

The primary care network handbook



General practice
and PCN support



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Let patient care be your number one priority

The primary care network handbook

This handbook has been created to give advice and options to groups of practices looking to establish and develop a primary care network. Most of the major elements are interdependent, so conversations and decisions should not be made in isolation; we recommend reading the whole document before meeting with others to make decisions. For example, the structure that you decide to create for your network will have an impact on how new network staff can be employed, and how funding may be distributed across the network.

Further guidance and tools will be provided in due course.

Background

The BMA GP (England) committee and NHS England have agreed, through the national contract negotiations, for the development and rollout of PCNs (primary care networks).

PCNs are groups of GP practices working more closely together, with other primary and community care staff and health and care organisations, providing integrated services to their local populations.

From April 2019, individual GP practices will be able to establish or join PCNs covering populations of between 30,000 to 50,000 (with some flexibility). A DES (directed enhanced service) will support the development of PCNs and will cover a number of areas, including funding for the provision of additional workforce and services that the PCN will be required to provide.

The BMA has been working with NHS England to ensure PCNs allow for the retention of what constitutes the very best of how general practice and wider primary care currently operates, retaining and building on the national GMS contract and the partnership model, while finding improved ways to deliver care that offer tangible benefits and improvements to patients, clinicians and the wider primary care team.

As a result individual practices joining the network will retain their GMS or PMS contract, with the PCN building on it.

Many practices have already been working collaboratively, sometimes as part of informal networks, on their own initiative – though the contractual changes that came out of the negotiations between GPC England and NHS England will contribute to provide recurrent funding and support for all practices participating in the DES.

The aim of primary care networks

Bringing care closer to community

Connecting the local primary care team

The intention behind changes inserted into the GP contract is to focus services around local communities and local GP practices to help rebuild and reconnect the primary healthcare team across the area they cover. PCN services will be delivered in the local area by the GP practices and multidisciplinary teams employed by the network. They will be commissioned and funded by CCGs through the network.

LMCs (local medical committees) have an important role to work with CCGs to ensure that practices will lead and direct these networks, ultimately becoming a vehicle through which GPs and other primary care practitioners can deliver an effective and sustainable model of care for their patients and communities. National direction will be given to establish the principle of GP leadership and the devolution of management of staff to work as part of practice-based and practice aligned primary healthcare teams.

LMCs will also support PCNs' engagement with STPs (sustainability and transformation partnerships) and ICSs (integrated care systems) to shape their strategic direction and improve and align population care on a wider scale.

Non-GP organisations working within the locality will be party (but not mandated) to the network agreement, but not party to the DES. Where they are to be a part of the network, their contribution in terms of funding, workforce and/or services will be agreed between the parties and recorded in the network agreement.

Bringing new benefits to patients

The development of PCNs will mean that patients and the public will be able to access:

- resilient high-quality care from local clinicians and health and care practitioners, with more services provided out of hospital and closer to home
- a more comprehensive and integrated set of services, that anticipate rising demand and support higher levels of self-care
- appropriate referrals and more 'one-stop shop' services where all of their needs can be met at the same time
- different care models for different population groups (such as frail older persons, adults with complex needs, children) that are person-centred rather than disease-centred.

Creating a PCN

Geography

The geographic coverage of the PCN is up to the member practices to decide through discussions with their colleagues and neighbours. **The only involvement of the CCG in this process should be when there are gaps in the total PCN coverage of their area.** In this scenario the CCG, in collaboration with the relevant LMC(s), should act as liaison between the proposed PCN groupings in the area and the practice(s) that are not currently included in any such grouping, either by choice of the practice or the PCN. If a practice chooses not to sign up to the DES at all, the CCG will need to arrange for an appropriate PCN to take on provision of network-level services to the patients in that practice (along with the relevant funding).

The total population of the PCN should cover around 30,000–50,000 patients. While there is no maximum size of a PCN, and commissioners can sign off on PCN proposals that go over 50,000, it is at around this size that networks will best keep the features of traditional community-based general practice, combined with the benefits of integrated working across a locality.

Only in exceptional circumstances will networks be allowed to cover a population smaller than 30,000; for example, in rural areas where reaching a 30,000+ population causes geographic problems.

Prerequisites to becoming a PCN

To be recognised as a PCN, individual GP practices will need to make a brief joint submission outlining:

- the names and the ODS codes of the member practices
- the network list size (ie the sum of member practices' lists as of 1 January 2019)
- a map clearly marking the agreed network area
- a copy of the initial network agreement signed by all member practices (see below)
- a named clinical director from among the GPs of the network (additional funding is provided for this role)
- the single practice or provider that will receive funding on behalf of the PCN.

Networks will need to complete a network agreement. The intention is that this will be a pro forma agreement with schedules that can be moulded to enable the individual parties to specify how they will handle network-specific issues such as:

- decision making, governance and collaboration arrangements
- arrangements regarding the delivery of different packages of care
- the agreement for distribution of funding between the practices
- arrangements regarding the employment of the expanded workforce
- internal governance arrangements (appointment processes, decision making process, etc).

The network agreement will have to be updated year on year as new services, workforce and funding are added.

The content of the network agreement is not within the remit of the CCG to challenge. As long as the practices have agreed, the CCG cannot refuse the DES based on its content.

Appointing a clinical director

While all networks must have a named clinical director, how that post is filled and by whom is up to the member practices, collectively, to decide. Selection and appointment could be undertaken in a number of ways – for example, by election among member practices or by an appointment process. Whichever method the network uses, it is highly recommended that appropriately robust governance procedures are put into place. This will ensure the appointment has been made with due diligence and the support of the network's membership.

The role profile for the clinical director is appended to the [contract agreement document](#) and outlines its responsibilities. It is expected that the clinical director will be selected from the GPs of the practices within the network, but any appropriate 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.

Networks may seek the support of the LMC in the appointment process, to provide a degree of separation and because LMCs have experience of running elections and appointment processes.

Consideration will need to be given to how the funding provided for the clinical director role is used. It could be given directly to the clinical director as a form of remuneration, or if the clinical director is a partner or employee of a member practice, it may be given to that practice to fund the necessary backfill to cover their absence from the practice while undertaking their PCN duties. In bigger PCNs, member practices may decide to provide additional staff support to their nominated clinical director, to reflect the increased scope of the role. **How the network's clinical director is selected is entirely at the discretion of the network.** However, there are two methods that practices should consider:

Appointment

Practices may wish to select a clinical director based on a normal appointment process, as they would for any other role within a practice. This would require inviting applications for the role from among the network's membership, convening a selection panel from the member practices and coming to a collective decision on whom to appoint, assessing the applications against an agreed person specification.

Election

Alternatively, practices may wish to select the clinical director by election. This can be undertaken by inviting expressions of interest, via submitting personal statements. An election process would then be held among the constituted network board, or across all partners in the network. If unsure as to how to hold the election, the relevant LMC can offer advice and support.

In both cases we highly recommend that there be an open and transparent process of selection, in which all interested candidates are able to participate, and which has the full support and sign-off of the constituent members of the network.

Practices may also want to ensure that those standing have the necessary competencies by using a prior assessment process. This would combine elements of both approaches, with assessment leading to a shortlist, from which candidates can then be put forward for election.

While there is no requirement for the clinical director to be appointed from within the network, we recommend that the first option should be to consider an appointment from within, as a failure to do so risks reducing the local ownership of leadership and decision making. Some practices may wish to recruit externally for someone to take on the role in the long term. Due to the need to be able to get various aspects of the network up and running in a relatively short space of time, however, an internal appointment is strongly recommended at least initially.

Establishing and enabling sustainable networks

First steps

A nascent PCN will have to establish structure and governance arrangements before it can move towards setting up services and acquiring the necessary workforce.

All primary care networks will need management and administrative support structures. Practices that form the network will also need to seek advice on any proposed legal agreements and financial matters, and will need to establish a regular meeting of their representatives to ensure that things are developing as planned.

Early stage delivery and maintenance

Following the establishment of their structure of governance and administration, networks will be expected to begin service delivery, primarily focused on developing expanded practice-based and connected teams to deliver the provision of workload support of the member practices by:

- working alongside the existing practice team and taking responsibility for some services of the member practices (to be decided by the network), focusing on extended-hours delivery in the first instance
- restructuring some service delivery (to be decided by the network)
- offering access to the extended PCN team (extending the workforce).

Networks should begin the recruitment of a pharmacist and social prescriber in the first year, as it starts to develop an extended primary care workforce, and also upskill staff already working within the network as they naturally take on more responsibilities.

As the workforce expands and services reconfigure, networks may find a need for additional or restructured premises and infrastructure. The Premises Cost Directions will remain the mechanism for funding for changes to premises.

Mature stage delivery and maintenance

When a PCN is established and has begun to deliver services at the level of the network, it should start to enjoy the benefits of the scheme and the impact of the expanded workforce on workload sustainability.

Only then is it able to build upon the foundations to expand its scope further and qualify to provide any PCN-specific services developed through the DES specification.

Any additional work should be linked to additional funding, to deliver a sustainable service of appropriate quality.

The DES will provide a menu of options in this regard, to enable PCNs to discuss and agree which services the network should provide to best fit the needs of its member practices and local patient population.

Mature stage – workforce expansion and development

At this stage there will be a continued development and expansion of services, including an enhanced offering of services in the community, learning from best practice and evidence from around the country. The network will receive long-term recurrent resources to ensure sustainability and require a willingness from practice members to invest their time and commitment into this.

At this stage, relying on the confidence and mutual trust built up through shared working, the network will become a mature forum for shared learning and quality improvement.

The network will need to organise regular meetings of its membership, keep receiving relevant legal and HR advice on maintenance and day-to-day running. Premises and infrastructure will need to be regularly reviewed to ensure best use of space and facilities.

PCN internal governance and decision making

Whichever organisational structure that practices chose to develop for their network, they will need to ensure there are robust and appropriate governance structures in place. In doing so, practices will need to consider a number of key questions regarding how they wish the network to operate on a day-to-day basis.

Key considerations

Governing/representative body

Practices will need to set out a clear decision-making process for the network. This should identify the relevant agents acting on behalf of network members (eg one representative from each practice, a selection of individuals from across the network, all partners from each practice, sessional representation, etc), the weighting of votes (eg one per practice or according to size), and the quorum requirements.

The network may have a 'board' comprising one representative from each member practice. Alternatively, the network may have a board comprising all the partners from member practices. Each 'bloc' of partners gets a vote share in line with their respective practice list size.

There are many ways in which these can be constituted and, ultimately, it is up to the member practices to decide what decision-making process they feel comfortable with.

Practices may wish to consider how similar staff working in different practices and settings might want to interact at network level (eg a board for nurses, a board for GPs, a board for practice managers) to share ideas, best practice, etc. However, this needs to be developed in line with available resources.

Whichever route practices take, the board should operate as the network's governing body, bringing all members together, overseeing joint decision making, the strategic direction of the network and the network's funding/financial layout. It is also the body to which the clinical director would be directly accountable.

Decision making

Once a structure of governance has been decided, decision-making processes for the network also need to be established.

These set out how network decisions are taken, and should cover:

- what is within the remit of the clinical director to act executively, what needs to go back to the practice representatives
- how the governing body makes decisions – does it require a simple majority, a conditional majority, unanimity, etc
- how often the governing body should meet
- how meetings are chaired (an elected chair, rotational chair, etc). As the clinical director will be accountable to the governing body, it may be better for the role to be excluded from chairing the governing body.

Accountability

Clear lines of accountability for all parts of the network should be agreed and established from the outset and practices should make sure they are all comfortable with the agreed systems.

For example, the clinical director could be accountable to the board, which is in turn accountable to the member practices, via the nominated representatives. There will also need to be a system in place to ensure individual practises are also accountable to each other, collectively, with respect of delivery of PCN services, under the DES specification and the network agreement. This could also be undertaken via the network board.

Data sharing

In order to operate effectively as an entity, data sharing agreements need to be set up between the constituent practices, as well as any non-GP organisations that are party to the network, to allow all parts of the network to access necessary patient data (medical records, etc). **In order to facilitate this, a national template data sharing agreement will be made available to all networks.** However, as this is only a template data sharing agreement, the details of which need to be populated by the network itself, it is strongly recommended that the final proposed agreement is reviewed by a qualified professional to ensure it is compliant with the various aspects of data protection legislation.

Dispute resolution

Practices need to ensure that there are clear dispute resolution procedures in place, so that any disagreements between constituent members of the network can be resolved appropriately. It's advised that the network draws on the relevant LMC as an independent mediator in such processes.

Finances

Governance procedures should also set out how the network's finances are handled. This will depend in part on how the network is constituted (ie is it using a 'lead provider' model, where one practice employs staff on the network's behalf, is it using a 'flat' model where employment is shared among member practices, etc) as well as how the services are reconfigured (ie if one practice provides all services to care homes in the area, they will be accountable for that care and may require additional funding from the other practices or the central PCN pot, or all care home patients may be encouraged to be registered with that one practice).

HR policies

Practices need to decide what HR policies apply to staff employed under the network. The simplest method may be to apply the policies from one of the member practices (the lead practice if that model is chosen) to these new staff, rather than draft an entirely new set of policies. This will be for the constituent practices to consider and decide.

Non-practice members

Over time PCNs will develop close working relationships with other primary and community care organisations, acting as the locus through which various aspects of non-hospital care come together. This could range from, for example, local community trusts to care homes, to the voluntary sector.

For this reason, practices also need to give consideration to how the network will interact with other healthcare bodies. They may wish to create seats on the governing body for these organisations, to allow them to be formally integrated into the network. Alternatively, the network could enter some form of agreement with the various bodies to identify (among other things) the services that are to be provided and by whom.

Potential PCN structures and employment options

There are a number of possible structures for PCNs operating under any potential DES. The way in which any PCN is structured will impact how it operates, including the relationship between participating practices, how funding flows under the DES, where any consequential liabilities sit and how any extended workforce is employed.

This section presents five potential structures for the interaction between the commissioner and the network, and between members of the network, in terms of the DES – including how funding, service reconfiguration and workforce might be affected. These structures are presented based on the most current information available at the time of publication and may be updated as further information is released.

Individual practices belonging to the network will have to carry out a risk assessment before agreeing the most appropriate structure – to include individual or collective liability for the DES, for the funding associated with the DES, for the structure of the workforce within the network, legality of any structures for the network, financial implications, potential tax implications (eg VAT), and the workload and bureaucracy associated with setting up and maintaining a structure. Below are the main potential issues but this is not an exhaustive list and we recommend seeking independent legal and financial advice at a network level, to help decide the most appropriate structure.

Employment liabilities

Over time the network-level workforce funded under the DES will expand, both in terms of the different roles eligible for funding, and the overall level of funding available to networks. Practices therefore need to give close consideration to the impact that such a workforce expansion will have on their exposure to employment liabilities (eg potential future redundancies). For this reason, they may wish to consider ways to limit their exposure to such liabilities through, for example, the use of limited liability vehicles or by sharing them equitably across members of the network.

Pensions

For healthcare staff to have access to the NHS pension scheme, the employing body must qualify as an 'employing authority' under the scheme. In short, this requires them to hold an NHS contract. For networks operating under a lead employer or flat practice model, or where staff are seconded from another NHS organisation such as a community trust, this will not be an issue. However, where the PCN is planning to set up or utilise an existing limited liability vehicle, such as a GP federation, the staff employed by that body under the DES may not be able to access the NHS pension scheme unless the body itself holds an NHS contract.

This issue is currently under discussion with NHS England, and we are hopeful of a resolution in the near future. However, practices should be aware that any agreed changes to the access arrangements for the NHS pension scheme are unlikely to be in place in time for July 2019. Practices thinking about a limited liability basis for their PCN may therefore wish to set up initially under one of the other structures outlined below before changing to a provider vehicle model at a later date, when this issue is resolved and when the operations and functions of the network develop to a greater extent.

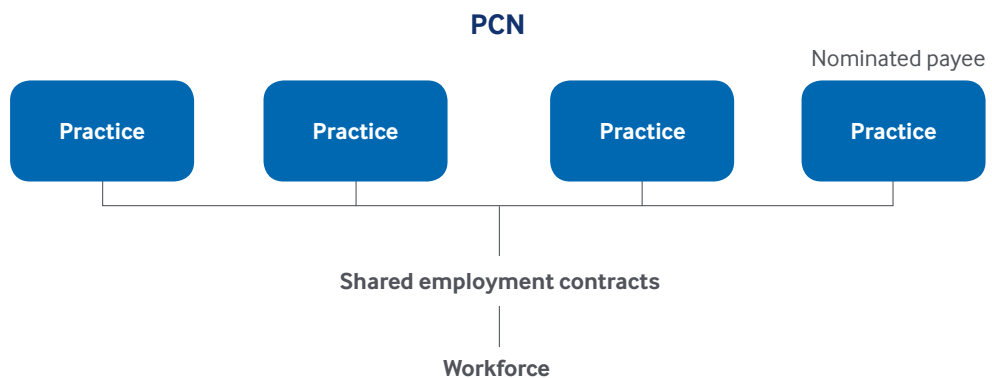
VAT

Practices will need to be very careful that the structure they choose does not inadvertently attract VAT charges. While the provision of healthcare services is exempt from VAT, the provision of healthcare and back-office staff is not and it is possible that under some structures this interpretation could apply. Practices therefore need to ensure their chosen network structure does not fall under the latter interpretation.

The BMA and NHS England are investigating this issue and will provide guidance as soon as possible. However, we strongly recommend that networks take advice on their specific proposals in order to fully safeguard themselves in the future.

Potential operating models

1. Flat practice network



While the DES requires that the network provides a nominated payee, this need only act effectively as the network's bank account, with responsibilities, contractual commitments (including the employment of additional workforce) and funding spread across its members as opposed to being fronted by a lead practice or some form of provider entity.

How this could work as a PCN

The practices in the network would jointly sign up to the network agreement, which would record the fact that contracts relating to the functions and workforce of the PCN are jointly entered into by all practices and that the liability arising from it are jointly split between them.

In relation to workforce, practices would use joint employment contracts to engage PCN staff. While all practices will be regarded as employers and the contract of employment for the relevant employees will need to record the fact that their place of work spans the entire network, for practical reasons, one practice will be nominated as the paymaster (likely to be the nominated payee for the purpose of receiving the DES network funding) and it will be recorded that it is their policies and procedures (such as those relating to grievance and disciplinary) that will be applied.

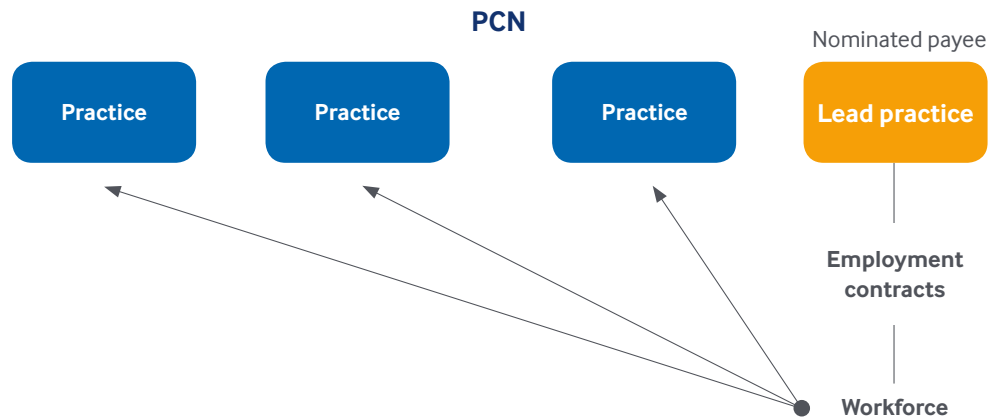
At a glance: risk assessment

- No NHS pension issues envisaged.
- No subcontracting issues envisaged.
- No significant issues envisaged in relation to employing the additional network staff beyond the necessity to jointly employ and the issues over liability (mentioned below).

Note: a nominated paymaster is likely to be needed (to handle pay and to act as the lead practice on HR policies and issues), the employees' 'place of work' will need to be carefully documented to enable additional employees to work across the network and it is strongly advised that the employment arrangements are discussed with your employee liability insurance providers to ensure full coverage.

- No VAT issues envisaged.
- No CQC issues envisaged.
- A robust agreement between the member practices to ensure that workforce, liability (in particular the split of liability), financial and other such arrangements are clearly documented is essential.
- Liabilities may prove an issue as these will need to be shared amongst the constituent practices (which, to the extent operated as partnerships or by sole contractors, will have unlimited liability).

2. Lead provider



The practices signed up to the DES and involved in the PCN will identify a lead practice. This practice will be the focal point for engaging additional workforce and entering additional contractual arrangements (if any) on behalf of the PCN. Service delivery will then flow to the network as a whole.

How this could work as a PCN

The practices in the network would jointly sign up to the network agreement, which would record the fact that contracts relating to the functions and workforce of the PCN are entered into by a specific lead practice (different lead practices could be identified to lead on differing things).

In relation to workforce, the lead practice could employ the network staff (or those that the practices agree the lead practice will directly employ) and they will either be seconded out to practices as required or work across the network by reference to a clause establishing the necessary 'place of work' as the network as a whole. Practices in the network will continue to employ their existing workforce. Funding under the DES (or the appropriate amount) will be provided directly to the relevant lead provider on behalf of the network to fund the employment costs.

Under this structure, the lead practice will be primarily responsible for meeting the employee costs and liabilities and will assume HR obligations, as they would for any other staff they employ.

At a glance: risk assessment

- No NHS pension issues envisaged.
- No CQC issues envisaged.
- No significant issues are envisaged when it comes to employing the additional network workforce other than the VAT and liability mentioned below.

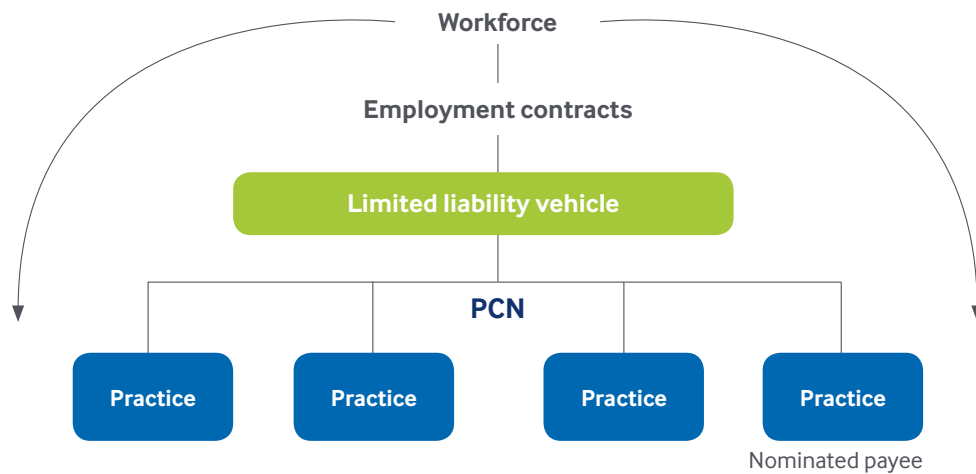
Note: If employees are to be seconded, they will have to agree to the secondment and the arrangements clearly documented. If the employees are to be engaged to work across the whole network, the employees' 'place of work' will need to be carefully written so they can be used across all providers. This aside, it is strongly advised that the employment arrangements are discussed with your employee liability providers to ensure full coverage.

- Possible VAT issues, depending on whether there is deemed to be a provision of healthcare to patients being VAT exempt or staff (whether medical or back office) who are not.
- A robust agreement between member practices is essential, to ensure that workforce, liability (in particular, and while the lead practice will be primarily liable,

the split of liability between the practices), financial and other such arrangements are clearly documented.

- Liabilities may prove an issue (including, in particular, employment liabilities) as these are likely to lie with the lead practice (which, to the extent operated as partnerships or by a sole contractor, will have unlimited liability).
- Could involve the need for subcontracting between constituent parts of the network, depending on service arrangements.

3. GP federation/provider entity



The member practices would continue to employ their normal staff and provide their core GMS services, but the provider entity would be subcontracted to deliver services required by the DES, and employ the range of staff necessary to do so. These services would be funded by the monies received via the DES.

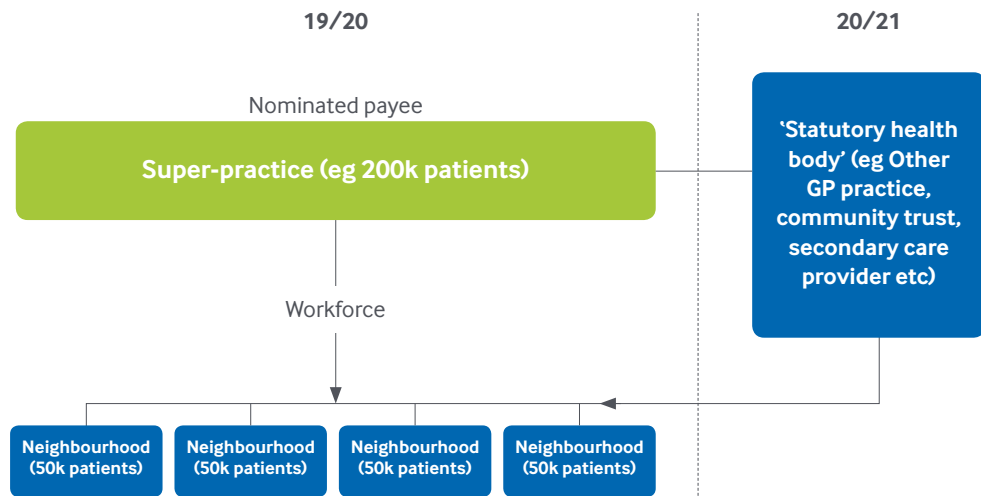
Under such an arrangement funding would need to be paid to the member practices, to then be passed on to the federation. If the provider entity itself was party to a primary medical services contract, theoretically it could sign up to the DES itself, alongside its constituent practices, and receive the funding directly under a lead provider model.

While this model limits the subsequent liabilities that practices are exposed to as the network workforce grows, staff employed by the limited liability vehicle are unlikely to be eligible to access the NHS pension fund, unless the employing organisation holds an NHS contract. This issue is currently under discussion with NHS England and we are hopeful of a resolution. However, it may be that practices decide to develop the network initially under a different model, with an expectation that they will change to a limited liability model once this and other potential issues are resolved.

At a glance: risk assessment

- No employment issues envisaged when recruiting additional network staff, but care will be needed to ensure the workforce employed by the provider entity is capable of being asked to work across the network.
- Employment liabilities arising from the employment of additional network staff are limited as the employer, being the provider entity, has limited liability.
- Pension issues – staff employed by the limited liability vehicle are unlikely to be able to access the NHS pension scheme under the current access rules (unless it held an NHS contract in its own right).
- Possible need for CQC registration depending on who is providing the 'regulated activity'.
- Possible VAT issues when it comes to moving funding to the provider entity, and in connection with the ultimate service delivery (depending on whether there is deemed to be a provision of healthcare to patients being VAT exempt or staff, whether medical or back office, who are not).
- Is the provider entity or federation too big or far removed from the PCN to deliver as the DES intends?
- Is the provider entity or federation undertaking other services which are likely to affect its ability to deliver under the DES?
- Care is needed to ensure that any subcontracting arrangements comply with the provisions of GMS regulations.

4. Super-practice as a network



It is possible under the DES for a single super-practice to sign up and develop a network itself, due to its existing size and patient population – particularly those with a patient population over 100,000. The details and viability of this may depend on the contractual and geographical status of the super-practice (eg how many sites it has, its geography, whether it holds one contract or multiple, etc).

How this could work as a PCN

As a single entity the super-practice would need to create an internal 'network' amongst its constituent sites, with each 'neighbourhood' of practices operating as a mini network in themselves.

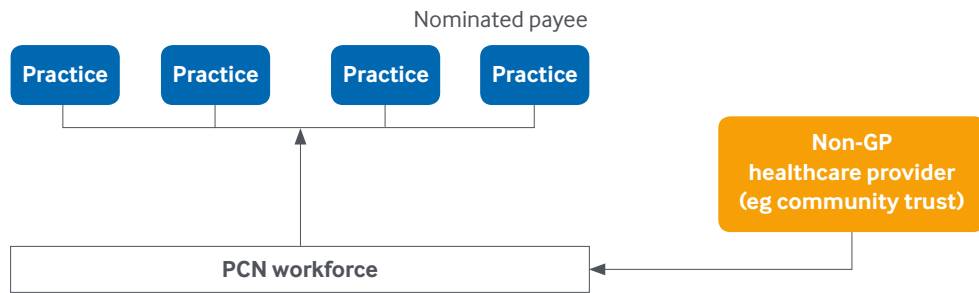
The super-practice would be the nominated payee and would then supply support and resources to its constituent neighbourhoods. Precisely how this internal 'network' operates is down to the super-practice itself to determine (ie will there be a single clinical director, will each neighbourhood have its own clinical director, how will the respective neighbourhoods interact, etc).

Note that while in the first year the super-practice would be able to operate solely, from 2020/21 it is expected that such a model will require the sign-up of another health body in order to qualify for 'network' status.

At a glance: risk assessment

- No pension issues envisaged.
- No employment issues envisaged when recruiting additional network staff, provided staff are employed to work across all constituent practices of the super-practice.
- Employment liabilities would exist for the super-practice (unless constituted as a limited company).
- No CQC issues envisaged.
- No VAT issues envisaged.
- Potential geography issue if the super-practice is split over a wide area that isn't coterminous with other providers in the locality.

5. Non-GP provider employer models



Practices may wish to ally themselves with another local healthcare provider from the start, such as a community trust, which through signing up to the network agreement alongside the GP practices can provide network-level services on behalf of the PCN.

How this could work as a PCN

Under this arrangement the non-GP provider would be signed up to the network agreement, along with the GP practices. They could employ staff available under the DES on behalf of the network, as well as using their own staff to further enhance the network's potential workforce.

As the funding for staff reimbursement is provided under the DES, this would still need to be paid to the nominated payer practice. Arrangements would therefore need to be made in the network agreement as to how that could be passed on to the non-GP provider.

At a glance: risk assessment

- No pension issues envisaged.
- No employment issues envisaged, provided staff are employed with the ability to work across the network.
- No employment liabilities for the constituent practices are envisaged as staff are employed by the non-GP provider.
- No CQC problems envisaged.
- Possible VAT issues if the network agreement is structured incorrectly and the non-GP provider is deemed to be providing staff (whether medical or back office), rather than health services.
- Will this arrangement allow constituent practices the control and longevity to develop and drive the PCN how they wish?

PCN funding

Under the PCN DES, several different funding streams will be made available to networks to fund their workforce and services. When developing the network, practices need to consider how the funding will be used and distributed across the network, as while all funding will be paid to the nominated payee set out in the network agreement, the flow of funding between different parts of the network will vary depending on its structure. This guidance sets out the different funding streams available within the first year of the DES and gives examples of how funding may be distributed under different models.

Funding streams

Funding under the DES will be paid to a nominated provider within the network as set out in its network agreement (with the exception of network engagement funding, which will go direct to practices), and will consist of several streams:

Network engagement funding – to practices individually

Practices will receive an additional annual payment of £1.76 per patient for engagement with the primary care network scheme, via the SFE. While paid in connection with the PCN DES, this is a practice payment and it is therefore up to practices to decide how they wish to use it (eg to cover core practice expenses).

Network payment

There will be a recurrent payment of £1.50 per patient as an entitlement for networks, from CCG central allocations. This is an extension of the £1.50 per head previously available between 2017–19 via CCGs, which was used in various ways across the country. Provision of this funding is an entitlement under the DES and is no longer discretionary or subject to any further requirements than those laid out within the DES specification. Its use will be entirely for the network collectively to decide and is intended to support the day-to-day operation of the network.

Extended Hours funding

The funding currently associated with the Extended Hours DES will transfer (with the associated responsibilities) to the network. This will be provided as an entitlement to the network's nominated bank account of £1.45 per patient. The network will decide how this funding is distributed in line with the provision of services required to fulfil the requirements of Extended Hours.

Extended Access funding

Over time, the £6 per patient that is currently provided for the Extended Access scheme will also transfer to the networks; the exact timing of this transfer will depend on the current arrangements in each area for the Extended Access scheme. Some CCGs may transfer the funding from 2019, if the commissioning arrangements for the Extended Access scheme allow, whereas others will need to be delayed until those Extended Access contracts come to an end. NHS England has advised that all Extended Access funding should have transferred to each network by 2021. The intention is to bring together extended hours and extended access activity to reduce fragmentation and confusion for practices and patients.

Investment and impact funding

Networks will be able to access an 'investment and impact' fund, starting in 2020 at £75m, building up to £300m by 2024. This savings scheme will be tied to the development of community-based services that enable reductions in hospital activity, such as accident and emergency attendances, delayed discharge and avoidable outpatient visits.

Workforce

The DES provides for workforce reimbursement for the network covering a number of specified health professions and designed to allow the network to build up an expanded primary care team. In the first year this will constitute one clinical pharmacist, funded at a 70/30 split between NHS England and the network (including on-costs), and one social prescriber, funded 100% by NHS England. The network will need to provide a monthly invoice with evidence of costs to its CCG, and will be reimbursed the required amount up to the maximum reimbursement. The maximum reimbursable amount for each of these roles will be set at the weighted mid-point of the respective Agenda for Change salary band.

	AfC band	Maximum reimbursable amount in 2019/20 with on-costs
Clinical pharmacist	7-8A	37,810
Social prescriber	5	34,113

In future, direct reimbursement will be replaced by an 'additional roles' sum for each network. This will correlate to the size of the network's patient population.

Clinical director funding

A total of £31m of funding will be available to fund the clinical lead post for each network on a basis of 0.25 WTE per 50,000 patients, at national average GP salary (including on-costs). This will be provided on a sliding scale based on network size.

Network clinical director funding	Estimated cost per 1 WTE £	Relevant WTE funded costs (2019/20) ¹ £
0.15 WTE per 30,000 population	137,516	20,627
0.2 WTE per 40,000 population	137,516	27,503
0.25 WTE per 50,000 population	137,516	34,379

Funding examples for different sizes of PCN

The level of funding available for a PCN will scale with its size. This will be especially true in future years when workforce funding switches from direct reimbursement to a capitated payment, based on the population size of the PCN.

PCN population	Network administration payment	Clinical director funding	Clinical pharmacist reimbursement (max 70%)	Social prescriber reimbursement (max 100%)	2019/20 maximum potential funding
30,000	£45,000	£20,627	£37,810	£34,113	£92,595
40,000	£60,000	£27,503	£37,810	£34,113	£159,426
50,000	£75,000	£34,279	£37,810	£34,113	£181,202
70,000	£105,000	£48,131	£37,810	£34,113	£225,054
100,000	£150,000	£68,558	£75,620	£68,226	£362,404

¹ Figures will increase over the five years to reflect uplifts

Additional funding

The funding entitlements for networks represent a baseline. Commissioners cannot remove or reduce the entitlements, but they can add to them. The planning guidance states real-terms investment in primary and community services 'should grow faster than CCGs overall revenue growth', as set out in the LTP, and further guidelines will be issued showing how to measure this.

Locally funded services

The network may wish to discuss with the CCG the possibility of providing additional services beyond the national specification in return for appropriate funding. This funding could then be used to cover the network's 30% workforce contribution, or even to recruit additional staff that could be used by the network and its constituent practices.

Commissioners may choose to transfer, where appropriate, their locally commissioned services contracts to the network, rather than with individual providers.

Funding the 30% staff costs

As the reimbursement for the majority of the workforce that will be introduced to networks over the next five years will be set at a 70/30 split, practices will need to collectively decide how they will fund the required 30% contribution for network staff. This could be done in a number of ways:

Network payment

Practices may choose to use the network payment to cover the 30% salary cost. While in the first year this pot of funding should be more than enough to cover the 30% required, note that as the network workforce grows in future years, practices will need to consider additional funding options as the network payment may no longer cover its whole workforce contribution.

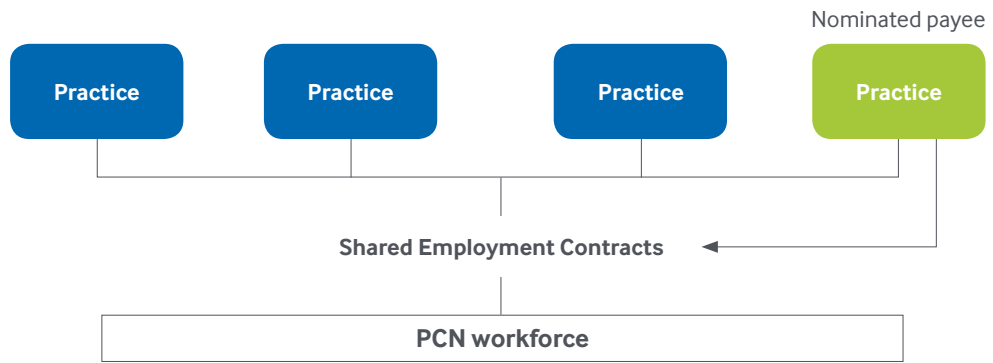
Practice pooled funding

Practices may each contribute an appropriate amount to the network to cover the 30% salary cost. This could be a flat contribution from all member practices, or it could operate on a per-head basis, so practices contribute in line with their size. If networks choose to use practice contributions, they should ensure that appropriate governance processes – detailing how the contribution is determined and how the funding is handled – are agreed and put in place beforehand. Note that alongside the increased central funding for PCN workforce expansion, there will also be an annual increase to the global sum over the next five years, and this can be used to contribute to staff costs both in the practice and in the PCN.

Funding distribution

The way funding flows across the network will be determined partly by its organisational structure. In all cases, practices will need to nominate a lead provider to whom the PCN funding is paid. The nominated payee should take care to ensure this funding is kept separate from their practice accounts. This funding can then be used or redistributed across the network as required. The below diagrams (based on the five PCN structures outlined above) illustrate some ways in which this could operate, with possible funding flows in green. These are examples of just some of the ways networks can be structured, and in all cases it is essential to take your own legal and financial advice on the potential legal and tax implications.

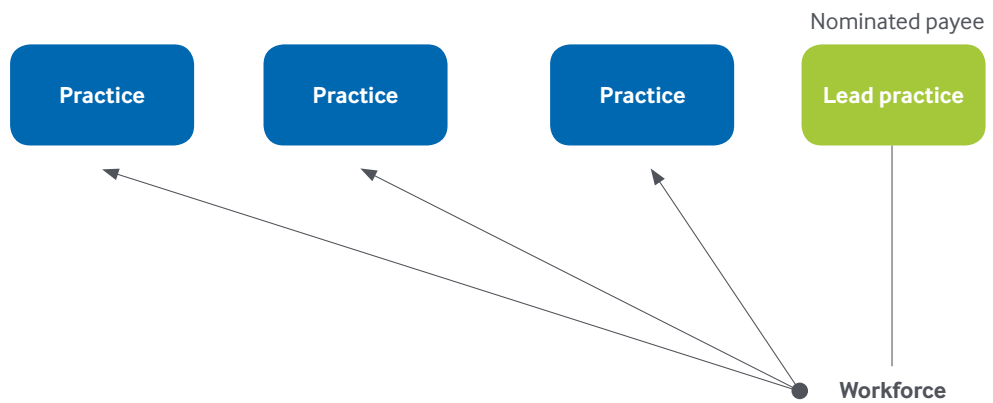
1. Flat practice model



In a 'flat practice model' network, workforce engagement and other expenses are shared across the member practices. This requires participant practices to have a clear agreement between them, setting out precisely how workforce will be employed (eg will they use shared employment contracts? Will one practice employ the clinical pharmacist and another the social prescriber, with each practice taking on a different part of the PCN workforce as they are introduced?), how funding is shared across the network to cover each practice's expenses, and how any subsequent liabilities may be shared across the partner practices.

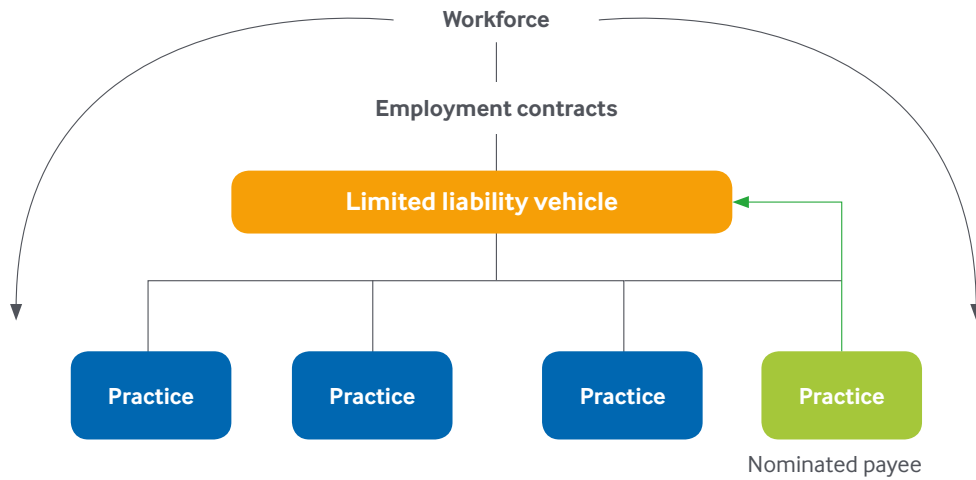
However practices decide to operate within this broad model, network-related payments will be paid by the commissioner to the nominated practice, as set out within the network agreement (excluding the network engagement funding, which is paid directly to the practices). The nominated practice then handles payment for the shared employment contracts.

2. Lead practice model



Under a 'lead practice model' a single constituent practice within the network, which is also the nominated payee in the network agreement, takes sole responsibility for the organisation of the PCN, including engaging and employing the additional workforce and the clinical director. In such a structure there will need to be appropriate governance arrangements between the member practices to ensure appropriate oversight of the funding and to avoid any potential conflict between practices over its use.

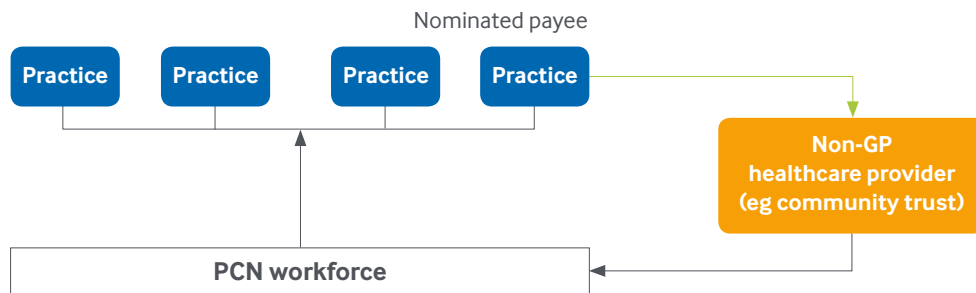
3. GP federation/provider entity



In this model, staff are engaged via a separate provider vehicle, which can be set up as a limited liability vehicle in order to minimise the potential increase in liability for member practices as the PCN workforce develops and grows over subsequent years.

Under this model the provider vehicle employs the network workforce and clinical director on behalf of the PCN. The nominated payee therefore needs to transfer funding to the provider vehicle as required to cover the workforce costs. Should the provider vehicle hold a GMS/PMS contract itself, however, as some provider entities/ federations do, this is not necessary as the provider entity/federation could be named as the nominated payee for the network.

4. Non-GP employer



If a non-GP provider is providing services or staff on behalf of the network, practices will need to set up a way for the workforce funding paid to the nominated payee to be passed on to the additional provider. As this funding is paid under a DES, even if the non-GP provider is formally included in the network agreement, the funding could not be paid directly to them – it would have to be paid to the nominated payee practice first. A subcontracting arrangement might be appropriate.

In producing this kind of arrangement, practices will need to be extremely careful that what is provided by the non-GP provider is a healthcare service, and not just staff, in order to avoid attracting VAT costs.

Workforce and employment

Introduction

Over the coming years, PCNs will be supported in developing an expanded primary care team, with member practices also working alongside other organisations such as community trusts and the voluntary sector, to help alleviate workload pressures on practices and allow GPs to concentrate on the most complex patients. While the engagement of additional staff is not a requirement of the DES, an expanded primary care workforce will be necessary in order to undertake elements of the scheme as it is expanded over the coming years.

The workforce and employment elements of setting up a network will depend on the structure of the network, and the reconfiguration of services.

What does the PCN DES mean for workforce and employment?

The DES provides reimbursement for workforce engagement across the network on a 70/30 split, which includes on-costs (such as employer pension contribution and National Insurance costs), covers a number of specified health professions and is designed to allow the network to build an expanded primary care team.

The new PCN workforce will be part funded **recurrently** at 70%, with 30% to be provided by network members, apart from social prescribers which will be 100% funded by NHS England, with the eligible posts increased over the next five years to enable PCNs to build up their expanded primary care team. The aim is to introduce over 20,000 additional workers to the primary care workforce over five years.

For practical purposes, and to enable networks to be up and running before the five-year scheme fully develops, for the first year of the DES (2019/20), every network with a population of at least 30,000 can claim **70% funding as above for one additional WTE (whole time equivalent) clinical pharmacist** and **100% funding for one additional WTE social prescribing link worker**. Beyond a population of 100,000, the 2019/20 reimbursement scheme doubles to two WTE pharmacists and two social prescribers; with a further WTE of each for every additional 50,000 in population size. Over the coming years, first contact physiotherapists, physician associates and community paramedics will all be added to the scheme too (see page 26 for more information about these clinicians) and the workforce reimbursement system will be altered so that it is linked to the patient population of the PCN.

What counts as 'additional workforce'?

To be eligible for workforce reimbursement, staff employed under the DES must be 'additional' to the existing workforce employed by the network's member practices. This will be measured on a 2018/19 baseline established as of 31 March 2019.

The baseline will be set against all five staff roles in March 2019 – clinical pharmacists, social prescribing link workers, physician associates, physiotherapists and paramedics. It will be determined by combining information from the National Workforce Reporting Service as of 31 March 2019 and a survey of commissioners during April 2019, to determine the number of staff employed in the five roles as at 31 March 2019 and who are being funded via local schemes. The only accepted exception will be those clinical pharmacists employed via either the national Clinical Pharmacist in General Practice scheme and Pharmacists in Care Homes scheme. For this exception to apply, approval to recruit must have been received and the employee must be in post prior to 31 March 2019. This will allow clinical pharmacists who finish on the scheme between 31 March and July 2019 to be eligible for reimbursement once the DES starts.

What employment terms should be used for PCN staff?

As is the case for practice-employed staff other than salaried GPs, there are no mandated contractual terms for staff employed under the PCN DES. However, when negotiating employment terms, practices should consider the levels of reimbursement available, which are linked to the Agenda for Change pay bands for each staff group.

PCN staff roles

Network clinical director

PCNs are required to appoint a named accountable clinical director, responsible for delivery. 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.

What they need to do

The clinical director's role includes:

- developing relationships and working closely with other PCN clinical directors, LMCs, local commissioners and clinical leaders of other health and social care providers
- working collaboratively with other PCN clinical directors, playing a critical role in helping to ensure full engagement of primary care in developing and implementing local system plans
- providing strategic and clinical leadership to the PCN, developing and implementing strategic plans, leading and supporting quality improvement and performance across member practices
- providing strategic leadership for workforce development through assessment of the clinical skill mix and development of a PCN workforce strategy
- supporting PCN implementation of agreed service changes and pathways, and working with member practices and the commissioner and other networks to develop, support and deliver local improvement programmes aligned to national priorities
- developing local initiatives that enable delivery of the PCN's agenda by working with commissioners and other networks to meet local needs and ensure comprehensive coordination
- facilitating member practices to take part in research studies and acting as a link between the PCN and local primary care research networks and research institutions
- representing the PCN at CCG, ICS and STP-level clinical meetings
- contributing to strategy development and the wider work of the ICS.

Clinical pharmacists

What they can do²

Clinical pharmacists can carry out a wide range of activities, including:

- medication reviews, particularly in high-risk groups including:
 - the frail elderly
 - polypharmacy
 - renal impairment
 - hepatic impairment
 - substance misuse
 - patients on high-risk medicines
 - STOPP (screening tool for older people's potentially inappropriate prescriptions)/START (screening tool to alert doctors to right/appropriate treatments) identified patients
 - recurrent hospital admissions
- managing the repeat prescribing reauthorisation process by reviewing requests for repeat prescriptions and medicines reaching review dates
- improving prescribing practice through educational support for all prescribers in the practice
- leading on evidence-based changes in prescribing across the patient population, eg where a drug is withdrawn or indications change

2 [Practice based pharmacist job description, Pharmacists and GP surgeries](#), RPS (October 2016)

- liaising with colleagues in community pharmacy to align support for medicines adherence, eg on Medicines Use Reviews and the New Medicine Service
- supporting improvements in clinical care through practice-based audit and implementing change
- offering prescribing advice to prescribers in the practice, eg temporary non-availability of drugs
- ensuring patient safety when they are transferred between care providers through reconciliation of prescribed medicine.

Job descriptions, sample job adverts and potential interview questions

To access template job descriptions, sample job adverts and interview questions you could use for clinical pharmacists, [visit the Primary Care Pharmacy Association website](#), scroll down and download the *Guide for GPs Considering Employing Pharmacists*, the *GP Senior Pharmacist Job Description* and the *GP Clinical Pharmacist Job Description*.

The Royal Pharmaceutical Society also offers guidance on the [practice-based pharmacist job description](#), role profile and purpose (scroll to the bottom of the page).

Benefits to patients

Patients often get to consult with pharmacists for two or three times longer than a doctor due to current GP workload intensity, eg 20–30 minutes, which they appreciate.

Medications are checked regularly and are appropriate for patients' conditions, and this improves wellbeing and quality of life if reviews have previously been too infrequent due to unmanageable GP and nurse workload. This reduces the likelihood of conditions worsening or leading to other complications and side effects that result in a future need for acute care.

All prescribers in the practice can learn from the clinical pharmacist and therefore use increasing medicines knowledge and expertise to improve patient treatment.

Benefits to practices

- GPs no longer carry out the activities that clinical pharmacists can carry out instead.
- Clinical pharmacists support the achievement of QOF indicators.
- Changes in prescribing practice can be implemented across the practice, eg where a drug is withdrawn or indications change
- Considerable savings can be made by improving prescribing processes across all prescribing staff
- Clinical pharmacists forge closer links with community pharmacy and improve patient advice/signposting
- All prescribers in the practice learn from the clinical pharmacist and therefore increase their own knowledge when consulting with and treating patients
- Patient access increases as patients consult with the clinical pharmacist rather than GP for medication needs and advice.

Benefits to the wider NHS

Closer monitoring and management of patient medicines improves their care, wellbeing, and their ability to self-care and manage their own conditions. This reduces avoidable urgent or emergency hospital attendances and the risks of medicine-related side effects, eg decreased renal or liver function or infrequently monitored dosages, are reduced. The demand on costly secondary and tertiary care services can be reduced due to improved management of patients following expansion of primary care capacity.

Clinical pharmacists can help reduce workload pressures for GPs and existing clinical colleagues across both primary and secondary care. Cost savings from improved prescribing practices will also have a positive impact in the practice and across the health system in terms of money saved and improved patient health and wellbeing.

Social prescribers

What they can do

Social prescribers can carry out a wide range of activities, including:

- identifying unmet needs – especially for the frail and vulnerable, those at risk of hospital admission, loss of independence or those coming toward the end of their lives
- spending time getting to know patients and their carers:
 - providing direct support
 - through regular contact by phone or home visits
 - open invitations to the surgery for a ‘catch up and cuppa’, and
 - regular ‘getting to know you’ events to meet with other people in similar situations.
- referring patients to appropriate VCS (voluntary, community and social enterprise) services
- continually building their knowledge of VCS groups and organisations that can help
- attending practice LTC (long-term condition) multi-disciplinary team meetings
- acting as a first port of call for nursing homes, initially handling issues such as prescription requests, visit requests and post-discharge coordination of services and medication.

Job descriptions, person specification and outcomes framework

NHS England has published a guide to [Social prescribing and community-based support](#). It contains an example job description and person specification, as well as information on an outcomes framework, the average cost of employing a social prescriber, an implementation checklist for local partners and commissioners.

Benefits to patients

- People with LTCs and their carers benefit from access to additional, non-clinical support options via primary care³
- Patients experience positive outcomes associated with their health and wellbeing, and
- Patients can become less socially isolated and more independent.

Benefits to practices

- Social prescribers can significantly reduce GP consultations ([by as much as 28%](#))
- One in five GPs regularly refer patients to social prescribing – 40% would refer if they had more information about available services
- GPs and their existing staff recognise the importance of social support as an alternative to medication
- Simple referral processes for GPs and other clinical staff are very helpful.

Benefits to the wider NHS

Social prescribers are already having a positive impact on GP consultation rates, A&E attendances, hospital stays, medication use and social care.⁴

The [University of Westminster led an evidence review](#) looking at the impact of social prescribing on demand for NHS healthcare. The review found:

- an average of 28% fewer GP consultations and 24% fewer A&E attendances where social prescribing ‘connector’ services are working well
- [as much as a 33% reduction in A&E attendances and 58% reduction in unscheduled hospital admissions](#)
- that social prescribing generally improves people’s health and wellbeing and contributes to building stronger communities
- social prescribing allows the provision of innovative community-based services that complement traditional medical interventions.

³ [Rotherham social prescribing service](#), 10 High Impact Actions: Case Study 68, NHS England

⁴ [Social prescribing](#), NHS England

Forthcoming roles in years two to five of the PCN DES (directed enhanced service)

Title	What they do	Benefits to patients	Benefits to GPs/practices	Benefits to the wider NHS system
MSK (musculoskeletal) FCP (first contact physiotherapist)	<ul style="list-style-type: none"> – Patients are directed to and can self-refer to the FCP service – MSK FCPs can safely and effectively manage an MSK caseload in primary care – They do not need supervising – They have their own insurance cover – Many can independently prescribe and provide injection therapy – They soon should be able to issue fit notes – They have considerable professional knowledge and skills – They provide frontline staff with training and ongoing advice – They can create stronger links with the multi-disciplinary team for wider MSK services – They can develop and make use of their scope of practice and skills, including those relating to independent prescribing, injection therapy and imaging referral rights – They can develop experience, learning and skills in service development, quality improvement and implementation science. 	<ul style="list-style-type: none"> – Quick access to expert MSK assessment, diagnosis, treatment and advice – Prevention of short-term problems becoming long-term conditions – Improved patient experience – A shorter pathway, so patients have fewer appointments to attend – Simple logistics, so patients are less likely to miss appointments or to suffer administrative errors – Opportunities to gain lifestyle / physical activity advice – Longer appointment times, meaning patients feel listened to, cared for and reassured 	<ul style="list-style-type: none"> – Release of GP time through reallocating appointments for patients with MSK problems – Reduced prescription costs – In-house MSK expertise gained – Increased clinical leadership and service development capacity – Support in meeting practice targets – Reduced pressure on GPs and other practice staff – Making this part of the GP business model can optimise resources and reduce costs – Services that generate additional income, eg the provision of steroid injections by MSK FCPs can often be funded by local CCGs whereby GP practices are paid per injection. 	<ul style="list-style-type: none"> – Reduced number of MSK referrals into secondary care – Reduced demand and waiting times for orthopaedics, pain services, rheumatology and community physiotherapy and CMATS (Clinical Musculoskeletal Assessment and Treatment Services) – Improved use of imaging – Improved conversion rate to surgery when referrals are required – Improved links with local voluntary sector and patient groups – Continued support of individuals with MSK conditions is assured – By providing these types of services, which decrease demand on costlier secondary care orthopaedic clinics, savings can be generated. This, in turn, can fund FCP roles.
Primary care paramedic/ ACCP (advanced clinical practitioner paramedic)	<ul style="list-style-type: none"> – See patients in 'same day care' clinics, eg minor injury and illness, abdominal pains, chest pain, tiredness and headache – Perform specialist health checks and reviews – Support the delivery of 'anticipatory care plans' – a process designed to support patients living with a chronic long-term condition to help plan for an expected change at some time in the future – Perform and interpret ECGs – Undertake acute home visits on behalf of GPs, especially for local elderly or immobile populations – Lead certain community services, eg monitoring blood pressure and diabetes risk for elderly patients living in sheltered housing to improve levels of cardiovascular and diabetes risk management – has led to a significant reduction in emergency calls for the monitored population. 	<ul style="list-style-type: none"> – Patients typically spend two to three times longer consulting with paramedic practitioners compared to GPs, eg 20–30 minutes – Patients receive the right care, first time – safely managed in their own homes or in the community⁴ 	<ul style="list-style-type: none"> – Frees up GP time, reduces GP stress by taking on home visits and often provides a much quicker response to patient need – Practice workload is supported by an extra generalist resource increasing capacity to provide the most appropriate response first time to 999 calls and providing proactive care within the community – Patient care improves due to the increase in access and timely interventions by skilled paramedic practitioners. 	<ul style="list-style-type: none"> – The ambulance service has increased capacity to respond to calls that are life-threatening – Role in the extended GP-led primary care team will relieve workload pressure and reduce impact on ambulance and secondary care – Reduces avoidable patient trips to A&E and associated admissions (Encompass – MCP vanguard serving 170,000 patients (across Whitstable, Faversham, Canterbury, Ash and Sandwich) and representing 122 GPs from 15 general practices – recently rolled out a paramedic practitioner scheme across its remit following a successful trial, which saw roughly 15% fewer hospital transfers, a more rapid response for patients and high levels of patient satisfaction – EMIS Web allows paramedics to have GP records on their tablet, at the scene (home visits) – they can establish video links with the practice in the patient's home and have a three or four-way conversation between GP, paramedic, patient and carer.
PAs (physician associates) <i>Not yet regulated but plans to do this have been announced</i>	<ul style="list-style-type: none"> – PAs work within a defined scope of practice and limits of competence.⁵ Their skills include: – taking medical histories from patients – conducting comprehensive physical examinations – requesting and interpreting certain investigations – seeing patients with undifferentiated diagnoses – seeing patients with long-term chronic conditions – formulating differential diagnoses and management plans – performing diagnostic and therapeutic procedures – developing and delivering appropriate treatment and management plans – requesting and interpreting diagnostic studies – counselling, providing health promotion and disease prevention advice for patients – venepuncture and blood culture sampling – cannulation – arterial gas sampling – catheterisation (male and female) – peak flow examination – urine dip stick. <p>Until regulated, PAs cannot yet:</p> <ul style="list-style-type: none"> – prescribe – request ionising radiation, eg chest X-ray or CT scan 	<ul style="list-style-type: none"> – Patients can currently spend two to three times longer consulting with PAs compared to GPs, eg 20–30 minutes – As an additional member of the workforce, PAs should increase access to care – Better access and longer consultations may increase the number of visits a patient makes to the surgery or NHS services. 	<ul style="list-style-type: none"> – Frees up GP time and reduces GP stress by consulting with patients with routine care needs – Ensures a level of continuity and added value – PAs can take part in audits and quality improvement – Practice workload is supported by an extra generalist resource – Easier access often results in better patient satisfaction. 	<ul style="list-style-type: none"> – Extra generalist staff resource will help alleviate workload pressures for doctors and other clinicians – In an evolving healthcare system used by patients with a changing set of needs, innovation and adaptability in the face of the pressures currently experienced in all areas of the NHS is necessary – Reduced GP workload should improve retention of the existing workforce and increase recruitment. This is the case for other clinicians too, e.g. GP nurses.

⁵ [Who are physician associates?](#) Faculty of Physician Associates, Royal College of Physicians

⁶ [Rotating paramedics – getting the right response, first time](#), Primary Care Commissioning (May 2018)

PCNs in the wider NHS landscape

ICSs (integrated care systems) are a new way of planning and organising the delivery of health and care services in England on a larger scale than PCNs.

They bring together NHS, local authority and third sector bodies to take on collective responsibility for the resources and population health of a defined area, with the aim of delivering better, more integrated care for patients.

The model is seen by NHS leaders as the next step for health and care integration in England. As of February 2019, 14 ICSs are in place but, in its Long Term Plan, NHS England has announced that they are now expected to cover the whole country by 2021.⁷

The BMA supports the overall concept of integration, which we believe has the potential – if implemented with the full input of clinicians – to improve both patient care and doctors' working lives.

The ICS model could deliver on some of these opportunities.

A more controversial model of integration, the ICP (Integrated Care Provider) has also been introduced by NHS England. ICPs involve merging multiple services into a single contract, held by a single provider. ICPs have been subject to controversy and the BMA has been clear that we oppose their introduction, as they increase the risk of privatisation and are incompatible with the independent contractor status of GPs. Only one ICP is known to be in development, in Dudley, and is expected to be in place by 2020.⁸

ICSs have a specific focus on enhancing the role and scope of primary and community care services. Every ICS will have a critical role in ensuring that PCNs work in an integrated way with other community staff and use integrated MDTs across primary and community care.

PCNs are central to the provision of integrated, at-scale primary care, encompassing services beyond core general practice and working closely with acute, community and mental health trusts, as well as with pharmacy, voluntary and local authority services.

There is no blueprint that ICSs are expected to follow, so their appearance and approach varies. However, general elements of structure for ICSs have emerged.

Every ICS will have to establish a partnership board drawn from commissioners, providers, PCNs, local authorities and third sector organisations within the ICS.

Every PCN will have a named accountable clinical director. While they will lead the PCN and oversee the service delivery elements, they will also play a critical role in shaping and supporting their ICS and dissolving the historic divide between primary and community care.

The general structure will operate on three levels: 'system', 'place' and 'neighbourhood' (also referred to as locality).

Most work within an ICS should occur at the 'place' and 'neighbourhood' levels, with the remainder carried out at the 'system' level.

The 'neighbourhood' level has a significantly smaller footprint and will be based around PCNs. At this level, practices will continue to provide core services. The new PCN DES gives an opportunity for practices working with partners from the voluntary, social care and community sectors to deliver new services at scale.

⁷ NHS England. *The NHS Long Term Plan*. January 2019. Available at: www.longtermplan.nhs.uk

⁸ Health Service Journal. *Plans for first integrated care trust delayed by a year*. January 2019. Available at: www.hsj.co.uk

At 'place' level, PCNs will interact with hospitals, mental health trusts, local authorities and community providers to plan and deliver integrated care.

At 'system' level, PCNs participate through their clinical directors as an equal partner in decision making on strategy and resource allocation (see page 24 for details on the role of clinical directors). Partners who belong to the ICS and signed up to an alliance agreement ensure collaboration across hospitals, community services and social care, helping to join up and improve care.



General practice
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British Medical Association, BMA House,
Tavistock Square, London WC1H 9JP
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