National GP Contract Agreement 2019: Update

Primary Care Networks (PCNs) and the Network Contract DES / Version 2 (April 2019)

For All London Practices supported by Londonwide LMCs

There has been more discussion about Primary Care Networks (PCNs) than any other element of the Contract Agreement; PCNs are in effect the contractualised incentivisation, through a Direct Enhanced Service (DES), of a process of collaboration and joint working between most practices that has been taking place for a number of years. The concept extends back to the establishment of OOHs GP co-ops in the 1990s, community fundholding, Primary Care Homes ('PCH' as per the NAPC model), and the London Tomlinson Collaborative Working Arrangements (originally termed 'Network Arrangements' subsequent to that.

The Primary Care Network Contract DES.
As a DES, all practices are eligible to participate; and if doing so will receive an annual, weighted Network Participation Payment of £1.76 for doing so, paid alongside Global Sum, from the commencement of the DES on 1 July 2019.

The DES has three elements:

- National Service Specifications: the first of these will not commence until April 2020, and these must be nationally negotiated,
- Supplementary Network Services: developed locally by CCGs and PCNs,
- Network Financial Entitlements (NFEs), these being:
    - The Additional Roles Reimbursement Scheme (ARRS),
    - Funding towards the role of Clinical Director (4.37, Contract),
    - £1.50 per head recurrent funding from CCG allocation,
    - £1.76 Network Participation Payment (which is paid directly to the practice, and not to the Network).

Clarification is being sought as to the definition of "closed" with regard to the DES contract specification reading "no PCN member GP Practice will be closed for half a day on a weekly basis and all patients must be able to access essential services, which meet the reasonable needs of patients during core hours, from their own practice or from any sub-contractor."

Guidance released in March 2019 references increased collaboration between practices and other community health and social care bodies, stating "to support this, the Network Contract DES will be amended from 2019/20 to include collaboration with non-GP providers as a requirement."

Establishment of a Primary Care Network
The target is to ensure 100% geographical coverage of the DES from 1 July 2019; the first key date is the submission to CCGs by 15 May 2019 of a Network Registration form. This comprises of six items:

- The names and ODS codes of the PCN member practices,
- The PCN list size, which is the sum of the member practices lists as of 1 January 2019,
- A map marking the PCN area, aggregating member practices' boundary areas,
- The Network Agreement signed by member practices. A template National Agreement is available, PCNs should not develop local ones,
- The 'account-holder' that will receive funding on behalf of the PCN,
- The named PCN Clinical Director.

On 31 May 2019 the CCGs will be asked to confirm that registration requirements for all PCNs within the CCG area are agreed. If there are any difficulties in achieving full PCN registration for all practices, LMCs have been asked to work with CCGs and NHS England to try and resolve these, so that the Network Contract DES for all practices can go live on 1 July 2019.

'Form follows function' is an essential guiding principle of PCNs:

- **Collaboration**

  To ease workload pressures on GPs and GPNs by practices being in a PCN with a wide range of health and social care professionals.

- **Coordination**

  To enable patients to access the care they need from the right services, allowing patient flow to wider primary, community, mental and social services.

- **PCN member practices**

  Many areas already have collaborative arrangements between practices, as Primary Care Homes, CCG or localities, networks, or neighbourhoods. These can, but do not have to, form the basis of PCNs. Membership of a particular PCN cannot be imposed on a practice, and although current arrangements may be appropriate, this should not be an assumption made either by CCGs, or the leadership or management of such organisations. It must be a positive choice, or reconfirmation, made by signing the Network Agreement. Practice colleagues should not feel pressurised to rush into such arrangements. In some areas current arrangements are likely to be too large to achieve the close working relationships and affiliation that are envisaged between PCN members. A single practice, with a list size of >30,000, may register as a PCN.

  The contract does state that PCNs must have 100% coverage of patients even when practices have not signed up. In those circumstances, the PCN would need to make provision through member practices or other means. The Mandatory Network Agreement says that whilst commissioner approval is not required for a Core Network Practice to cease to be signed up to the Network Contract DES, or to the PCN itself, "there will need to be commissioner involvement in the process" but they "may not unreasonably withhold consent to any changes."

- **PCN list size**

  The aim is for PCNs to serve populations of between 30-50k. The upper list size is indicative and not a strict requirement, PCNs much larger than 50k are likely to defeat the purpose of locally focussed, close working relationships between people who can get to know each other as a team. PCNs will be able to collaborate amongst themselves for wider service delivery and so this should not be seen as a criterion justifying a larger PCN size.

- **PCN patients**

  Guidance released in March 2019 (the Network Agreement Contract Specification) references an expectation that the PCN will engage with "seldom heard groups" and assist commissioners "in the performance of [its] duties to engage patients in the provision of and/or reconfiguration of services where applicable to the registered population."

- **Role of Federations**

  Each PCN will decide which provider organisation will employ the PCN's staff. This could be a lead practice, community or other provider, or existing Federation or network. Each PCN will also determine the most suitable delivery model for itself, which could be through a Federation.

- **PCN area**

  PCNs should have boundaries that 'make sense' in terms of constituent practices, and "other community services, who configure their teams accordingly" (3.7, Network Contract DES Specification). Practices boundaries may overlap across more than one PCN (as they do now between CCGs or boroughs), but it would be exceptional for a practice to join more than one PCN.

- **The Network Agreement**

  The published guidance accompanying the Mandatory Network Agreement template states clearly that "nothing in this Network Agreement is intended to vary, relax or waive any rights or obligations contained in the Core Network Practices primary medical services contract relating to the provision of essential services under those contracts."

  The template Network Agreement was published at the end of March 2019. The Agreement contains several schedules which must be agreed and completed by Core Network Members. In general terms it includes:

  - Arrangements to claim the PCNs collective financial entitlements.
  - How individual practices will collaborate to share resources and deliver PCN services; under the DES, all practices must be active participants.

- How decision-making will occur within the PCN including agreement on quorum, voting, decision making, attendance, expulsion of members.
- Arrangements for employing and supervising/appraising staff.
- How PCNs will work with other community services.
- Identification of the account-holder, which could be a lead practice, Federation, NHS provider or social enterprise partner, but not the CCG.

Information is pending regarding a new patient data sharing agreement, and an agreement to share data within the PCN and with the CCG; contributing to the National Dashboard.

The Agreement will need to be clear that the nominated fund holder reclaiming the Network payment from commissioners receives and holds that payment "on trust from commissioners as a disclosed agent so that payment of those fees by the fund-holder will not have a negative VAT impact on the lead practice or other Network partner or agent receiving them.

All PCNs will have to sign a Network Agreement, even if they only comprise of one practice. The Agreement should make clear what measures will be in place to manage the departure of one or more members.

- **Appointment of a PCN Clinical Director**

  Much of the LMCs advice in relation to PCN membership (above) applies to the appointment of the PCN Clinical Director; only a PCN can appoint their Clinical Director, current leadership roles cannot be assumed to map over to the PCN Clinical Director post. There should effectively be a newly confirmed appointment and PCNs themselves are responsible for deciding not only who is appointed, but also how that will be done. The Clinical Director should be a local clinician, likely to be a GP, who once in post, will have two key roles:

  - Encouraging and being accountable to PCN members for the successful delivery of PCN services and working relationships amongst constituent PCN member practices. They should also avoid any Conflicts of Interest (for example, being current CCG governing body/board members).
  - Supporting the PCNs in the wider integrated healthcare system, given that PCNs are integral to the delivery of community services to the local population.

  See Annex 1 for a more detailed description of the role and responsibilities as set out in the January BMA/NHS England Contract.

Whilst in some areas establishing PCNs may be straightforward, current arrangements should not be a 'shoe-in'; they should be confirmed only if member practices believe they are appropriate and the LMC recommends there must be an open process for any candidate wishing to be appointed as a PCN Clinical Director. Colleagues should not accept CCG involvement except on request. If local arrangements need to be reformed, or in some areas created from scratch, this will require practice-led meetings. The LMC is available to provide support for this process if there are difficulties, and colleagues in practices who anticipate not being able to sign a Network Agreement by 15 May 2019 are asked to contact us.

The aim is for other community services, including district and community nursing, midwifery, and health visiting services, to align themselves with PCNs.

There are outstanding questions in terms of, for example, employment liability, indemnity arrangements, VAT implications, and TUPE, in relation to existing staff, about which further guidance is awaited.

- **PCN Support**
  Participation in PCNs will attract network funding through the DES, in the form of:
  - The Additional Roles Reimbursement Scheme; rising from £110 million in 2019/20 to £891 million in 2023/24.
  - PCN Clinical Director funding; at 0.25 FTE per 50,000 population size, based on the average national GP salary.
  - £1.50 per head from CCGs.
  - £1.76 Network Participation Payment (which is however paid to the practice directly, and not to the Network).

- **Other Support**
  NHS England is to establish, in collaboration with the BMA, RCGP and NAPC, a significant development programme for both PCNs and PCN Clinical Directors.

Dr Michelle Drage, CEO of Londonwide LMCs - with thanks to Dr Julius Parker, CEO of Surrey and Sussex LMCs; Dr Matt Mayer, CEO of BBOLMCs, and Alex Orton and Sam Dowling of Londonwide LMCs

Annex 1

Network Clinical Director

Description of role/core responsibilities

Each PCN will have a named accountable Clinical Director, supporting delivery. They provide leadership for networks' strategic plans, through working with member practices and the wider PCN to improve the quality and effectiveness of the network services.

Together, the Clinical Directors will play a critical role in shaping and supporting their Integrated Care System (ICS), helping to ensure full engagement of primary care in developing and implementing local system plans to implement the NHS Long Term Plan. These local plans will go much further than the national parts of the Network Contract DES in addressing how each ICS will integrate care. The role of the clinical lead will vary according to the particular characteristics of the network, including its maturity and local context, but the key responsibilities may include:

- Providing strategic and clinical leadership to the network, developing and implementing strategic plans, leading and supporting quality improvement and performance across member practices (including professional leadership of the Quality and Outcomes Framework Quality Improvement activity across the network).
- Influencing, leading and supporting the development of excellent relationships across the network to enable collaboration for better patient outcomes.
- Providing strategic leadership for workforce development, through assessment of clinical skill-mix and development of network workforce strategy.
- Supporting network implementation of agreed service changes and pathways, working closely with member practices, the wider PCN and the commissioner to develop, support and deliver local improvement programmes aligned to national and local priorities.
- Developing relationships and working closely with other network Clinical Directors, clinical leaders of other health and social care providers, local commissioners and Local Medical Committees (LMCs).
- Facilitating practices within the network to take part in research studies and will act as a link between the network and local primary care research networks and research institutions.
- Representing the network at CCG-level clinical meetings and the ICS/STP, contributing to the strategy and wider work of the ICS.
- The Clinical Director would not be solely responsible for the operational delivery of services. This will also be a collective responsibility of the network.

As outlined in section 4, each PCN will receive an additional ongoing entitlement equivalent to 0.25 WTE funding per 50,000 population size. This entitlement is a contribution towards the costs and not a reflection of the time commitment required to undertake the role.

Annex 2

Network Implementation Timetable

Date	Action
Jan-Apr 2019	Practices liaise with each other and LMC re: forming networks
By 29 March 2019	GPC and NHS England release Network Agreement and 2019/20 DES specification details
By 15 May 2019	Networks submit registration information to their CCGs
By 31 May 2019	CCGs confirm network coverage footprints
Early June	GPC and NHS England work with CCGs and LMCs to resolve any issues
1 July 2019	Network DES goes live and financial entitlements paid