Primary care networks – Contract questions

Questions raised on calls held on 3 April and 9 April.

Contracting questions:

1. **The understanding is that in 19/20 each PCN is entitled to claim for clinical pharmacy and social prescribing working. Please can you explain what the funding changes will be in 20/21?**
   In 19/20 all networks can claim 1 WTE clinical pharmacist and 1 WTE social prescriber. Networks above 100k can claim for two of each post. In 20/21 the reimbursement will change; every network will receive a workforce reimbursement allocation based on their population. The funding for the workforce reimbursement increases over five years. If in 19/20 the network recruits a clinical pharmacist and a social prescriber, they will need to fund those out of their overall workforce reimbursement allocation from 20/21 onwards.

2. **What will the workforce reimbursement allocation be 20/21?**
   Information has not been issued on this yet, but we recognise that this needs to be addressed soon. It can be estimated at a crude level if you take the total funding available for the network for the workforce reimbursement scheme which is £891million by the end of year five and work off an average population for 60 million for England you could find a nominal amount. We will confirm how the calculation will be made for 20/21 in due course (we are hoping to publish this in May).

3. **There is concern around smaller primary care networks taking on a full time clinical pharmacist and social prescriber in 19/20 and whether they will have sufficient funding to cover the posts going forwards.**
   A typical PCN with a population of around 50,000 by year five would expect to receive £1.47million in entitlement under the network contract, of which £726,000 would be available roughly towards its workforce costs. Table 1 below shows the total national funding and how this increases. The workforce reimbursement allocation should provide sufficient funding for posts recruited in year one, particularly given not all staff are likely to start in post on 1 July.

   TABLE 1: INTENDED FUNDING FOR ADDITIONAL ROLE REIMBURSEMENT

	2019/20 (from July)	2020/21	2021/22	2022/23	2023/24
National total	£110m	£257m	£415m	£634m	£891m
Average maximum per 50k typical network	£92,000	£213,000	£342,000	£519,000	£726,000

4. **If you have a PCN of 30k population, is there a chance the funding wouldn't cover a WTE?**
   This is not likely to be an issue for most networks (see answer to question 3 above).

   See Table 1 above.

5. **A typical PCN in year one will have one pharmacist, unless they also have posts that transfer over from the national scheme. Is there going to be an issue with these being funded in year two?**
   The PCN will need to fund the pharmacist that they transferred in from the national scheme out of their workforce reimbursement allocation in Year 2. The available workforce funding increases significantly in 20/21 and over the course of the five years

6. **If you are in a PCN that has two existing pharmacists who were transferred over from the national scheme, by the end of year one you would have three pharmacists. Would it be accurate to suggest that in year two you would have to take this into consideration for the additional post that you can appoint in year two?**
   Yes, this will need to be considered, and inform decisions about recruitment in subsequent years.

7. **The pharmacist posts are not spread evenly across the country and our local finance teams are concerned that if a number of them transfer across we will have more cost pressures.**
   Practices and the employed pharmacists can choose whether to transfer the posts to the Network DES. For those who do not wish to be transferred, they can continue to claim funding via the national Clinical Pharmacist in General Practice scheme that they originally committed too. PCNs need to determine locally the optimum number of pharmacists (and staff in the other four roles) for the network. If they are transferred over, they will be part of the overall workforce sum, but it should be noted that the funding will be extending over the next five years.

8. **Most of the PCN areas based on practice boundaries in our CCG are likely to overlap and cross into other CCG boundaries. Is this ok?**
   Further national guidance is being prepared on cross-boundary issues. Practices and networks need to work together in the most effective way. It may make local sense for networks to overlap, they will need to work together collectively to liaise with the community providers and neighbouring CCGs.

9. **Is there any guidance on whether a PCN with a clinical director who is also a CCG board member would need to go through the conflict of interest route?**

We will not be producing any further guidance on conflicts of interest. The existing principles in the conflict of interest guidance on the NHS England website would apply to primary care networks and the employment of clinical directors as it would do to any other CCG post.

10. **The signature box for the PCN lead is not on the latest version of the registration form, is this correct?**
    At the point of registration, the practices do need to identify a clinical director but there is no requirement for a signature from the PCN lead. An earlier version of the registration form was published with the *Investment and Evolution: A five-year framework for GP contract reform to implement the NHS Long term Plan* documents on 31 January 2019 as the GPC were keen to give people an indication of what it would look like, but this has since been revised.

11. **We have heard of some CCGs who have already developed a number of templates locally. Is it ok for us to use these templates and adapt them as needed or shall we draft our own?**
    Regarding the network agreement, it is clearly set out what can be amended and what needs to remain unchanged. This is a mandated agreement however there is opportunity to supplement or vary certain elements.
    Other resources that CCGs have confirmed they are happy to share can be found on the PCN page within the NHS Futures platform. Please email england.pcn@nhs.net if you would like access to this platform.

12. **If practices set up a separate bank account for their PCN, is this subject to VAT as it is a non-clinical service?**
    The national contract team cannot provide VAT advice and there is currently no plan to issue further information beyond what is published on the NHS England website on the GP contracts webpage. Networks and member practices should ensure they consider the potential VAT implications as these can differ depending on the contracting models being used.

13. **Is the PCN payment based on weighted population figures? This would have significant impact if one of the practices is a university practice with a fluctuating patient list. If it is based on weighted population, how would this discrepancy be handled?**
    All PCN payments are based on weighted population, other than the network participation payment. Please see the table below for further clarity.

	Payment	**Weighted or actual?**
1. Core PCN funding	£1.50 per registered patient per year (equating to £0.125 per patient per month)	**Per actual registered pts**

2. Clinical Director contribution	£0.514 per registered patient to cover July 2019 to March 2020 (equating to £0.057 per patient per month)	**Per actual registered pts**
3. Staff reimbursements	Actual costs to the maximum amounts per the Five-Year Framework Agreement, paid from July 2019 following employment	**From April 2020/21, each PCN will be allocated a single combined maximum sum under the Additional Roles Reimbursement Scheme. This sum will be calculated on a weighted capitation basis (to be confirmed during 2019).**
4. Extended hours access	£1.099 per registered patient* to cover period July 2019 to March 2020 (i.e. equating to £0.122 per patient per month)	**Per actual registered pts**
Network Participation Payment	Monthly - £0.147 multiplied by number of the Contractor Weighted Population	**Per weighted pts**

14. **Where it makes sense geographically, can a single practice with a PMS contract be split across two PCNs? For example a practice that covers a population of 30k in a single core location but also has branch surgeries - if some of the branch surgeries fit better geographically in a different PCN could they sit between two networks?**
    Further guidance will be issued shortly on this but seeking to divide the registered population of a practice in the manner could be legally and operationally complex for a number of reasons. The contract DES is a variation to the GMS and PMS contract so practices can only sign up to one network contract.

15. **On the registration forms some PCNs have listed the bank account of the federation to receive funding thinking this would be an acceptable option. Please can you confirm this is appropriate?**
    A federation cannot receive PCN funding unless it holds a PMS, GMS or APMS contract. This is detailed within section 5.2 of the specification.

16. **For 19/20 it appears explicit in the guidance that there is flexibility around whether it is social prescribing or pharmacy in terms of the additional roles, is there any flexibility for physio roles in 19/20?**
    In 19/20, the only flexibility is to substitute pharmacists for social prescribers or vice versa. From 20/21, PCNs can use the workforce reimbursement sum for clinical pharmacists, social prescribers, physician associates and physiotherapists. Paramedics will be introduced in 21/22.

17. **Do we know when the national data sharing agreement is likely to be released?**
    This is currently in development and will need to be agreed by GPC. The aim is for this to be available in May.

18. **The contract and guidance says that federations cannot hold the Network DES – does this mean that they also cannot hold the funding for the DES? Our federations are asking if it can be paid directly to them, even if a practice holds the DES contract.**
    The DES must be held by a provider of essential services under GMS, PMS or APMS arrangements, but the funding can be paid to any payee who holds a primary medical services contract. If the federation holds an APMS contract, the funding can be directed to the federation, but it is the practices that hold the DES.

19. **Will there be any reporting arrangements around the £1.50 per head allocation? Are there any expectations around how this funding is utilised?**
    There will be no national reporting arrangements relating to this funding and it is for the PCN to determine how the funding is used.

20. **The workforce baseline will be from 31 March 2019. Is this date applicable for just the Clinical Pharmacists and Social Prescribers? When will the baseline be taken for First Contact Practitioners?**
    The baseline is for all of the five workforce roles eligible for reimbursement under the Network Contract DES.

21. **In terms of the registration requirement for the initial submission, is it just Schedule 1 of the network specifications that is required with the registration?**
    Yes that is correct, this is the one that sets out who the clinical director is and who the nominated payee is.

22. **Now that a detailed specification has been delivered around Clinical Pharmacists, it has started to talk about the supervision requirement including the ratio for senior clinical staff pharmacists to clinical pharmacists. What is the expectation of how this is compiled? Individual PCNs might only be recruiting one or two Clinical Pharmacists but may not have a senior member to provide the supervision requirement and may there incur an additional cost to resolve this.**
    The clinical supervision does not need to be from someone who is a Clinical Pharmacist in the same network, it can be within a wider professional network that the clinical pharmacist has connections with.

23. **Practices have asked if the 30,000 lower population limit has been based on financial viability?**
    These figures are based the learning from the Primary Care Home model.

24. **We would like to be clear about what extended hours funding is available and what arrangements need to be made to potentially claim any monies in the global sum.**

Additional monies were invested in global sum in addition to transferring the existing Extended Hours DES funding in to the network contract DES. The GP Contracts webpage has a copy of letters from Ed Waller, Director of Primary Care Strategy and NHS Contracts where the funding arrangements are outlined in detail. There was £30 million added to the global sum for extended hours and to take account of the new direct booking from NHS 111 and that is in the allocations.

25. **In terms of the workforce survey that commissioners must do in April to do the baseline do we know when this will be made available?**
    This is in the process is being finalised and will be shared in May.

26. **The DPO role is required to be offered out to practices and CCGs but we are not clear on where the funding will come from for that role?**
    The DPO function will have guidance coming out in the GPIT operating model which is due for publication April/May time. CCGs will no longer be able to charge for the DPO function that they might have done before, so it will move to be a core and mandated requirement for CCGs to be funded from their allocations.

27. **For the Clinical Director role, how should practices be employing and funding that role?**
    The funding towards this role is included in the network contract. It is a contribution to the role but is not allocated for a specific amount of time. The network will need to agree how to allocate that money.

28. **For the new extended hours DES, is there a requirement for emergency and same day appointments?**
    Under the terms of the old DES it talks about pre-bookable and same day appointments. The new DES has the same requirements. The specification has been published on the NHS England website, but the main changes relate to 100% coverage and aggregating the number of minutes/hours to a PCN level. The network needs to determine the proportion of extended hours that each individual practice will deliver.

29. **Can you provide clarity on whether the practice needs to be physically open during extended hours or whether it is just the services that need to be available? For example, could access be provided over the phone or virtually.**
    The intent of extended hours DES is to have a balance between face to face appointments and other modes of access. Practices wouldn't be able to say there is no availability for a patient to receive a face to face appointment with a clinician Monday to Friday as this wouldn't be keeping with the spirit of the ask. It would be suitable to provide face to face alongside other modes of access such as telephone or online consultations. The specification is clear on requiring a mix between modes of access.

30. **What is happening between April and July with regards to the extended hours DES that is being transferred to the network DES?**
    The current Extended Hours DES remains unchanged until end of June at individual practice level, so whatever the normal commissioning process is for this it should be followed for the first quarter.

    If practices currently close half a day, to be part of the PCN would they need a practice to cover the full core hours or potentially sub contract the hours that they currently close?
    Yes, that is correct. The extended hours requirements in the Network Contract are clear that PCN member practices should not operate half-day closing without prior written approval from the commissioner.

31. **For practices that aren't currently providing the Extended Hours DES are they able to set up sub-contracting arrangements in future?**
    Normal sub-contracting arrangements apply so it would be possible for a practice to put in place arrangements between now and 1 July.

For any contracting specific questions, you can email the GP Contracts team at: england.gpcontracts@nhs.net

You can also view a wider range of PCN related FAQs on the NHS England website at the following link: https://www.england.nhs.uk/gp/gpfv/redesign/primary-care-networks/pcn-faqs/