Primary Care Networks DES

Frequently Asked Questions

Clinical Director and Leadership

How will the Clinical Lead of the Network be appointed?
The appointment process for the role of the Network's Clinical Lead is down to the respective Network to decide and will need to be outlined within the Network Agreement. Whilst this can be discussed with the commissioner and LMC, the decision ultimately lies with the PCN.

What will be the role of the Clinical Director?
The Clinical Director will provide leadership for the network's strategic plans, working with members to improve the quality, cost and effectiveness of the services it offers. More detail can be found in the recently published PCN Handbook by the BMA available at: https://bma-mail.org.uk/JVX-6635Z-C336HRO535/cr.aspx

To whom are the PCN clinical directors accountable?
They will be accountable to the member practices. This will be set out in the Network agreement and therefore, exactly how this is done will be decided by the practices within Network.

How should PCNs appoint Clinical Directors?
GPC are currently preparing guidance on various aspects of PCNs, and aiming to give practical advice on various things. The contract agreement is simply that the networks themselves will decide who the Clinical Director is, and therefore one of the guidance documents currently being drafted is about the Clinical Director, who should it be and how to decide – providing options for PCNs and LMCs, to decide how to proceed.

What funding exists for the PCN Clinical Director?
Equivalent of 0.25 WTE will be funded per 50,000 patients (or one day per 40,000 patients) which is the funding contribution, not the expected commitment of the role which may exceed one day per week (to be determined by the PCN). It is envisaged that 1 day a week will be sufficient for the first year.

Can an existing CCG Board Member stand for appointment as a Network Clinical Director or is there a potential conflict of interest?
It is recognised that to be on the governing board of the commissioning body whilst also a network Clinical Director will produce conflicts of interest. It is the view of the local LMC and the Accountable Officer for Calderdale CCG that any Clinical Director may only serve in one

capacity. This does not preclude any network Clinical Director from completing agreed work for the CCG.

Does the Clinical Director have to be a GP?
It is expected that the Clinical Director will be selected from the GP's of the practices within the network, but any appropriately clinically qualified individual may be appointed. The Clinical Director must know and understand the practices of the network, in order to provide the appropriate leadership required to establish and develop a successful network. How the post is filled and by whom is up to the member practices, collectively, to decide.

Funding

Who will hold the funds allocated to the PCN through the network DES?
It is for the network to decide who holds the funds made available, but this must be decided and included in the registration documentation to be submitted by 15th May 2019. There are several options available to the network including an agreed lead practice or a federation on behalf of the network.

What will happen to the local funding we already receive to support collaboration?
If there are current arrangements that have been funded for collaborative structures locally, then local discussions between the LMC, CCG and the PCNs should take place to decide if and how that needs to change to fit in to the structures of PCNs. This may involve previous funding being reinvested in new primary care activities.

What happens to the unspent money if a PCN has difficulty recruiting in to their network?
A PCN will only be reimbursed for the workforce they have employed. However, if recruitment proves difficult for certain groups or specific areas of the country, there is a shared wish between GPCE and NHSE to use unspent workforce expansion funding. If this proves to be the case GPCE and NHSE will discuss how to ensure the funding is retained within general practice.

How will the funding work in the network contract?
Practices will directly receive £1.76 per head via SFE if signed up to the PCN as an entitlement. It is not intended to be used to fund PCN activity. Networks will receive recurrent payment of £1.50 per patient as an entitlement, from CCG central allocations, to assist in the general administration costs. Precisely how this funding is utilised will be for the Network collectively to decide. The first payment will be received on 1 July 2019, paying 4 months in arrears and monthly thereafter.

From 2019/20 the requirements and funding of the Extended Hours DES will be transferred to Networks. This will provide approximately £1.45 per patient and following an Access Review in 2019, a more coherent set of access arrangements will start being implemented in 2020, including transferring the £6 per patient funding under the GPFV Improving Access scheme to Networks.
There will be additional funding for workforce paid on a reimbursement basis.

We have a LES which many practices rely on, how will this be impacted by PCNs?
It is possible that the CCG may want to avoid double payment for areas now covered by the national deal but the funding they currently spend locally should be retained in general practice. CCGs and LMCs should discuss how this funding is reinvested in general practice.

How is the funding for extra staff (pharmacists, social prescribers, etc.) worked out, i.e. is it based on a population of a care community or by PCN?
For the first year only each PCN will get funding for one pharmacist and one social prescriber. From the second year onwards the funding allocation is based on the population size of the PCN.

Is there clarity on how the money can be used? For example using the Pharmacist funding proposal - is it a requirement that a new member of staff is employed for the network (i.e. someone who doesn't current work within that setting) or could the funding be used to pay for existing pharmacists within the practices who are part of the PCN?
The funding is for new employees, with the exception of pharmacists on the current national scheme that can be transferred across to the new 70% recurrent reimbursement scheme. This doesn't apply to pharmacists already employed directly by the practice who are not part of the national scheme.

Who funds the other 30% of PCN employed staff?
The remaining 30% comes from the PCN practices. It's for the PCN to decide who employs the new staff and further guidance about the different options will be issued shortly. The governance arrangements and network agreement will also cover this.

Workforce

Who employs the extended workforce funded under the DES?
The network workforce could be employed in a number of ways, depending upon the structure of the Network, and how its member practices wish it to operate. For example, the Network may wish for the practice which has been nominated to hold the funding to use that funding to directly employ the staff that can then be utilised across the Network. Alternatively, employment of staff could be spread across the member practices, with funding redistributed from the fundholding practice as required.

What are the associated VAT and employment liabilities for the employing practices in a PCN?
GPC will be issuing joint guidance with NHS England in the coming weeks.

Will we be able to claim reimbursement for existing staff under the DES?
The scheme is designed to grow additional capacity through new roles, not to fill existing vacancies or subsidise the costs of employing people who are already working in primary care, whether funded by a practice, a CCG or a local NHS provider. Reimbursement through this route will only be for demonstrably additional people (or, in future years, replacement of those additional people as a result of staff turnover). The only exception to the 'additionality' rule is existing clinical pharmacists reimbursed under either (i) the national Clinical Pharmacists in General Practice scheme, or (ii) the national Pharmacists in Care

Homes scheme. Both schemes have tapered funding. Both will be subsumed into the new more generous arrangement.

This new workforce and new funding, how will the PCN utilise them?
It is for the network to agree how the new workforce is employed (by practices, a lead practice, a federation or community trust on behalf of the network etc). The PCN must also agree how the workforce is deployed, in line with agreeing how services are configured on a local level.

Function and Service Delivery

Can CCGs dictate Network configurations?
No. The decision about how Networks will be configured rests almost entirely with the practices who can define their own structure subject to the rules around size and geographical contiguity. The exception to this rule is that CCGs have a responsibility to ensure that all practices can be a part of a Network and may need to intervene to ensure this. It is expected that CCGs will work with LMCs in these discussions, but outside of this caveat the power to define structure rests completely with the practices themselves.

Does the Network have to be a set size?
It is expected the most Networks will be between 30,000 and 50,000 patients. However, there will be exceptions to this, depending on local geography and what fits best with GP practices. For example, in rural areas a Network of less than 30,000 patients may exceptionally be necessary. In contrast, some areas may wish to have, or may have already developed, Networks of greater than 50,000 patients. In these cases, practices should discuss with the commissioner, what they think the best size for the Network should be, and the reasoning behind it prior to submitting their application documentation.

We are a practice with a patient list of over 100,000, can we be a network on our own?
There will be some practices with patients' lists in excess of the suggested 30,000 – 50,000, and which already operate across multiple sites within a geographic area. In such cases it is possible for the practice to operate as a Network itself, with an informal split of its constituent sites into 'neighbourhoods' of approximately 30,000-50,000 patients. More detail on how this will operate will be available in later guidance.

Can practices in different areas form a Network?
Networks should form a single coherent area, without any gaps in coverage within the Networks outer boundaries.

What happens if my practice does not want to join a Network?
The 2019/20 contract agreement includes additional funding for engagement and participation within a Network. Should a practice not wish to engage in the Network DES, the respective practice will no longer qualify for this and the network will take responsibility (and the network level funding) for the provision of Network level service to that practice's patients, following discussions between the LMC, CCG and PCN.

What will the Network Services within the DES contain?
The service requirements within the DES will be phased in gradually over the next 5 years, covering the 7 areas as below:
1. Medication review and optimisation
2. Enhanced health in care home service
3. Anticipatory care (with community services)
4. Personalised care
5. Supporting early cancer diagnosis
6. Cardiovascular disease prevention and diagnosis, through case finding
7. Action to tackle inequalities

These will be discussed and agreed with GPC England prior to each implementation, and full guidance will be issued as each service specification is introduced to the DES. Further information on what is broadly expected that each of these 7 services will cover will be available within the full DES guidance.

Will practices own the PCN?
As a PCN is based on a DES, which is part of the GMS/PMS contract, it is for practices to lead and shape them.

If the CCG wishes to commission additional service from the PCN, on top of those contained within the DES, will these require competitive procurement?
As with current Locally Enhanced Services, there will be a reduced emphasis on competitive procurement as PCNs will be built through the GMS contract and PCNs will have entitlements to funding for specific service provision, and contracts can be awarded without competitive tendering if they are based on the Network list.

How will the PCN make decisions?
This is to be determined by the network (e.g. majority vote, CD discretion, unanimity). The number of votes or weighting for each practice, may be determined by the network (e.g. it could be based on respective practice list size, or by staff numbers, or one vote per practice)