1. Can the CCG determine the size and make up of our PCN?

The simple answer is no they can't. There will be a new DES - called the Network Contract DES and as part of this practices will need to detail which practices are involved and also ensure geographical cover. For most of our area these Networks are already established but it is largely for practices to decide who will be involved.

There is a caveat which is the PCNs need to be based in a community because it is expected, with new resources, to take greater responsibility in terms of delivering care to that community, above and beyond the registered list of individual practices. There may be some areas where there are gaps, or practices do not naturally fit into a PCN or there is disagreement, it is then expected that practices will work with the CCG and the LMC to resolve these difficulties.

I have already seen in some parts of the country that the local GP federation has said that they will run the PCN or that the CCG has localities of 100,000+ and already employ staff to work in these localities so the CCG will turn these into PCNs - the answer to both is **no.**

Federations may play an important part in delivering care at scale but the PCN is based in a community and configured around practices. The Network Contract DES will be offered to groups of practices.

CCGs cannot 'run' a PCN, they are a provider organisation responsible for delivering care. It is expected that as PCNs evolve that the funding that has been agreed nationally is the baseline and additional resources will be invested in PCNs by CCGs and also STPs.

2. Why do they have to be geographically based and why is there a population limit of 30-50,000?

This is about providing care to a community and also providing additional services at a level greater than an individual practice that would support general practice and be integrated with general practice.

The 30-50,000 has some evidence that it is big enough to have influence in the system and attract others who would want to work with a Network and potentially provide services to the network and small enough to engage and retain local ownership and autonomy.

I expect that adjoining PCNs may well work together in some areas and where Federations are well established they will be working with PCNs when the delivery of care is required at scale.

3. Can we exclude a local practice because relationships are poor and they will potentially damage our PCN?

The simple answer is no, the population coverage is important and therefore you cannot exclude practices and the additional investment that is being made will hopefully incentivise practices to work together and reduce unwarranted variation.

4. What are the incentives in terms of joining a network?

In Wessex many practices are already working together in communities of 30-50,000 with support from CCGs to try and stabalise and sustain general practice and to improve care for their patients.

I see PCNs as the vehicle that will narrow the ever expanding gap between the specialist generalist, namely the GP and the super specialist who works in the hospital. It will mean more services will be locally based both in terms of some traditional hospital specialities but also community services but more importantly it is the vehicle whereby there will be significant additional investment to support communities, local populations and general practice and to massively expand the workforce.

So by July you will have hopefully established your PCN and signed up to the Network DES.

The PCN will receive funding for 0.2 WTE GP (for a network of 40,000) who will become the Clinical Director of the PCN and in addition there will be £1.50 per patient going to the PCN - so a population of 50,000 will receive £75,000, which it can use to develop, transform or invest in services within the PCN.

Practices will receive a payment for working in a PCN which will be £1.76 per patient.

PCNs will also then have an entitlement next year to funding for Pharmacists and Social Prescribers - which is part of the workforce offer which will potentially fund an additional 22,000 staff working in general practice by 2024.

So year one the focus will be on Pharmacists and Social Prescribers - you will receive 70% of the funding for a Pharmacists and 100% of the cost of a Social Prescriber. In future years the scheme will expand to include Paramedics, First point of contact MSK specialists, and Physicians Associates.

These posts must be additional and not simply substitute funding for existing posts. So if CCGs or Practices currently employ people in these roles you cannot claim funding for your existing employees only for additional ones. The only exception is the national Pharmacists scheme where there was tapering funding.

So for example by 2024 a typical PCN of 50,000 might expect to employ 6 Pharmacists working across all the practices ranging from senior Pharmacists to newly qualified and potentially trainees and may included pharmacy technicians.

The Pharmacists have shown that when working in practices they can help with workload both the provision of direct patient care but also in the area of prescribing and additional incentives will be available in terms of a new prescribing incentive scheme but based at Network level.

The **Extended Access DES** delivered at practice level**,** is currently worth about £88m nationally and this was going to end and there was the potential for this funding to be lost. It has been agreed that the funding for Extended Access will be transferred to the PCN who will become responsible for delivering this services with the same specification. The PCN could agree to continue to provide the same service that it does now at practice level or develop a new service and collaborate across the PCN.

The **Improving Access Fund** which aims to provide better access but provided at scale is worth £6 per patient and was started with the Prime Minsters Challenge Fund and then gradually spread finally gaining national coverage in October 2018. To me it seems to duplicated the practice DES. Some CCGs contracted this service at scale from local practices or federations whereas some when to open procurement.

As part of the Partnership Review I saw practices who lost GPs who went to work in the newly established service following the commissioning of this service at scale. Concern over safe working limits and also capacity at the end of the day resulted in my recommendation which was that the £6/pt should go to PCNs and they should work with their practices and with the additional funding have the opportunity to provide those services and also add a degree of support and resilience to their practices.

5. What happens if we decide not to join the network?

Practices will not receive the funding or benefits detailed above and their patients might be put at a disadvantage.

Following the announcement of the GP contract for England, Krishna Kasaraneni, GPC England Executive member, has written a blog about what practices should be considering with regards to the structures for Primary Care Networks. This follows on from his previous blog about PCNs.

Further guidance and information relating to GP contract will be published in the coming weeks.