

The Schedules to the Mandatory Network Agreement

SCHEDULE 1

This schedule sets out in more detail those matters initially specified in the initial registration process of 15th May. Items 1 – 6 have already been submitted and just need to be repeated. It is noted that although not specified it would be a good opportunity to reiterate the name of your Primary Care Network.

Items 7 onwards set out how decisions are to be made in the PCN. These need to be specified in sufficient detail to give assurance that good governance arrangements, without being overly bureaucratic, will support effective and inclusive decision making that can command the confidence of PCN practices and other stakeholders involved in the PCN.

I would suggest that these arrangements be kept as simple as possible in the first year. They can be refined in the light of experience as the PCN grows in experience and responsibilities. It may be worth including a clause that the schedules will be reviewed in March each year in readiness for the next planning year.

A particularly complex area will be in relation to the arrangements that were in place before the new GP Contract. Many areas had neighbourhood teams, locality clusters, integrated care communities or primary care networks. These would have meetings with a range of participants although the governance arrangements would be less formal than the new requirements of the DES. The PCN needs to decide how much of the previous arrangements, in terms of meeting schedules, attendances and reporting arrangements are of relevance for carrying over into this schedule. In doing so it is worth considering if there is any differentiation between Core Member Practices and their accountability for delivering the DES and any wider stakeholder involvement that promotes integration.

NAME OF NETWORK

1. The name of our network is [insert]

NETWORK AREA

2. The geographical area covered by our Network is [insert].

NOMINATED PAYEE

3. The name and address of the entity that the Core Network Practices nominate to receive funding under the Network Contract DES from the commissioner is [insert].

CLINICAL DIRECTOR

4. The Clinical Director of our Network is [insert].
5. The Clinical Director was appointed by the process set out below.
6. [insert process of appointment]

MEETINGS AND DECISION-MAKING

Meetings of Core Network Practices

7. The general arrangements for meetings and decision making are set out in clauses 49 to 52 of the Mandatory Network Agreement. The requirement is that meetings of the Core Network Practices will be arranged as often as necessary to discuss issues relating to the Network Contract DES.
8. The arrangements by which Core Practice representatives can commit their practice to the decisions of the PCN are set out in the Declaration of Intent signed by the partners at each practice to join the primary care network.

“We recognise that we will be core members of the Primary Care Network and as such will have certain rights and responsibilities as set out in the Mandatory Network Agreement. We will play our full part in Network decision making to ensure the success of our Primary Care Network.

We have agreed that our representative to take part in Network meetings and decision making and the principle point of communication between our practice and the Network.

This person has full delegated authority to take part in PCN decision making processes on behalf of the practice. In the event that our representative feels unable to commit to a decision on behalf of our practice without further practice consideration this will be considered by the practice as soon as possible and fed back to the next PCN meeting.

In the event that our representative is unavailable the practice will nominate and inform the PCN of a designated deputy.”

9. I would suggest that meetings are scheduled on a monthly basis in the first instance and that these are attended by the designated lead from each Core Practice. (Whether to call this meeting the Network Board or some other name is up to the PCN. It is a useful shorthand but maybe conveys a level of formality and substance beyond what the PCN wishes to convey)
10. The business to be transacted at these meetings will encompass the collective and individual responsibilities of the practices in delivering the Network DES. Specifically:
 - Developing the strategy of the PCN to meet current and future years requirements

- Developing the PCN workforce strategy
- Implementing agreed service changes and pathways
- Developing local initiatives to reflect local needs
- Developing relationships internally and external to the PCN
- Developing a research strategy for practices
- Receiving monitoring reports on PCN activities
- Reviewing the financial performance of the PCN
- Considering the PCN view on issues to be fed into the CCG and ICP
- General governance arrangements relating to joiners and leavers, conflict of interest matters and hearing representations from individual practices.

11. The designated monthly meetings will be held at _____ or other venue to be agreed from time to time. An agenda for such meetings will be prepared by the Clinical Director and shared with all designated practice leads at least 4 working days before the meeting. It will deem to have been served by sending to the agreed contact point for each Core Practice Representative.

12. Core Practice representatives will be able to put forward items for the agenda and must notify the Clinical Director by e-mail at least 6 working days before the meeting.

13. In addition to this arrangement the Clinical Director can call ad hoc meetings of representatives from the Core Practices, as necessary to deal with PCN business. Such business can be transacted through ad hoc meetings, telephone conferences or a series of bilateral discussions, on the proviso that all practices are fully engaged and agree with the eventual decision. A record shall be kept of such ad hoc meetings, telephone conferences or bilateral discussions and presented to the next formal monthly Core Practice meeting for ratification.

14. A quorum for all meetings, scheduled or ad hoc is a representative from all Core Practices. In the event that the Clinical Director is away from duties a designated deputy will be nominated. Similarly, each Core Practice can nominate a deputy in the absence of the Core Practice Representative. Each such deputy must be a practicing clinician within the PCN.

15. Decisions of the Core Network Practices will, wherever possible, be reached by consensus as it is important that all practices within the Network are fully committed and signed up to the development and direction of travel of the Network. In the event that it is not possible, despite best endeavours, to reach a consensus then the following arrangements will apply:

- Certain issues will require a unanimous decision of all practices
 - i. Additions and removals

- ii. Annual budget setting
- iii. Appointment of Clinical Director
- Issues outside 12.a will require a two thirds majority.
- This majority will be decided by a voting mechanism

(The PCN will need to decide how, in the event of a vote being necessary, such a vote is conducted. For a PCN with practices that are of roughly the same size it is suggested that it is on the basis of one practice – one vote. In PCNs where there is wide variation in the size of practices it is clearly unreasonable that one small practice can have a right of veto over a large practice. In these circumstances it might be appropriate to have a proportional voting procedure with one vote per 5000 patients.)

Additional Network Members

16. It is recognised that the Primary Care Network is more than just our Core Practices and that we need to involve our partner organisations within our locality in achieving integration and seamless working to meet the needs of the people we serve.

17. We are conscious that the scope of our work within the Network will develop over the coming years and our membership will need to increase to reflect our increasing responsibilities and levels of integrated working.

18. In the first year of our operation the following organisations will be invited to our Network Meetings.

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19. Each of these organisations will nominate a designated person to be a member of the PCN and will also designate a deputy to attend in the absence of the designated person.

20. The wider members of the Network will be able to request items for the Network Meetings in the same way that Core Practice members can.

21. These Non-Core members will not be able to vote on any practice based issues relating to the fulfilment of the DES but are expected to take a full part in operational discussions regarding the delivery, integration and development of services. It is expected that these members will be of sufficient seniority to be able to commit their organisation to the decision-making processes of the PCN.

22. For the sake of quoracy the following organisations need to be present at the Network Meeting:

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23. In terms of decision making on these wider operational issues it is our aim to reach decisions by consensus. In the event that agreement cannot be reached with a particular

party we will escalate the issue to the next level of management within the relevant organisation to seek a resolution. Particular difficult issues, and ones that apply across a number of PCNs within the ICP will be escalated for discussion at the wider ICP integrated management team.

Administrative Arrangements for Meetings and Network Business

24. The PCN will appoint a Meeting Secretary to support the Clinical Director in the servicing of Network Meetings. This person will be accountable to the Clinical Director and will be the formal communications point for PCN business, will prepare agendas and papers for meetings and will record and disseminate minutes of these meetings.
25. The Meeting Secretary will also support the Clinical Director in undertaking follow up actions agreed at Network Meetings.
26. The Primary Care Network will need management support, guidance and advice to fulfil its responsibilities and will need to call on planning, statistical, finance, HR and IT expertise from time to time. The PCN is looking to formalise the required level of support through the CCG and enter into a service level agreement with whichever parties provide this support

SCHEDULE 2

ADDITIONAL TERMS

It is clear in the guidance that this schedule enables a PCN to add anything local to personalise the Network Agreement to the particular circumstances and values they aspire to.

What is important to note is that these additional clauses do not replace the mandatory clauses, cannot contradict or override them but can only add to them.

PRINCIPLES

This section enables a PCN to add to clauses 8 – 14 in the mandatory terms. These clauses largely relate to the relationship between the Core Member Practices. A PCN may wish to add something about its relationships with the wider health and social care community and how it wishes to work with staff, patients and the general public. It could include:

- A mission statement if you have one
- A statement about equality and diversity
- A statement about valuing staff and engaging with them through the process of change
- A statement about how you intend to engage with the public
- A general comment about how you see the PCN as an opportunity to “do things differently” to meet the needs of your community

CLINICAL DIRECTOR

This is an optional expansion of clause 30. A PCN could include here the agreed Job Description of the Clinical Director or say something about the term of office.

INFORMATION SHARING AND CONFIDENTIALITY

This section enables a PCN to add to clauses 32 – 39. These sections are couched in legal terms so I would recommend that any additions are checked out from a legal point of view. Clause 39 seems particularly contentious. There is a weak caveat at 39g suggesting “where practical” any disclosure is discussed with the Clinical Director prior to disclosure. PCNs may wish to consider strengthening this to allow discussion with the party whose information is about to be disclosed and an appeal mechanism.

There is also due to be a Data Sharing agreement made available to PCNs and it may be appropriate to include some detail of this here.

INTELLECTUAL PROPERTY

Unlike the other sections, this does allow a PCN to replace the mandatory clauses 44 – 47. PCNs may wish to research this area to arrive at their own view on intellectual property rights, considering the balance between sharing good practice and innovation and preserving intellectual property.

JOINING THE NETWORK

This section enables a PCN to add to clauses 55 – 58. These clauses do not differentiate between a potential new Core Network Practice and any other individual person or organisation joining the PCN.

Any additions to this section need to be considered against the overall governance arrangements of the PCN including the arrangements for Core Network Practice meetings and the involvement / engagement of other organisations as set out in Schedule 1. Hopefully schedule 1 will have set out the other organisations that you will invite to join the PCN in Year 1 and any requests for others to join will need to be considered against the list of existing organisations and the objectives / business plan of the PCN for that year.

LEAVING THE NETWORK

Unfortunately the largest section of the Network Agreement relates to this subject and is covered comprehensively in clauses 60 – 79. These clauses cannot be replaced and any additions will need to be checked out from a legal point of view in view of the nature of this section

VARIATION PROCEDURE

This can only relate to any non mandatory clauses that are added in Schedule 2. The proposal in clause 81 is that such changes can only be agreed and signed off by all members. It is not clear whether this relates to Core member Practices or the wider PCN membership. PCNs may wish to make this clear.

All the mandatory clauses can only be changed by national agreement.

EXPIRY OR TERMINATION

This relates to any additions to clauses 84 – 87. Clause 84 suggests a PCN may wish to add the circumstances in which Core Network Practices can decide to wind up the PCN.

If any PCN wishes to elaborate on Clause 84 I suggest legal advice would be necessary

EVENTS OUTSIDE OUR CONTROL

This allows elaboration of Clauses 89 – 90 to describe additional arrangements over and above clause 89 a) to d)

DISPUTE RESOLUTION

The procedure proposed in Clause 93 is that any dispute regarding this agreement will be referred to the LMC to agree a process for hearing and hopefully resolving the dispute. Both clauses 92 and 93 can be replaced if the PCN wishes to follow a different process for dispute resolution.

A PCN may wish to develop a more detailed procedure than that stipulated in Clause 92 “by holding meetings.” It may wish to differentiate between any disputes involving core member practices and those involving the wider PCN Membership.

It may wish to have an informal procedure for raising “concerns” that can be heard by a panel in the first instance. Such a panel could then give a report to the full meeting . Only if there is a “Failure to Agree” at this stage would reference to a formal dispute be made.

It is open to a PCN to use an alternative body for dispute resolution than the LMC. The LMC has expert knowledge of contractual issues but a PCN may wish to deal with non contractual disputes in an alternative manner.

ADDITIONAL RIGHTS AND OBLIGATIONS

Clause 105 refers to additional methods of serving notice over and above those set out in Clause 104. It is worth considering whether e-mail notification, (with Read Receipt) is appropriate and whether a minuted meeting of all participants would also qualify as due notice.

PCNs are also invited here to add any requirements they have over:

- Freedom of Information Requests – process for dealing with
- Any restrictions on what members can and cannot do regarding insurance requirements, non-solicitation of other members staff, storage of information, place of business or licences

SCHEDULE 3

ACTIVITIES

This Schedule sets out the detail of how Core Member Practices and other PCN members will deliver the requirements of the Network Contract DES. The first requirement therefore is to set out how the immediate requirements relating to Extended Hours will be delivered by the practices. Also, the activities to be carried out by the “Additional Roles” appointments. (Clinical Pharmacists and Social Prescribers in Year 1.) Who will host them and how will their work be apportioned across the member practices.

In subsequent years the activities of the other “additional roles will need to be included, together with how the 7 Service Specifications are to be met and from 2020 (or sooner if relevant) the extended access DES.

Other activities carried out by members practices such as any specialist service offered by one practice that is available to other practices can be included here.

It would also afford an opportunity to set out the services offered as part of the PCN by partner organisations such as community services, local authority services and outreach specialist clinics.

It would seem appropriate in all circumstances to include indicative activity levels. The purpose of this Schedule is to enable every Member to know what is expected of them and every other Member to avoid misunderstandings and any disputes.

It is open to PCNs to decide whether they would wish to include in this section service levels and key performance indicators and how overall activity levels will be reported and considered by the PCN.

It is suggested that a simple table such as that below could be used, together with a covering narrative.

ACCESS REQUIREMENTS

Requirement	Core Network Practices				Members that are not Core Network Practices	
	Practice [A]	Practice [B]	Practice [C]	Practice [D]	X	Y
Extended Hours						
Hours						
Appointments						

OTHER ACTIVITIES

	Core Network Practices				Members that are not Core Network Practices	
Requirement	Practice [A]	Practice [B]	Practice [C]	Practice [D]	X	Y
Activity 1						
Indicative volume						
Performance Indicator						
Monitoring arrangement						

SCHEDULE 4

FINANCIAL ARRANGEMENTS

This section sets out how payments into the PCN will be made to the nominated bank account. It covers the nature of the payments, the governance arrangements and the method by which member practices and other providers receive payment for the activities they carry out on behalf of the PCN.

The way that the nominated PCN bank account will be managed is set out as follows.

1. The practices in the ... PCN, namely:
 - a. (Practice name)
 - b. (Practice name)

agree to establish a bank account by the name of ... Bank Account (Insert Bank, Sort Code and Account number)

2. The bank Account shall be held by - - - - - , being a Core Network Practice or an organisation holding a primary medical services contract
3. The provider designated in 2 has no other purpose regarding this account other than administering the bank account. It has no direct authority to utilise or make payments from the account other than as instructed by the PCN.
4. This bank account will be separate and independent of the main bank account of the nominated practice / provider
5. The purpose of this bank account is to receive the designated Network funding associated with the Network DES and provide a mechanism for distributing these funds to Core Network Practices and other Members of the PCN commensurate with the proportion of Network Activities that they perform.
6. The funds to be paid directly into this bank account in connection with the Network DES in 2019/ 20 are specifically:
 - a. £1.50 per patient Network DES
 - b. £1.45 per patient extended hours funding
 - c. Contribution to Clinical Director post, including on costs @ 51p per patient
 - d. Funding with on costs for Social Prescriber
 - e. Funding with on costs for 70% of Clinical Pharmacist
7. As other specific DES related network funds become available, they will also be paid into this bank account. At all times a schedule of income and payments and their specific purpose will be maintained, regularly updated and be available for members inspection.
8. Other payments may from time to time be received by the PCN not directly associated with the DES but will also be paid into this account
9. Core Network practices and other Providers in the PCN will also pay into this account for services they have received from the PCN or member Practices
10. The Bank Account will be used to pay Core Member Practices and other providers for services they have delivered for the Network in connection with the Network DES or other agreed services.
11. The PCN shall appoint a subcommittee comprising the Clinical Director or designated Core Practice GP, a Practice Manager and one other member of the PCN to manage these funds on behalf of the PCN.
12. This subcommittee will have powers to:
 - a. authorise use of the funds in line with the functions set out in paragraph 5, 6 and 7,
 - b. commit funds and make payments from the bank account up to a limit of £x for any individual transaction

- c. Authorise any two of the three subcommittee members to sign cheques / make payments via BACS
13. A monthly budget report of expenditure from the Bank Account will be made to each PCN Core Practice and to the wider PCN membership as appropriate.
 14. Any expenditure requests over the authorised limit shall be brought back to the full PCN for a decision.
 15. Decisions to widen the scope of this agreement or to change the organisation providing this bank account shall be made by the full PCN meeting after giving due notice of at least 28 days that such a decision is to be considered.

SCHEDULE 5

WORKFORCE

This schedule needs to specify the arrangements in the PCN for the employment and deployment of the additional staff roles. It will need to be amended as the PCN decides what additional roles it requires each year.

This section could also be used to set out how any other staff who work across the network will be shared between the practices or deployed in a central role for the PCN.

A model contract of employment and “joint employment agreement” between practices is available on the LMC website. It is recommended for such situations to ensure a robust employment status, clarity in the responsibilities between the host employer and the other practices receiving a service from this member of staff and to give some clarity to the member of staff concerned. Specific advice in this area may be sought from our HR team.

SCHEDULE 6
INSOLVENCY EVENTS

1. The following events are to be considered events of insolvency referred to in Clause 75. References to “Member” below are, where a Member is a Core Network Practice, references to the legal entity that makes up that Core Network Practice which is the “Contractor” as defined in that Core Network Practice’s primary medical care contract:

A suggested list of insolvency events is set out below which could be used to trigger Clause 75. Other events can be added if the PCN considers this is necessary.

- a) where a Member is, or is deemed for the purposes of any law to be, unable to pay its debts or insolvent;
- b) where a Member admits its inability to pay its debts as they fall due;
- c) the value of a Member’s assets being less than its liabilities (taking into account contingent and prospective liabilities);
- d) where, by reason of actual or anticipated financial difficulties, a Member commences negotiations with creditors generally with a view to rescheduling any of its indebtedness;
- e) where a Member suspends, or threatens to suspend, payment of its debts (whether principal or interest) or is deemed to be unable to pay its debts within the meaning of Section 123(1) of the Insolvency Act 1986;
- f) where a moratorium is declared in respect of any of a Member's indebtedness;
- g) where a Member calls a meeting, gives a notice, passes a resolution or files a petition, or an order is made, in connection with the winding up of that Member (save for the sole purpose of a solvent voluntary reconstruction or amalgamation);
- h) where a Member has an application to appoint an administrator made or a notice of intention to appoint an administrator filed or an administrator is appointed in respect of it or all or any part of its assets;
- i) where a Member has a liquidator, trustee in bankruptcy, judicial custodian, compulsory manager, receiver, administrative receiver or similar officer (in each case, whether out of court or otherwise) appointed over all or any part of its assets;
- j) where a Member takes any steps in connection with proposing an individual or company voluntary arrangement or an individual or company voluntary arrangement is passed in relation to it, or it commences negotiations with all or any of its creditors with a view to rescheduling any of its debts;
- k) where a Member has any steps taken by a secured lender to obtain possession of the property on which it has security or otherwise to enforce its security;
- l) where a Member has any distress, execution or sequestration or other such process levied or enforced on any of its assets which is not discharged within 30 calendar days of it being levied;

- m) where a Member substantially or materially ceases to operate, is dissolved, or is de-authorised;
- n) where a Member is clinically and/or financially unsustainable as a result of any clinical or financial intervention or sanction by the regulator responsible for that Member or the Secretary of State and which has a material adverse effect on the carrying out of that Member's obligations under this Agreement; or
- o) where a trust special administrator is appointed over a Member under the National Health Service Act 2006 or a future analogous event occurs.]

SCHEDULE 7

ARRANGEMENTS WITH ORGANISATIONS OUTSIDE THE NETWORK

The arrangements by which organisations and individuals other than core member practices can become a member of the Network and participate in its business are set out in Schedule 1.

This schedule describes those bodies, individuals and organisations with which individual member practices may individually, or collectively engage in business with and which it would be advantageous for the working and governance of the Network for all member practices to know about.

One way of fulfilling this requirement would be for each core practice member to complete a list of those organisations outside the PCN that the practice is working with. Such lists could be very long but, essentially can be limited to those organisations which might have some relevance to the working of the Network. Further guidance is being sought on the extent of such lists.

In the meantime, it is suggested that the following could be used as an initial guide.

- Those organisations that a member practice does business with that might lead to a conflict of interest in participating in PCN decision making
- Organisations to whom the practice sub contracts work
- Organisations for which a member practice is contracted to do work
- Consultancy and advisory bodies that are working with a practice or for which a practice partner or member of staff provides services to.
- Research interests and studies
- Organisations and individuals with which the member practice has developed a good working relationship with for the benefit of patients and the wider community that could be developed on a wider basis across the PCN.