GP CONTRACT 20/21

SUMMARY

Contents Page

The GP Contract Deal 20-21

The BMA's GP England (GPCE) committee has voted to accept a package of changes to the GP contract for 2020-21, which includes funding to attract more doctors to take up partnership roles and expand the practice team seeing patients in surgeries.

This is the result of months of negotiations between the BMA and NHS England and NHS Improvement and comes three weeks after GPCE rejected an earlier deal.

Draft service specifications for Primary Care Networks (PCNs) – outlining the responsibilities of these groups of practices and community providers in the coming years – have been significantly pared back after widespread criticism from the profession.

The revised and significantly reduced PCN service specifications mean that GPs will not be asked to perform fortnightly care home visits as earlier proposed. Instead, working with a community multidisciplinary team, it will be for PCNs to decide who delivers a weekly review of those care home residents, based on clinical need. Networks will also receive £120 per care home bed to reflect the varying size of populations.

The extent to which PCNs provide structured medicine reviews with patients will now depend on the capacity of the clinical pharmacists recruited. Two other specifications, on personalised care and anticipatory care have been postponed and will be reviewed and negotiated in time for April 2021.

The package[1], with additional investment in practices and PCNs this year, includes:

- £94m to address recruitment and retention issues. This includes a Partnership Premium, which is a one-off payment of £20,000 available to new partners with additional training support.
- 100% reimbursement for all additional staff recruited via the Primary Care Networks.[2]
- £173m for PCNs to employ a wider range of professionals to help manage workload and provide appointments, including pharmacy technicians. These build on previously agreed roles such as clinical pharmacists, physiotherapists and paramedics.
- An expansion to the Targeted Enhanced Recruitment Scheme (TERS), which offers a one-off payment of £20,000 to attract trainee GPs to under-doctored areas. Places on the scheme will increase from 276 to 500 in 2021, and 800 in 2022.
- A greater proportion of GP trainees' time spent in general practice. This means GP trainees will spend 24 months of their 36 months' training in general practice (up from 18 months), with the remainder spent in hospitals and other settings.
- Funding to pay for childcare for doctors returning to general practice through the GP Induction and Refresher Scheme.
- Plans to introduce enhanced shared parental leave arrangements for salaried GPs.
- Funding to support practices to deliver a 6-8-week postnatal health check for new mothers.
- An above inflation pay uplift for staff, as agreed in the 2019/20 deal.

Chapter 1: Enhancing the Additional Roles Reimbursement Scheme

New national workforce target is; 26,000 (previously 20,000) additional Roles Reimbursement Scheme (ARRS) and 6,000 extra doctors.

Existing ARRS are; clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and community paramedics.

Adding more roles

New ARRS are **pharmacy technicians (only 1 in each PCN to begin with (2020-2022) or 2 in PCNs over 100,000), health and wellbeing coaches and care co-ordinators, occupational therapists, dietitians and podiatrists.**
From 2021 **mental health practitioners** are to be included. Possible inclusion of Advanced Nurse Practitioners in the future.

There will be no baseline exercise required for these new roles. **ALL TO BE FUNDED AT 100%**

It is up to each PCN to decide the distribution of roles required, limited only by differentially available supply of different roles in different parts of the country.

The following link describes the re-imbursement process but bear in mind it has not yet been amended to reflect 100% re-imbursement.

More operational flexibility

There is more operational flexibility allowed in the contract, particularly for voluntary sector partners and short-term vacancies for practice funded roles. Also, from 1 April 2020, PCNs may substitute between clinical pharmacists, first contact physiotherapists and physician associates within their practice-funded baseline.

From April 2020/21, each PCN will be allocated a single combined maximum sum under the Scheme. The sum will be based upon its weighted population share.

Three measures have been put in place to address the worries around accrued employment liabilities. They are as follows;

- For those PCNs who do not wish to employ extra staff directly, they are to be encouraged to engage with their community-based partners, who can employ staff on their behalf. CCGs can help broker these arrangements
- The level of reimbursement already drawn down to support new staff employed by a PCN will now be guaranteed during this GP contract period with their ongoing participation in the Network Contract DES, and these staff will be treated as part of the core general practice cost base beyond 2023/24 when considered for future GP contract funding, for example the practice global sum.
- If all the practices which comprise a PCN decide in the future to hand back the DES, the commissioner must arrange timely alternative provision for the same services from another provider, e.g. another PCN or an NHS community provider.

Making full use of funding

GPC England and NHS England and NHS Improvement have made it clear that the additional roles funding should be fully used each year, rather than lost to general practice. There must be a clear and simple workforce planning process put in place with explicit support from CCGs and the ICS.

All PCNs will be expected to try and utilise 100% of their available funding. CCGs have a duty to support their PCNs in doing so. A CCG-wide plan to use the available Additional Roles Reimbursement Scheme budget will be developed every year, jointly with Clinical Directors and **LMCs.** Community partners should also be fully engaged.

PCN intentions

A simple workforce planning template will be developed and agreed with GPC England soon, for PCNs to share their intentions. PCNs will be asked to indicate the number of each additional reimbursable roles to which they realistically intend to recruit and by when. This is so they spend their funding every year, including firm initial intentions for 2020/21, with indicative intentions for the remaining years of the contract through to 2023/24. The plans are flexible and PCNs will be free to change these plans at any stage but must at the same time keep their CCG and local primary care training hub informed.

There is a requirement for CCGs and local systems to explore different ways to support PCNs including;

- The immediate offer of support from their own staff to help with co-ordinating and running recruitment exercises;
- The offer of collective/batch recruitment across PCNs. Where groups of PCNs wish to advertise vacancies collectively, CCGs or Integrated Care Systems (ICSs) will be tasked with supporting this;
- Brokering arrangements to support full-time direct employment of staff by community partners, or to support rotational working across acute, community and (in time) mental health trusts, as well as community pharmacy.
- Ensuring that NHS workforce plans for the local system are as helpful as possible in meeting PCN intentions**.**

2020/21 ADDITIONAL ROLES WORKFORCE PLANNING TIMETABLE:

Task	**Date**
PCN discusses and works out its intentions	From now
Each PCN seeks to accelerate recruitment exercises that are being planned, supported by CCG staff if requested	From now
Each PCN submits its intentions to its CCG	By no later than 30 June 2020
Each CCG confirms an effective local plan. This must be agreed with PCN Clinical Directors, before being shared with Regions	By no later than 31 July 2020
Regional engagement and support	Early June 2020 onwards
CCGs declare amount for in-year redistribution to other PCNs	By end July and again in October

Chapter 2: More Doctors in General Practice

This chapter focuses on recruitment and retention measures alongside investment and action to increase the number of doctors in General Practice:

New investment to achieve 6000 extra doctors

The government commits to funding HEE to increase the number of GP trainee places. They will also increase NHSE/I revenue budget to support recruitment and retention schemes that already exist. It is hoped this will enable the **NHS to meet the government's target of increasing the number of extra doctors working in Primary Care by 6000.**

Solving Pension issues

The government has agreed to urgently review the pensions allowance taper problem.

More GP trainees spending more of their time in general practice

From 2021, HEE will increase the number of GP training places to 4000 a year.

- A significant proportion of these extra trainees are likely to be international medical graduates. **From 20/21 all international medical graduates entering training will be offered a fixed 5-year NHS contract.**
- **The GP training model will undergo significant reform**. From 2022 there will be a more balanced distribution between the amount of time trainees spend in GP.

More trainees in under doctored areas

The targeted enhanced recruitment scheme (TERS) will offer more trainees in under doctored areas: backed by extra manifesto investment, NHSE/I will work with HEE to increase the number of TERS places offered to at least 500 by 2021, and 800 by 2022.

Two-year Fellowship Programme for all newly qualified GPs and Nurses

By 2021, every newly qualified GP coming out of training will benefit from enhanced support through the scheme. Fellows will get guaranteed funded mentorship, funded CPD and rotational placements within/ across PCNs to develop experience. From 2021, all new entrants to GP training will automatically be enrolled in the programme.

New to Partnership Payment

There will be a new national scheme designed to attract GPs into partnership opportunities. From **April 2020 new partners will benefit from £3k of business allowance and a one-off payment of £20k for full time GPs to support their establishment as a new partner.**

- The scheme will be available to GPs who have never been partners before.

Locum Support Scheme

Locum GPs will benefit from greater peer support and networking opportunities. **Each locum GP engaged through the Locum Support Scheme will receive a funded session of CPD per month in exchange for a minimum contribution of sessions per week to the group of PCNs.**

- 20/21: implementation will be supported by ICS/STPs and LMCs, working closely with training hubs and local PCNs.

Return to Practice

During 2020, NHSE/I will work with the RCGP, BMA and local systems to consider if changes to **the national GP retention scheme** provide a sufficiently worthwhile impact.

The Induction and refresher scheme will be expanded/ enhanced during 20/21 to provide more support for GPs with caring responsibilities. From April 20, GPs on the scheme can claim up to £2k towards cost of childcare for each child whilst on the scheme (for children under 11).

Supporting Mentors Scheme

From April 20 this new national scheme will be implemented and will offer experienced GPs the opportunity to mentor newly qualified GPs entering the workforce through the fellowship programme.

Chapter 3: Releasing Time for Care

Reducing unnecessary bureaucracy – The Government will instigate a full review to reduce the burden on GPs and other health professionals.

NHS England and NHS Improvement will review:

- Mandatory training requirements
- Annual appraisals process
- Ensure the revalidation process is simpler for GPs
- Reduce burden with annual coding for patients with long-term conditions
- Remove unnecessary barriers for patient self-referral
- Improve the e-referral and electronic prescribing systems
- Operation of the performs list

Digitisation of paper 'Lloyd George' Records is in progress and this will also help free up physical space within the practices for additional staff. Third-party redaction software could be made available to support practices to deliver full historic online access to records for their patients.

The newly established Community Pharmacist Consultation Service (CPCS) went live in October 19 and has taken over 150,000 referrals which would have been made to a GP. (From NHS 111) Referrals from other settings will be live from 20/21 subject to piloting. It has replaced NUMSAS (NHS Urgent Medical Supply Advanced Service) and DMIRS (Digital Minor Illness Referral Service) pilots.

The Time for Care Programme has been active for the past four years to improve productivity in General Practice. It is funded by NHS England and NHS Improvement and delivered by Primary Care Improvement. The programme is there to help practices manage their workload and free-up clinical time for care. Increasing capability and providing hands on support. It's led to teams having greater energy and motivation.

Chapter 4: Improving access for patients

This chapter states progress towards delivering the extra 50 million appointments will be driven by increasing staff numbers and sets out initial actions arising from NHSE's review of access to General Practice. Some detail is offered on initiatives to collect better GP appointment data, the Access Improvement Programme, Digital First services, Extended hours and options to involve PCNs in urgent care services but timelines for implementation are not firm for all areas.

Better data

- An **improved appointments dataset** will be introduced in 2020/21, to help practices understand their current relative position on how long patients are waiting to access services, the type of care they are receiving, and which professional is providing it.
- The details are still to be agreed between NHSEI and BMA GPC, including the date when practices are required to use the dataset from.
- This section also references to **a new measure of patient experience** that will be designed and tested in 2020, for nationwide introduction by no later than 1 April 2021.

Access Improvement Programme

- To be established in early 2020, it will inform how at least a third of funding under the Investment and Impact Fund can be best directed to improve patient access and experience. **Performance against the new patient reported experience metric will be incentivised:**
  - During 2020/21 at the equivalent rate of £30m/annum pro rata
  - At least £30m in 2021/22
  - At least £75m in 2022/23
  - At least £100m in 2023/24
- The programme will involve a review exercise – looking at previous standards set for primary care access and incorporating existing Time for Care work. There will also be **work with PCNs** to identify ways to improve booking experience and reduce waiting times as well as "moderating demand growth for A&E attendances".
- The plan is to **start applying proven methods in Q3 and Q4** for those practices/PCNs whose patients are experiencing the longest routine waits.

Digital First services

- The expectation for every PCN and practice to be offering a **core digital service offer** to all patients from 2021 will be delivered through a national supplier framework and 'other support activity' including **additional STP/ICS support.**

Extended hours

- **From April 2021** there will be a **combined access offer** as part of the Network Contract DES (utilising current extended hours access DES funding and CCG commissioned extended access schemes funding). It will be a nationally consistent offer, developed and discussed with BMA GPC and patient groups, reflecting what works best in existing local schemes.
- In the meantime, PCNs and practices are encouraged to work with their CCGs to enable more **flex between existing in-hours and extended hours capacity.**

Fuller join-up with urgent care services

- NHSEI will develop and then consult on options for creating **a newly expanded role for PCNs** in joining up and running urgent care in the community, as **an option rather than an obligation**. This would enable better integration of primary care with urgent care and increase their ability in being able to moderate increases in A&E demand.

Chapter 5: Reforming arrangements for vaccinations and immunisations

The need for reform

- Reforms grown out of current issues with the payment system including variations in payment rates; limited oversight of practices' current performance; and misalignment with levels of coverage required for population protection.
- These reforms will give practices confidence that more vaccinations will lead to higher payments, which will in turn lead to improved population outcomes.

Global sum payment and new core standards

- **Vacc and Imms will become an essential service rather than an additional service**. All practices will be expected to offer all routine, pre and post-exposure vaccinations and NHS travel vaccinations.
- **The global sum that practices receive will be protected, in line with the five-year agreement.** This is worth £164.5m in 2020/21. It will continue to cover NHS travel vaccinations and pre/post prophylaxis vaccinations.
- **Five core components** to address historical difference in practices' approaches:
    - **All practices will have a named lead** who takes responsibility for the contractual requirements and liaises with others both in and out of the PCN.
    - **The availability of sufficient trained staff and convenient, timely appointments to cover 100% of their eligible population**
    - **Call/recall and opportunistic offers are being made in line with national standards.** Practices should move towards text-based reminders as soon as the infrastructure is in place.
    - **Participation in agreed national catch-up campaigns.** For 2020/21 this will be a continuation of the MMR catch-up in 10/11 year olds. Practices will be eligible for an Item of Service (IoS) fee for each vaccine delivered (rather than it be linked to the call/recall activity).
    - **Adherence to defined standards of record keeping and reporting of coverage data.**
- **Working with BMA to update the current list of pre/post exposure vaccines.**
- **Further guidance will clarify the division of responsibilities between general practice, commissioners and public health.** Outbreak management will continue to be a responsibility of commissioners and would normally accrue additional funding (unless this relates to a vaccine which already accrues an IoS payment).

IoS fees

- Standardisation of the IoS fees at £10.06 for the delivery of each dose of all routine and annual vaccines, fixed for the remaining 3 years of the contract deal.
- This will also apply for routine vaccines given outside of the routine schedule where clinically indicated.
- For 2021/21 the IoS payment will apply to all MMR vaccines, with rollout from 21/22 to other childhood vaccines.

Incentive payments

- From 2021, there will be incentive payments for achieving specified levels of population coverage. For routine schedule vaccinations, this incentive will operate at practice level and form part of a new QOF domain.

- Achievement will be measured in a timelier way. All investment currently committed to routine vaccination that is not redistributed into IoS payments, will be used to fund this new routine QOF domain.
- Additional general practice incentives for flu, beyond the IoS, will be channelled through the PCN Investment and Impact Fund. This will start in 2020/21 with an indicator worth £8m for flu vaccination coverage in over 65s.
- During 2020/21 there will be a review of the existing QOF indicators incentivising flu vaccinations for specified at risk groups. The QOF points freed up through this exercise will be redistributed to the new routine immunisation domain in order to protect practice level investment.

Repayment for lower coverage

- For practices not achieving a minimum of 79% coverage on the routine childhood vaccs, a repayment of a proportion of earnings will be triggered according to the formula: *value of the IoS fee x 50% of eligible cohort size*. This calculation will be made annually using data extracted directly from practice clinical systems.
- A baseline calculation of achievement on all the vaccines will be completed in 2020/21 and repayment will commence in April 21, giving practices 1 year to prepare for the introduction of the scheme.
- A practice may demonstrate extenuating circumstances and therefore be exempt from repayment. In this situation the practice would need to demonstrate that the core contractual requirements had all been met and they had made efforts to improve the vaccination rate.
- There is an anticipation that practices will be paid an aspiration payment on a monthly basis with a final balancing payment at year end.

Two-year transition plan

These changes are going to be phased over 2 years:

- Year 1
    - Introducing the core contractual requirements
    - Introduce an IoS payment for MMR 1 and 2 at £10.06
    - Introduce an incentive worth £6.5m into the IIF for PCNs to improve seasonal flu coverage for the over 65 group, in collaboration with community pharmacies
- Year 2
    - Expand the IoS payment and associated repayment system to all outstanding vaccinations
    - Introduce the new QOF domain for routine vaccinations
    - Restructure and consolidate all flu incentives at network level through the IIF
    - Retire the existing Childhood Immunisation DES from April 2021

Chapter 6: Updating the Quality and Outcomes Framework

Further Improvements to QOF

Further improvements have been agreed to the Quality and Outcomes Framework in 2020/21, in line with the findings of the 2018 QOF Review.

Implementation guidance will be published by the end of March 2020. Changes to the Statements of Financial Entitlements will be made for 1 April 2020.

Indicator changes from April 2020

QOF currently comprises 559 points. Agreed to recycle 97 points into 11 more clinically appropriate indicators. NHS E is also investing an additional £10m, total points available is 567 from 2020/21.

Introductions of improvements to Asthma, COPOD and Heart Failure domains:

Asthma domain

- the patient diagnosed register has increased to include those aged 6 years and over.
- Two diagnostic tests now required. 6 months grace is given for the tests to be performed.
- Personalised action plan added in to encourage better self-management.
- Record of smoking exposure in patient aged 19 and under is required.

COPD domain

- Changes to the recording of diagnosis. Previously register consisted of patient diagnosed on/after 1.4.2011 with post bronchodilator carried out 3 months before or 12 months after diagnosis. New register is broken into 3 groups.
    - Those diagnosed prior to 1.4.20
    - Those diagnosed on/after 1.4.20 using described method 3 months prior or 6 months post. Grace given for those diagnosed elsewhere.
    - Those unable to perform the described method of diagnosis.
- Number of exacerbations in previous 12 months to be records in effort to reduce poor management and hospital admission.

Heart Failure domain

- Period of grace for required method of diagnosis as reduce from 12 months to 6 months
- Period of grace for newly registered patients included. 6 months grace given.
- Treated with ACE and a beta blocker as an additional med changed to treated with ACE or beta blocker.
- New indicator worth 7 points – functional capacity and med review.

Non-diabetic Hyperglycaemia

New indicator will be introduced to incentivise practices to offer annual HbA1C tests. The aim is to support early identification of those who would have gone on to develop Type 2 Diabetes. Supported by new investment and retirement of CVD PP001 indictor (see Annex B in original document).

Quality Improvement – New Modules (see Annex Bi in original document)

In 2019/20 two area of QI were Prescribing Safety and End of Life Care with 74 points. Guidance suggests that this work is still carried out at the optimum level, however the points will be transferred to two new modules;

- **Early Cancer Diagnosis** The aim is to**;**
    - Improve participation in national breast, cervical and bowel cancer screening programmes.

    - Improve referral and safety netting for patients suspected of having caner. Developed to support the roll out of the PCN Early Cancer Diagnosis in the Service Spec.
- **The Care of People with Learning Disabilities**. Builds upon work published earlier this year to improve identification of these patients in general practice. The aim is to;
    - Promote increased uptake of annual health checks.
    - Optimisation of medication in line with STOMP.
    - Identification and recording of reasonable adjustments and the patient engagement with community resources through social prescribing.

Payment thresholds

- Based on NICE recommendations and previous practice activity
- Points and payment threshold for unchanged indicators will be held at 19/20 for another year, pending full review.
- For payment for new and revised indictors see Annex B in original document.

Further Development of QOF

- NHS E, NHS Improvement and GPC E have agreed ongoing programme of indicator review in key priority areas, including Mental Health in 2020/21.
- Further QI modules in development are
    - CVD prevention and detection
    - Shared decision making
    - Anxiety and depression
    - Anti-microbial resistance including antibiotic prescribing
    - Wider primary prevention
    - Preventing prescription drug dependency

Obesity

- This domain is introduced as a new non-contractual requirement and is based on weight management services. This will appear as a QOF module in 21/22.
- NHS E will commission additional weight management services for those who are obese and have either Type 2 DM or Hypertension in areas with greatest unmet need from 21/22.
- As these plans develop an incentive in QOF for ensure that these patients are appropriately offered referral to weight management services will be explored.

Maternity Services

Agreed a number of improvements from 20/21;

- Practices are required to **deliver** a maternal 6-8 week post-natal check as a separate appointment to that of the baby's physical 6-8 week check. Currently this is optional.
- All Maternity Medical Services will become an essential service.
- Child Health Surveillance will become an essential service.
- Post Natal period increased from 2 to 8 weeks.

From 20/21 a new requirement will be introduced for GPs to offer a 6-8 week postnatal check for new mothers. An additional £12m has been invested through the global sum to support all Practices to deliver this.

Further details of indicator changes are set out in Annex B in original document.

Chapter 7: Delivering PCN Service Specifications

Overriding principle – this is new money and can't disinvest current resources and substitute these. LMC role in overseeing

The major concerns raised during the consultation, and addressed in the revised agreement included:

- the workforce and workload implications of the initial drafts;
- the resources to support the work;
- the level of specificity; and
- the implied performance management approach.

The agreed service specifications are radically shorter at three pages in total with far fewer targets- and only 3 Service Specs. Eventually to be incentivised through the Investment and Impact Fund (£50m next year)

Structured Medication Reviews

- Targeted at patients in care homes, those with complex and problematic polypharmacy, (eg 10 or more) medicines associated with medication errors and severe frailty (with isolation, recent hospital admission, falls and addictive pain management medication)
- Determined and limited by Clinical pharmacist capacity
- Delivered by appropriately trained clinicians
- Actively work with their CCG to optimise quality of prescribing of (a) antimicrobial medicines, (b) medicines which can cause dependency, (c) metered dose inhalers, where a low carbon alternative may be appropriate and (d) nationally identified medicines of low priority
- Work with community pharmacies to connect patients appropriately to the New Medicines Service which supports adherence to newly prescribed medicines.

Care Home Spec

- Starts Oct 2020
- Care Home Premium of £120 per bed to reflect different numbers of care homes in each PCN
- Where existing schemes exist, can't decommission, and if it offers a higher level of service than Network DES, consider maintaining it. Any freed-up funds to be redeployed within primary medical care.
- By 31st July agree the care homes covered and lead GP(s) for each. Agree simple plan with community services about how to provide
- Medical input to care home no longer explicit but "appropriate & consistent "based on clinical judgement of the PCN
- Weekly "home round" prioritising those to be seen
- Stable MDT
- Personalised care plans for new residents within 7 days

Supporting Early Cancer Diagnosis

- Purpose of scheme is to enable and support practices to review the quality of their referrals for suspected cancer, in line with NICE Guideline 12. This should make use of Clinical Decision Support Tools;
- Safety netting urgent referrals and ensuring patients receive information
- Contribute to improving uptake of national screening programmes, including actions to engage with a low participating group
- Peer to peer learning events between practices and link to system partners

Chapter 8: Introducing the Investment and Impact Fund

Introduced as part of the network contract DES in 2020/21. PCNs will be rewarded for delivering objectives set out in the NHS Long Term Plan & five-year agreement.

- The IIF for 2020/21 was originally set to be worth £75m however the revisions to the Service Specifications mean it will now be worth £40.5m
- The rest of the £75m will be reinvested in the wider GP Contract to support new commitments: Postnatal checks, Diabetes QOF points and care homes premium
- The IIF for 2021/22 will be £150m, at least £30m of which will reward better access
- The IIF for 2023/24 will be £300m, at least £100m of which will reward better access
- Monies earned from the fund must be used for workforce expansion and services in primary care
- Each PCN will need to agree with their CCG how they reinvest monies earned

Design principles

The IIF will operate in a similar way to the QOF;

- It will be a points-based system
- Each IIF point will be worth a defined amount of money (set out in the Network Contract DES)
- Payments will be proportional to points earned, with adjustment for list size and (where relevant) prevalence

It will have aspiration payments from 2021/22;

- Funds earned via the IIF will be paid partly through aspiration payments
- This will need to be approved by the PCN's aligned CCG

It will fairly reward performance based on national priorities;

- Indicators will reward PCNs for attainment in relation to national goals
- There will be a sliding scale relating to attainment to reward performance between the lower and upper thresholds

Network Dashboard

- A new network dashboard from April 2020 will include key metrics to allow every PCN to see the benefits it is achieving for its local community and patients.
- This will help identify areas of opportunity to reduce variations within and across PCNs and improve services for patients.

Chapter 9: Network Arrangements

The need for reform

- Improvements are needed which give PCNs certainty and confidence to develop.
- Stability is needed as frequently changing membership to PCNs threatens the agreements which they strive to make, including on how services will be delivered, how workforce will be employed, how payments will operate and how liabilities will be shared.

The network agreement

- The network agreement is seen as being like a partnership agreement in that it sets out the arrangements and responsibilities of each member.
- Having a robust agreement is a vital first stage and then defining clear terms of which new members are invited in is the second stage.
- As stated by NHSE and the BMA in the 'Investment and evolution: a five year framework for GP contract reform to deliver the NHS Long Term Plan', this chapter of the contract confirms that they are committed to amending the Network Contract DES to include collaboration with non-GP providers as a requirement.
- The network agreement will be the formal basis for working with the other non-GP providers and community-based organisations.
- From April 2020 the PCNs are being asked to agree with their local Community Services provider(s), community mental health provider(s) and Community Pharmacies how they will work together.
- The DES will have to be signed again to confirm the existing PCN footprints, as it will each year.
- Practices can opt out of the DES and will be able to serve the required one month's notice up until 31st May. Where practices choose to opt out then arrangements for alternative provisions of core GMS network services will automatically apply.
- To ensure that the whole of the country benefits from the investment and service improvements that PCNs offer, CCGs must ensure 100% population coverage of PCNs.
- The LMC will act as a mediator alongside the CCG where a practice that wishes to sign up to the DES, but they don't have a PCN to join may come into difficulty.
- Furthermore, the LMC will support the parties involved to come to some agreement with the practice joining the PCN.
- From 1st April the ability for the CCGs to assign a practice to a PCN is being introduced and they have to work closely with the LMC to manage the sensitivity of the issue.
- Finally, looking forward to next year, there will be a specific need for mental health providers to agree arrangements with PCNs for delivering integrated care across PCN footprints by April 2021.