Care Adjustments

- C6.1. A **PCA** may be applied for the Indicators and reasons set out in this paragraph. All indicators to which a PCA may be applied have a denominator consisting of a count of eligible patients. The effect of applying a PCA to a patient for a given Indicator will be to remove them from the denominator for that Indicator. The Indicators and reasons to which a PCA may be applied are:
- a. PR01 (defined in Annex D): Clinically not appropriate, patient refused.
 - b. HI01 (defined in Annex D): Patient refused.

C7. Timing conventions and payment calculation period

- C7.1. Unless otherwise stated or unless any of the provisions of section C8 apply, the following timing conventions will be employed for the purpose of calculating performance, Achievement Points and Achievement Payments. If any of the provisions of section C8 apply, the following timing conventions will apply to the extent they are compatible with the provisions of section C8.
- a. Except where explicitly noted below, calculations in respect of the Indicators will be made in relation to the period 1 October 2020 to 31 March 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 March 2021. For avoidance of doubt, this means that practice-level numerators and denominators will be aggregated to PCN level using PCN membership as at 31 March 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 denominator for indicator PC01 (defined in Annex D).
 - ii. The Prevalence Adjustment for each indicator.
 - iii. The List Size Adjustment.
 - d. For indicator PR01 (defined in Annex D):

- i. The denominator will be measured by an extract using the General Practice Extraction Service (“GPES”) on 31 March 2021.
 - ii. The numerator will also be measured by an extract using GPES. The numerator will be defined with respect to the denominator defined on 31 March 2021 and will count all activity undertaken between September 2020 and 31 March 2021.
- e. For indicator HI01 (defined in Annex D):
 - i. The denominator will be measured by an extract using the General Practice Extraction Service (“GPES”) on 31 March 2021.
 - ii. The numerator will also be measured by an extract using GPES. The numerator will be defined with respect to the denominator defined on 31 March 2021 and will count all activity undertaken between 1 April 2020 and 31 March 2021.
- f. For indicator PC01 (defined in Annex D), the numerator will be measured by a GPES extract on 31 March 2021, and will count all activity undertaken between 1 April 2020 and 31 March 2021.
- g. The following items will be measured using a single or composite extract of prescribing data held by NHS Business Services Authority covering the period 1 October 2020 to 31 March 2021:
 - i. The numerator and denominator of indicators MS01, MS02 and MS03 (defined in Annex D).

C8. Impact of PCN changes on calculation of payments

- C8.1. Where a Core Network Practice of a PCN ceases (for whatever reason) to be a Core Network Practice of that PCN before 31 March 2021:
 - a. That Core Network Practice’s performance in relation to IIF Indicators will not enter in any way into the calculation of that PCN’s performance.
 - b. That Core Network Practice’s practice list size will not enter into the calculation of PCN list size.
 - c. That Core Network Practice’s denominator and practice list size will not enter into the calculation of PCN prevalence.
- C8.2. Where a practice (for whatever reason but provided it is not a New Practice) becomes a Core Network Practice of a PCN at any time after 1 April 2020, and remains a Core Network Practice of that PCN on 31 March 2021, then that Core Network Practice’s performance in relation to the Indicators for the entire period from 1 October 2020 to 31 March 2021 (or 1 April 2020 to 31 March 2021, where specified in Section C7) will enter into the calculation of that PCN’s

Achievement Points and Achievement Payments, including that portion of the period from 1 October 2020 to 31 March 2021 (or 1 April 2020 to 31 March 2021, where specified in Section C7) during which the practice was not a Core Network Practice of the PCN.

- C8.3. Where a New Practice becomes a Core Network Practice of a PCN at any time after 30 May 2020, and remains a Core Network Practice of that PCN on 31 March 2021 then that practice's performance in relation to the Indicators from the period it became a New Practice to 31 March 2021 will enter into the calculation of that PCN's Achievement Points and Achievement Payments as though it had existed and been a Core Network Practice of a PCN since 1 April 2020, including any portion of the period from when it became a New Practice to 31 March 2021 during which the practice was not a Core Network Practice of the PCN.
- C8.4. If a new PCN is approved (for whatever reason) in the period 1 October 2020 to 31 March 2021, 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 October 2020 to 31 March 2021 (or 1 April 2020 to 31 March 2021, where specified in Section C7) will enter into the calculation of that PCN's Achievement Points and Achievement Payments, including that portion of the period from 1 October 2020 to 31 March 2021 (or 1 April 2020 to 31 March 2021, where specified in Section C7) 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 119 points in the Prevention and Tackling Health Inequalities domain. The following indicator definitions apply for this domain.

| ID | Points | Description | Numerator | Denominator | Desired direction | Thresholds | |
|---|--------|--|--|--|-------------------|------------|-------|
| | | | | | | Lower | Upper |
| a. Prevention (PR) | | | | | | | |
| PR01 | 72 | Percentage of patients aged 65 and over who received a seasonal flu vaccination | Number of patients aged 65 and over who received a seasonal flu vaccination | Total number of patients aged 65 and over | Upwards | 70% | 77% |
| b. Tackling health inequalities (HI) | | | | | | | |
| HI01 | 47 | Percentage of patients on the Learning Disability register who received an annual Learning Disability health check | Number of patients on the Learning Disability register who received an annual Learning Disability health check | Total number of patients on the Learning Disability register | Upwards | 49% | 80% |

D2. Providing High Quality Care domain

D2.1. A PCN is able to earn up to 75 points in the Providing High Quality Care domain. The following indicator definitions apply for the indicators in this domain.

| ID | Points | Description | Numerator | Denominator | Desired direction | Thresholds | |
|----------------------------------|--------|--|--|---|-------------------|------------|-------|
| | | | | | | Lower | Upper |
| a. Personalised care (PC) | | | | | | | |
| PC 01 | 25 | Percentage of patients referred to social prescribing | Number of patients referred to social prescribing | PCN list size | Upwards | 0.4% | 0.8% |
| b. Medicines safety (MS) | | | | | | | |
| MS 01 | 32 | Percentage of patients aged 65 and over currently prescribed a non-steroidal anti-inflammatory drug (NSAID) without a gastro-protective medicine | Number of patients aged 65 and over currently prescribed an NSAID without a gastro-protective medicine | Number of patients aged 65 and over currently prescribed an NSAID | Downwards | 43% | 30% |
| MS 02 | 6 | Percentage of patients aged 18 and over currently prescribed an oral anticoagulant and an anti-platelet without a gastro-protective medicine | Number of patients aged 18 and over currently prescribed an oral anticoagulant and an anti-platelet without a gastro-protective medicine | Number of patients aged 18 and over currently prescribed an oral anticoagulant and an anti-platelet | Downwards | 40% | 25% |
| MS 03 | 12 | Percentage of patients aged 18 and over currently prescribed | Number of patients aged 18 and over currently prescribed | Number of patients aged 18 and over currently prescribed aspirin and | Downwards | 42% | 25% |

| ID | Points | Description | Numerator | Denominator | Desired direction | Thresholds | |
|----|--------|--|--|-----------------------|-------------------|------------|-------|
| | | | | | | Lower | Upper |
| | | aspirin and another anti-platelet without a gastro-protective medicine | aspirin and another anti-platelet without a gastro-protective medicine | another anti-platelet | | | |