surrey and sussex lmcs

To: All Practices in Surrey and Sussex LMCs

22 February 2019

Dear Colleagues

GP Contract Agreement 2019: Update – Primary Care Networks (PCNs) and the Network Contract DES

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, although the concept extends back, for those with longer memories, to the establishment of OOHs GP Co-ops in the 1990s and Fundholding 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 1st July 2019.

The DES has three elements:

- National Service Specifications; the first of these will not commence until April 2020, and have to be nationally negotiated (see separate LMC Update)
- Supplementary Network Services: these can be developed locally by CCGs and PCNs
- Network Financial Entitlements, these being:
    - The Additional Roles Reimbursement Scheme
    - Funding for the role of Clinical Director
    - £1.50 per head from CCG allocation
    - £1.76 Network Participation Payment (which is paid directly to the practice, and not to the Network)

Establishment of a Primary Care Network
The target is to ensure 100% geographical coverage of the DES from 1st July 2019; the first key date is the submission to CCGs by 15th May 2019 of a Network Registration form. This comprises 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 1st January 2019.
- A map marking the network area, which is the aggregate of member practices boundary areas.

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- The Network Agreement signed by member practices. A template National Agreement will be published, PCNs should not develop local ones.
- The 'account-holder' that will receive funding on behalf of the PCN.
- The named PCN Clinical Director.

On 31st May 2019 the CCGs will be asked to confirm registration requirements for all PCNs within the CCG area are agreed; if there are any difficulties in achieving this, 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 1st July 2019.

The LMCs detailed analysis of each component part of the Network Agreement is:

- **PCN Member Practices**
  In many areas there are already collaborative arrangements between practices, as Primary Care Homes, CCG or Federation 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 any 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 PCN Network Agreement. Practice colleagues should not feel pressurised to rush into such arrangements and these may not be finalised until after Easter. 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, and there may be advantages in this approach.

- **PCN list size**
  The aim is for PCNs to serve populations of between 30-50k; exceptionally, in very rural isolated areas, it may be less. 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 Area**
  PCNs should have boundaries that "make sense" in terms of constituent practices, and other community services, who can however configure their teams accordingly. Practices boundaries may overlap across more than one network (as they do now between CCGs or Boroughs in London), but it would be exceptional for a practice to join more than one network.

- **The Network Agreement**
  A national template Network Agreement will be available by March end 2019, details are therefore awaited, but in general terms it will include:

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

- How decision-making will occur within the PCN
- How PCNs will work with other community services.
- A patient data sharing agreement, and agreement to share data within the PCN and with the CCG; this will contribute to the National Dashboard (6.37 and 6.38)
- Identification of the account-holder, which could be a lead practice, GP Federation, NHS provider or social enterprise partner, but not the CCG.

All PCNs will have to sign a Network Agreement, even if they only comprise one practice.

- **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 GP. PCN Clinical Directors are likely to have two key roles:

  - Encouraging and being accountable for the successful delivery of PCN services and working relationships amongst constituent PCN member practices; thus tact, finesse and being able to justify the confidence of their local professional colleagues would be essential characteristics. They should also avoid any Conflicts of Interest (for example, being current CCG Governing Body/Board members)
  - Representing the PCNs in the wider integrated healthcare system, given that PCNs are integral to the delivery of community services to the local population; thus tact, and a certain critical independence of mind, to avoid becoming merely a mouthpiece for NHS England management expectations, and instead being a champion of and for General Practice, would in the LMCs view be highly desirable professional characteristics, and should be asked of every candidate.

  A more detailed description of the role and responsibilities is available at Annex A.

Clearly therefore 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 CCGs involvement except on request. If local arrangements need to be reformed, or in some areas created de novo, this will require practice-led meetings. The LMC is available to provide support for this process if there are difficulties, and to colleagues in any practice which does not anticipate being able to sign a Network Agreement to be submitted to their CCG by 15th May 2019; such practices, if there are any, are asked to contact the LMC.

The ultimate aim is for other community services, including district and community nurses, midwifery, and health visiting services, to align themselves with Primary Care Networks.

Clearly 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
Network funding
Participation in Networks 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.
- GP PCN Clinical Director funding; at 0.25 FTE per 50,000 population size, based on 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 Primary Care Networks, and also PCN Clinical Directors.

This update should be read in conjunction with LMC updates on:

- National Service Specifications and the NHS Long Term Plan.
- Additional Roles Reimbursement Scheme.
- Integrating Urgent Care Services.

With best wishes

Dr Julius Parker
Chief Executive

Annex A

1.1. Network Clinical Director

Description of role/core responsibilities

Each network will have a named accountable Clinical Director, responsible for delivery. They provide leadership for networks strategic plans, through working with member practices and the wider Primary Care Network 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 Network will receive an additional ongoing entitlement to the equivalent of 0.255 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