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PRIMARY CARE NETWORK SPECIAL

The AISMA Really Useful Quick Guide To Primary Care Networks

Read on for a mine of information, packed with smart advice and tips, to help everyone in your practice understand not only what's going on but how to make the most of it! This guide has been prepared exclusively for AISMA clients by our vice chairman **Deborah Wood**

So what is a Primary Care Network (PCN)?

A PCN is a group of general practices working together. Initially it is not likely to be a separate legal entity but may become one in due course to jointly deliver commissioned services.

The CCG will only be able to contract directly with a PCN if it has created a separate legal entity, otherwise the contracts will be with the underlying practices.

A PCN will work collaboratively with a range of local primary care, community services, social care and voluntary sector providers to offer personalised, co-ordinated health and social care to local populations.

It will typically cover a community of 30,000 to 50,000 patients.

PCNs have been created via the new PCN DES effective from 1 July 2019. There is a published DES Directions and Enhanced Contract Specification. The PCN DES is a contractual arrangement for practice-based delivery as an addition to the core in-hours (essential services) primary medical care contract.

CCGs will oversee the PCNs delivery against the DES requirements.

Primary Care Home (PCH) is a model of how a PCN might work.

Some local incentive schemes (LISs) may in due course be funded via PCNs.

CQC regulations will need to be considered if the PCN is a legal entity providing regulated activities. Practices in the PCN may need to

ensure their statements of purpose cover the additional roles/service delivery under the DES.

Network agreements

PCNs will be governed through their network agreement.

All PCNs must appoint a named accountable clinical director, who does not have to be a GP.

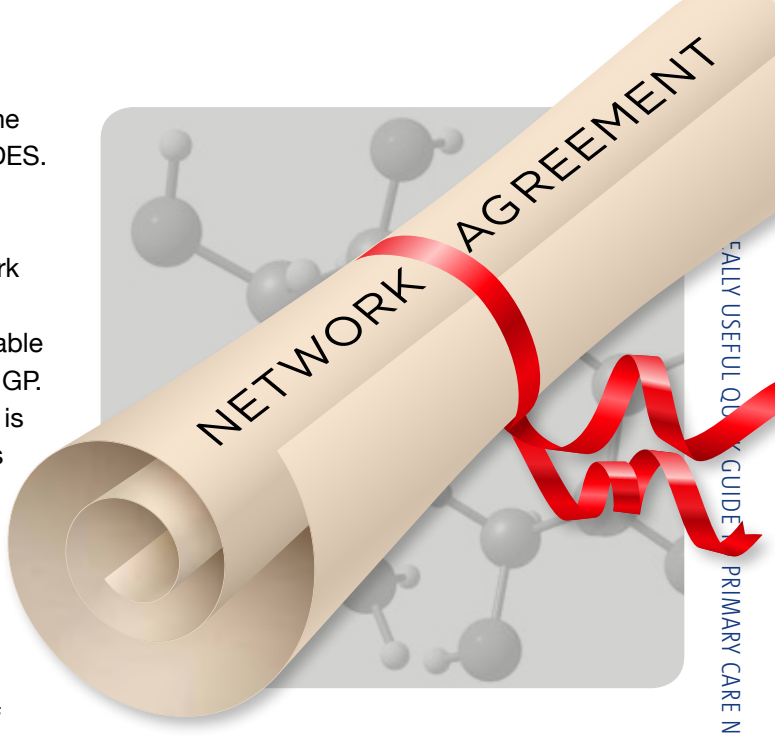
The agreement should clearly reflect who is responsible for the CQC regulated activities being provided on behalf of the network.

Can network services be sub-contracted? Yes, but within the provisions of the practices' GMS/PMS contracts.

Although there is a template available there are many elements that need to be specifically written for the circumstances of each PCN.

Practices should not sign the agreement without taking legal and financial advice regarding the content of the agreement and any additional knock on impact into their own partnership agreements.

Under this DES general practice takes the lead role in every PCN.



Funding

The network contract is effective from 1 July 2019 with funding set over a five-year period to reach £1.799 billion by 2023-24, equivalent to £1.47m for a typical 50,000 patient network.

The investment includes £1.235 billion of new funding, the existing enhanced access and extended hours DESs, and £1.50 per patient cash support. The PCN has full discretion as to how the funding of £1.50 per patient is utilised (see table below).

The CCG will pay PCN funding into one designated bank account on behalf of the network. The nominated payee does not have to hold a registered list but must hold a primary medical services contract (GMS, PMS, APMS).

The nominated payee must be party to the network agreement. A qualifying federation can therefore hold the funds on behalf of one or more PCNs. These funds are held on trust for the underlying PCN practices. It should be clear that the practices will be entitled to withdraw their funds at any time and spend them as they see fit within the remit of the DES and without penalty.

The money is held in this way purely for simplicity and administrative purposes. Payments from these funds should only be made on the authority of the practices, for relevant invoices, with a suitable audit trail.

The PCN clinical director may be delegated to authorise payments on behalf of the PCN practices.

The fundholder will need to keep a transparent record of the transactions through the PCN bank

PCN funding

	2019-20	2020-21	2021-22	2022-23	2023-24
Additional role	£110m	£257m	£415m	£634m	£891m
£1.50 per head (ph)	£90m	£90m	£91m	£91m	£92m
Clinical director	£31m	£42m	£43m	£44m	£45m
Extended hours	£66m	£87m	£87m	£87m	£87m
Improving access (£6ph)			£367m	£376m	£385m
Investment/Impact		£75m	£150m	£225m	£300m
Total	£296m	£552m	£1,153m	£1,457m	£1,799m

2019-20 funding

Core PCN funding	£1.50 per patient registered at 1 January 2019, paid for first 4 months April-July in July 2019 then monthly
Clinical director contribution	£0.514 per patient registered at 1 January 2019, payable monthly from July 2019-March 2020
Additional role reimbursements	actual salary plus employer on-costs up to the maximum set out paid from July 2019-March 2020
Extended hours access	£1.099 per patient registered at 1 January 2019, payable monthly from July 2019-March 2020

The above will be paid to the PCN nominated bank account

Network participation payment	£1.76 per weighted contractor population patient as at 1 January 2019. First 4 months paid in July then monthly

This is paid directly to each practice. There will be a manual claims process for 2019-20.

2020-21 funding

Core PCN funding	£1.50 per patient registered at 1 January 2020
Clinical director contribution	1% pa uplift to 2019-20 pro-rated for the year based on patients registered at 1 January 2020
Additional role reimbursements	Networks need to plan during 2019-20 for their requirements for 2020-21 when they will receive a single combined share based on weighted capitation for the additional roles. Funding is substantially increased and linked to the 5 new national services specifications starting in April
Extended hours access	1% pa uplift to 2019-20 pro-rated for the year based on patients registered at 1 January 2020

account which summarises practice by practice the income received, and payments made.

The summary will need to be provided to each practice at 31 March each year so that the income and expenditure can be reflected correctly into the practice accounts for tax and NHS pension purposes. If practices have a non-March year end statements at other dates are likely to be required.

If practices are dispensing practices, they will be VAT registered and will need details of their share of the PCN bank account transactions to feed into their monthly or quarterly VAT returns. This needs to be provided in a digital form to comply with Making Tax Digital (MTD).

Any surplus left from the funds at 31 March will either be carried forward to spend the following year or distributed back to the practices under an agreed method.

The funds in the PCN bank account should be managed to avoid deficits.

I recommend that the summary is prepared by a specialist medical accountant and their certification report attached to it.

VAT matters

Where a practice provides services to meet the DES requirements and calls down funds from the PCN bank account to cover the costs of those services the practice will need to consider if the service it provides qualifies for exemption from VAT.

There are various BMA and NHSE guidance documents published around the VAT issues. But this is a complex area, particularly:

- Where staff might be employed by one practice and used by another practice
- The supply of staff is a standard rated supply, or
- The services supplied do not meet the criteria for health or welfare exemptions.

There is a belief that nearly everything practices do is covered by the provision of medical services exemption when this may not always be the case. I strongly recommend that advice is taken from a specialist medical accountant to assess the nature of any proposed transactions and to mitigate exposure to VAT.

Employment obligations

There may be an HMRC requirement for payments made to the clinical director to be treated as 'office holder' payments, with PAYE/NIC deductions at source and employer's NIC due even if the clinical director is doing the role as a self-employed individual or via their practice.

When staff are employed under the additional role element of the DES, consideration needs to be given to who is employing them and whether they will be eligible to be a member of the NHS Pension Scheme for that employment.

I recommend that further advice is sought from a specialist medical accountant who understands the HMRC regulations and the NHS Pension Scheme Employing Authority rules.

For further information see:
www.nhsbsa.nhs.uk/nhs-pensions

Clinical directors

PCNs will need to agree who will employ the clinical directors. In doing so consideration needs to be given to:

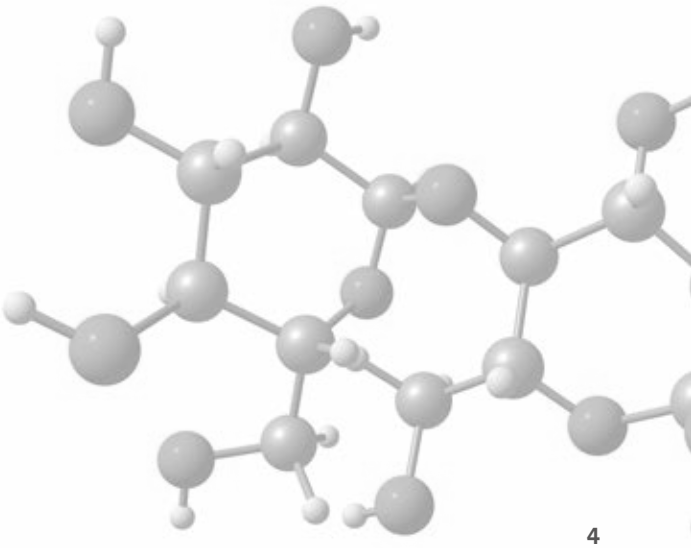
- Where the funding sits relative to the costs
- Any potential VAT implications for charging between practices, the network and any third-party provider organisation
- Employer obligations, auto enrolment and entitlement to the NHS Pension Scheme
- Appropriate content in the network agreement.

What will the role involve?

- Leadership
- Not necessarily operational delivery
- Working to support an integrated care system (ICS)
- Primary care engagement.

Key responsibilities

- Strategic and clinical leadership
- Developing and implementing local improvement plans
- Supporting quality improvement across the practices in the network
- Influencing relationships to enable better collaboration
- Workforce development strategies
- Innovation aligned to local and national priorities
- Facilitation for research activities
- Representation at CCG level, within the ICS, across the LMC.



Options for 'employing' clinical directors

- Contract of employment with the lead practice or federation
- Joint contract of employment with all PCN practices
- Contract for services between the PCN on behalf of the underlying practices and the individual GP or a contract for services between the lead practice/federation and the individual GP
- Contract for services between the PCN on behalf of the underlying practices and the individual GP's practice or a contract for services between the lead practice/federation and the individual GP's practice.

Where the clinical director is employed by the federation/lead practice on behalf of the PCN under a contract of employment, the clinical director will be spending their time delivering the required network contract services.

This could be under a GMS contract/sub-contract between the federation/lead practice and the PCN practices or by way of a supply of a member of staff.

The employment costs to the federation/lead practice, the salary plus employer's NIC and employer's pension contributions, will be invoiced to the PCN by the federation/lead practice for payment from the PCN nominated bank account. There is a need to allocate the invoice information by practice.

Where there is a joint contract version, there is a problem as the GP cannot be an employee in their own partnership.

If the appointment is personal to an individual who invoices the PCN for services done on a sessional self-employed GP basis outside of the GP's practice commitments…

Note that as the PCN is made up of several practices each holding GMS/PMS contracts, the sessional GP is effectively contracted to all the practices to provide their services. The total earnings would have to be apportioned across each of the practices.

If a similar contract exists with the federation/lead practice, they would have to consider employment status and whether the role is genuinely one of self-employment. The federation/lead practice might then be sub-contracted by the PCN to provide clinical director services.

Or the federation/lead practice would be making a supply of a 'worker' that it has engaged. There could be IR35 implications to consider.

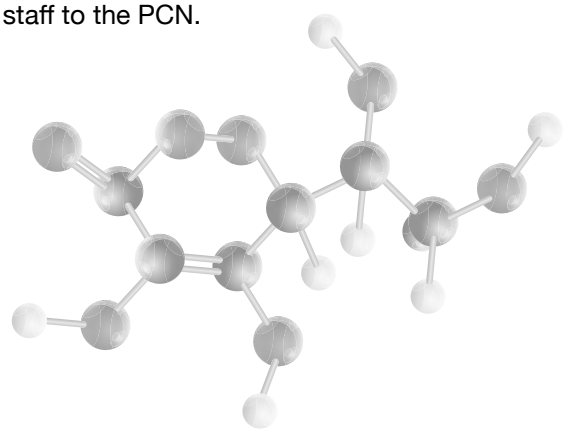
If the appointment is carried out by an individual during their normal practice time and their practice invoices the PCN for the provision of back fill in the practice…

Note that the funding in the PCN bank account to pay the practice's invoice is made up of an allocation for each of the underlying practices.

Again, there are complications with sub-contracts and IR35 if the lead practice/federation contract route is taken. In my view it is unlikely that it will be possible for the GP's personal service company to be the clinical director.

VAT status of services provided by a clinical director

My view is that the services provided by a clinical director do not fit within the definition of the provision of exempt medical services.
So, if the federation employs the clinical lead, then either **1)** the federation is sub-contracted to provide the clinical director role by the PCN or **2)** the federation makes a supply of a member of staff to the PCN.



1) This is unlikely to be a supply of exempt medical services but likely to be a supply of standard rated management/leadership services.

2) Supply of staff is a supply of standard rated services.

In some circumstances the cost sharing group exemption might be available to utilise to mitigate general VAT issues.

For the individual or the GP practice: If employed - no personal VAT implications, if self-employed - is there a supply of exempt medical services or standard rated management/leadership services? If the latter, is the VAT threshold breached or the practice already VAT registered?

NHS Pension Scheme implications for a clinical director

Is the federation an employing authority? If so, is it a classic APMS or independent provider (IP)?

For a classic APMS federation model then for the individual it employs, this is likely to be treated as a salaried practitioner post requiring a type 2 certificate.

With an IP, for the individual it employs this is then likely to be an officer post, fully pensioned at source and will have its own ring-fenced tiered rate for superannuation contributions. The post will not be included within the individual's type 1 or type 2 certificate. In this case the position is pensionable via a temporary direction status application.

For a self-employed individual providing sessional services to the PCN practices, this is likely to be deemed to be dealt with as a type 2 salaried GP with the earnings counting as pensionable alongside all their other pensionable practitioner earnings.

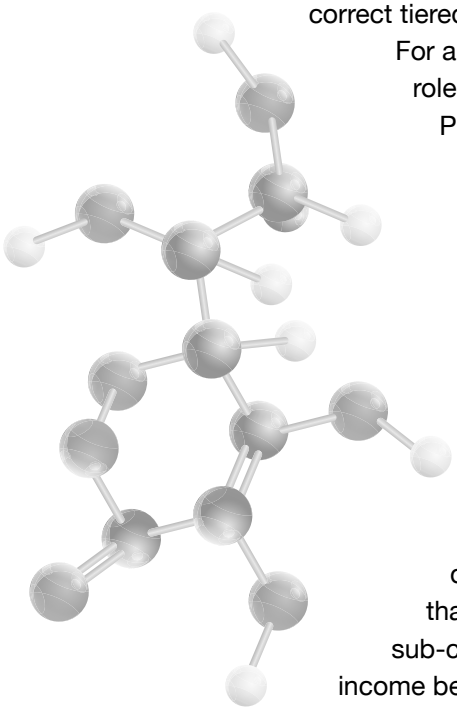
If so, the total earnings would have to be apportioned across each of the practices with the relevant pension contributions deducted at source by them before making the sessional payment to the GP.

The contributions would then be collected

"...a practice needs to take a careful look at future strategy and work on finding the best and most profitable way of using time and resources before it starts"

from the practices via the Exeter statement following submission of an estimate of pensionable pay form.

The GP would need to complete a type 2 certificate for the earnings to determine the correct tiered rate contribution.



For a practice providing a GP for the role, the funding held within the PCN bank account to pay the practice's invoice is made up of an allocation in respect of each of the underlying practices.

The element relating to the practice that invoices for the clinical director will be superannuable income in that practice.

The element funded with the shares of the other PCN practices' funding will not be deemed superannuable income in that practice as you cannot pension sub-contracted GMS/PMS contract income between practices.

Please note: we await further guidance from NHS Pensions to confirm the superannuation position for the clinical director.

I recommend that advice is taken from a specialist medical accountant to assess the nature of any proposed transactions from an NHS Pensions perspective.

What is next?

PCNs will need to consider the role of primary care in Integrated Care Systems and how they will provide services at different levels: neighbourhood, place, system.

There is an Extended Access Review being undertaken which will also impact on the way PCNs operate.

Conclusion

As ever practices must be fully aware of these changes and their impact on practice funding and workload.

Collaboration across networks will be a key change and advice should be taken at an early stage regarding how best to make the network arrangements work.

The 2019-20 contract is the start of a five-year programme with many financial matters now clarified for the whole of that period.

It follows that practices need to take a careful look at future strategy and work on finding the best and most profitable way of using time and resources.

This should encourage practices to be able to plan with more certainty over a meaningful period.

Deborah Wood is healthcare services partner at MHA Moore and Smalley and AISMA vice chairman

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