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AISMA Doctor Newsline

The heartbeat of medical finance

Three golden rules for higher profits for Personally Administered Items (PAIs)

Profits on drugs are declining and practices must do everything they can to remain profitable. **Richard Hole** explains the essentials to ensure drugs claims profitability

Practices in England are reimbursed for the Personally Administered Items (PAIs) they have purchased and given via the FP34 submission and resulting PCSE drugs payment.

The gross profit margin for drugs – income minus cost divided by income — is an excellent indicator of how well the practice is performing in relation to their PAIs, and for dispensing practices it also applies for all their dispensed drugs.

Income includes dispensing fees. Cost is only for the reimbursable drugs, and so some invoices will need to be split to separate the non-reimbursable drugs.

Drugs profits are declining

In the past, profits of 40%-50% were possible, but now the maximum achievable profit is more

likely to be 20%-30%, mainly due to fewer supplier discounts.

It is therefore more important than ever to understand how your practice is performing, and we recommend that you check your drugs gross profit margin to see how you are doing: if it is less than 20%-30% then there is the opportunity to make an immediate improvement.

We work with practices throughout the country to transform their drugs income from loss making to profit. From our work, we have identified the many different issues that can occur at every stage of the process, from purchasing the drugs to being reimbursed for them (see diagram below).

The three golden rules

We have developed solutions to the issues, which can be summarised in the following three golden rules:

1. Ensure everything is claimed: tighten up the FP34 claims process
2. Ensure everything is paid: introduce a 'revenue assurance' process
3. Optimise drugs and suppliers: choose the right drugs to purchase, and suppliers to use.

By adopting all three, drugs losses will be transformed to profits.

Ensure everything is claimed

All the clinical team are responsible for ensuring drugs are claimed, so make things as easy as you can for them.

But also assume that mistakes will always be made and so introduce checks.

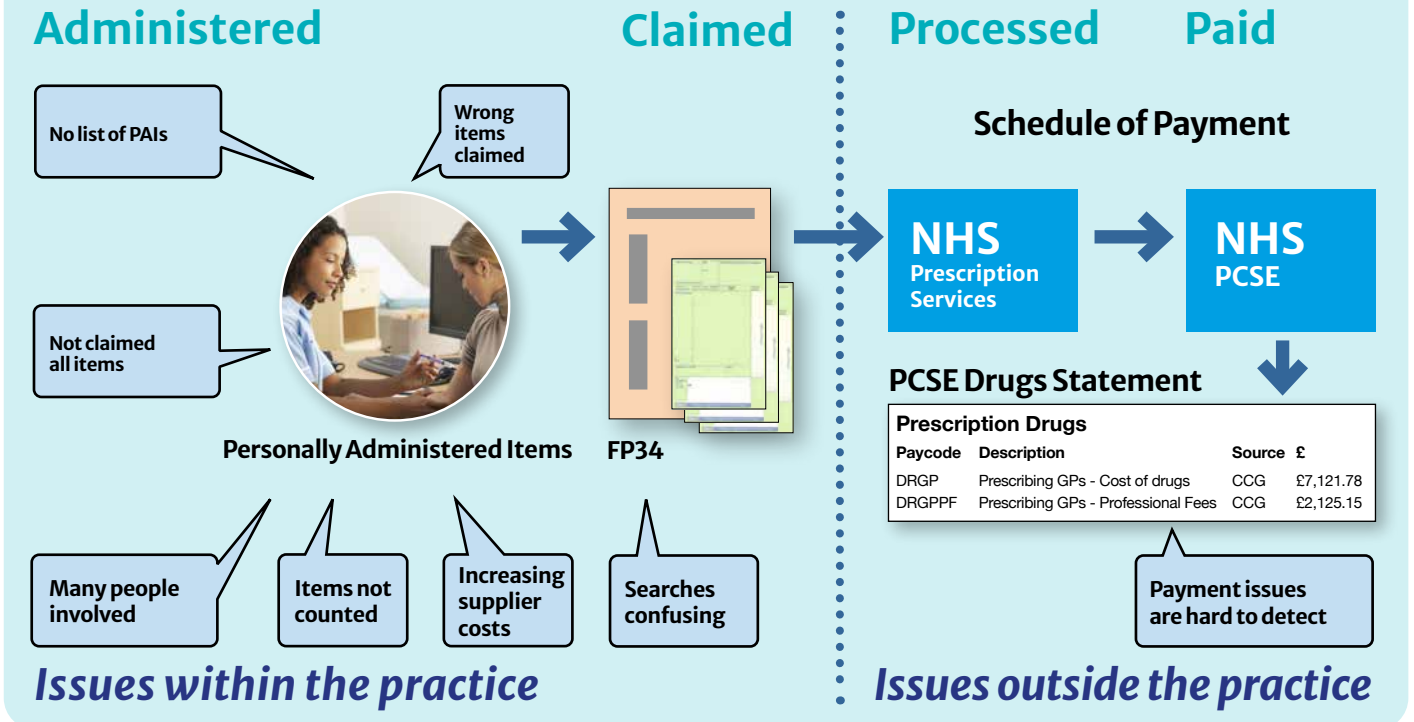
Here are our top tips:

- Identify which drugs you purchase are claimable. Download the list of common PAIs from www.ashlane.co.uk/list
- Ensure everyone knows: label up the shelves and boxes to identify PAIs
- Issue a prescription when the item is given to the patient (not before or after) and immediately place it in the 'PAI' pigeonhole
- Use templates to prompt clinicians
- Don't assume the flu you claim is the same as last year. Each season review the codes used for flus, and how to describe them on the FP34 Appendix
- Use searches when preparing the FP34 to ensure nothing has been missed. Make sure there is a search for each of the drugs you identified in the first step
- Send the claim using Royal Mail Special Delivery, and check that it is delivered.

Ensure everything is paid

If payment errors occur, it is unlikely that you will be told. Therefore, it is essential that you check

What is the reason for a drop in profits?



"We recommend that you let staff know what the profit margin is now, and the role they can play in helping to improve it"

every payment is correct. Revenue assurance achieves this and should be implemented as a recurring monthly process.

Revenue assurance:

- Is a process and system to ensure all revenue is received
- Enables revenue leakage to be spotted and fixed
- Identifies both internal and external issues.

The key to revenue assurance is calculating the value of the claim before it is sent off, and then checking this against the PCSE drugs payment two months later.

This will ensure payment discrepancies are spotted. It is then possible to determine the cause and fix it before further losses occur. If revenue assurance checks are not undertaken, revenue leakage can go undetected for many months, or may not be detected at all.

The important thing is not to become complacent. Payment errors are not common, so practices often get out of the habit of checking. But when issues do occur, there is rarely any indicator of a problem.

Optimise drugs and suppliers

PAIs are generally profitable, but profits vary significantly between drugs, and in a handful of cases they can make a loss. The choice of which drugs to purchase, and which suppliers to use, can make a significant difference in the overall profitability.

Here are our tips:

- Always check the supplier price against the NHS Refund Rate for the drug. You should not be paying more than the NHS Refund Rate. If you are, then switch suppliers.
- Calculate the profit you make on each drug you purchase using the refund formula which is: PAI income minus NHS refund price, minus NHS discount, plus VAT, plus dispensing fee.
- Check whether supplier discounts are available. Supplier discounts on drugs are becoming increasingly hard to find, but there are still some, so shop around.
- Low value drugs are highly profitable: between 50% and 80%. All drugs are paid the same dispensing fee, and this results in low value drugs being very profitable. Examples include lidocaine, steri-strips, water for injection and instillagel.
- Be careful when buying high value drugs as profitability varies widely. For example, Zoladex and Prostap are highly profitable (up to £45 per injection) due to supplier discount, whereas Nebido will usually result in a loss.
- Flus are the most valuable drug purchased, but great care is needed to ensure they are profitable. Order early to get the best discount, be conservative with your order quantity to avoid wastage, and make your communications to patients personal.

Also be persistent to ensure that every flu is given, while maintaining careful records of deliveries and claims so that you can spot if errors have occurred.

- Consider not purchasing drugs that result in a loss and instead, give a prescription to the patient.

An end-to-end process for PAIs

Our three golden rules apply to every aspect of the drugs, from their purchase through to the eventual receipt of the PCSE drugs payment. Therefore, many people in the practice have a role to play in ensuring that profits are maximised.

When implementing the three golden rules you will need to take an end-to-end view across the practice. We recommend that you let staff know what the profit margin is now, and the role they can play in helping to improve it. Then regularly feedback how the performance increases as you make changes.

Richard Hole is a founding director of Ash Lane Consulting, whose team of GP business and finance managers support the drugs claims of hundreds of practices. Its Compass PPA Revenue Assurance service simplifies the process of claiming and provides a monthly report to ensure everything stays on track richard@ashlane.co.uk www.ashlane.co.uk

What general practice needs to see now

OPINION

Andy Pow*
AISMA board member

By now you will know the outcome of the election, but as I write this the future is a little unknown. What is clear though, is that general practice is at a point where change in some form is needed in all UK countries to deal with the significant challenges ahead.

The instant reaction of new politicians when they come to power is to make substantial changes to systems as the way of tackling the underlying issues. General practice, though, does not need substantial change in systems but does need changes in funding.

In many parts of the country, general practice continues to over deliver on the services it offers compared to the resource put into that part of the NHS. But if it is to succeed, we need politicians to recognise the huge efforts being made by practice teams and support them in developing services.

As accountants working closely with GP practices and their partners, we recognise a number of core problems which can be overcome if the desire is there.

Funding in all four countries has fallen significantly behind how costs have grown at practice level. In Northern Ireland some changes have been announced recently around simplification of the contract and also indemnity.

While these are to be welcomed, they are to an extent simply catching up with the rest of the UK and practice level funding remains difficult. In Scotland there are challenges around the suspension of sustainability loans which were designed to help practices with the challenges around premises and recruitment.

In Wales contract changes have been minimal but again funding has been low and uplifts below what its neighbours in England have received.

And finally in England we face potential industrial action falling short of strike levels as practice level funding has stagnated over the past five years. Primary Care Networks (PCNs) seem to be the only show in town for commissioners but they forget practices at their peril.

We have been here before and I have been working with GPs long enough to know that the NHS moves in cycles and we are currently in the trough of the latest one.

First and foremost, resource needs to flow to primary care - not just general practice but also to dentistry, ophthalmology and community pharmacy, as well as other community services like district nursing which provide vital services to patients.

The percentage of total NHS funding going into primary care has fallen consistently over the last decade and that needs to reverse - and reverse quickly.

Funding alone will not solve the problem and there does need to be some discussion as to what the contract looks like in all four countries. When the new GMS contract came to England back in the early 2000s, it was designed to make the financial system easier to follow and to give GP practices a clear ability to forecast their income and cash flow.

Where we stand in 2024 this position has reversed and AISMA accountants are increasingly supporting their clients with financial projections to try and predict income streams.

Simpler contracts are needed which allow practices to regain control of their cash flow and to allow them to be confident in investing in the resources they need to deliver the service.

Premises investment has equally stagnated. It was encouraging to see the new premises directions legislation coming into existence recently. This will allow more flexibility in funding practice developments as well as less bureaucracy around dealing with leased premises.

It seems no coincidence that one of the major investors in primary care properties, Assura, recently announced a £250m injection of capital from the University Pensions Fund. Clearly, they see the need for investment and are more confident that this will be unlocked in future.

Pensions for higher earning GPs and non GP partners remain problematic and we wait to see if a new government will reinstate the lifetime allowance tax charge. However, no political party has mentioned annual allowance tax charges, which remain an issue for some.

If the NHS is to reduce backlogs it needs capacity in both primary and secondary care to expand. It needs people working and not restricted from working due to tax barriers. This is a point AISMA has put forward for a long time in submissions to the government.

What is certain with the election of a new government is that there will be change. Changes to the tax system, changes to the NHS and most importantly in the context of this article's author, changes to general practice.

Positive change can bring great benefits and we hope that the next cycle in the NHS is an upward curve.

Rest assured that AISMA accountants will stand alongside their clients to support them through what lies ahead.

ASK AISMA!

GPs' questions about a variety of issues involving their help from specialist medical accountants are tackled here by Abi Newbury**

You can ask a question by contacting your local AISMA accountant or messaging us via X @AISMANewsline

ACCOUNTANTS' QUESTIONS BRING HANDSOME REWARDS

Q **My accountant wants more information from my practice manager – but she does not have the time to answer all their questions. Why are they being so fussy?**

A I can quite understand a practice manager getting frustrated when they have 100 things on their to-do list and then the accountant asks lots of seemingly nit-picking questions.

However, a knowledgeable accountant will not be asking questions for the fun of it – but to ensure that they fully understand the practice.

They need to see that the accounts represent the correct position in terms of profit and allocations between the partners, and for tax purposes. They also need to look at patterns and trends to help the practice become more profitable.

Normally, there will be a lot more queries from a new accountant in the first year as they get to know the practice. These will tail off as the practice manager and the accountant get used to each other.

We usually find the practice manager anticipates the regular questions and provides answers as part of the year end information, which makes it less stressful for both.

It is much more efficient for the practice manager to answer all the questions at once and most accountants try to organise things so that there is only one set of main questions. If detailed answers are provided, there should not normally be a need for the accountant to follow up.

What stresses both the practice manager and the accountant is where some but not all of the questions are answered, or answers are provided

one at a time – that just creates more work for both sides.

Here are some examples of the value of accountants' 'fussiness' from my own firm, where attention to detail and perseverance for answers has really paid off:

- Over £1m of 'missing money' found in the last seven years – from claims not made, or made and not paid, or invoices paid twice, or incorrect PCSE adjustments.
- Several clients were found money in excess of the annual accountancy fee – so it was definitely worth being fussy!

And if your accountant is not asking enough questions, then you need to ask why!

SOLUTIONS WHEN A MANAGER WANTS MORE ACCOUNTANT'S HELP

Q **My practice manager wants more help from the accountant – how do I balance cost versus benefit?**

A Firstly, understand what the practice manager wants from the accountant and how this is going to benefit your practice. There are many types of practice manager with varying degrees of experience and roles. Different levels will require different levels of support.

Do they need help with their workload? If there is a short-term problem, then using the practice accountant to help with bookkeeping can be cost effective, but probably not as a long term solution.

Is there a learning need? If the practice manager wants bookkeeping or reporting training, then that is a worthwhile cost as it will save the practice money in the long run.

It might just be basic management help that is required — I helped a practice manager with some general time management training in the past and that had a huge effect on her productivity.

If it is payroll that is getting them down, then either the accountant or a specialist payroll service could help, but bear in mind that the time-consuming part of hours/overtime/pay adjustments cannot be delegated to an outsider.

If the practice manager wants something from the accountant that is beyond the current terms of engagement, perhaps budgets and cash flow projections, then that is something the partners need to agree they want or not, but it could be good value for money.

Is the practice demanding too much of one person? Make sure you understand what your practice manager is juggling on a day-to-day basis and whether it is reasonable.

Consider the use of a part time assistant to take on the lower end of the practice manager's work. This could create capacity for them to look at the bigger picture, spot problem areas more easily, or free them up for other, better value work.

Collaboration with the accountant can have many benefits, but it is best to establish what 'more help' actually means – and then to determine the most cost effective and practical way of achieving it.

WHAT IS SPECIAL ABOUT SPECIALIST MEDICAL ACCOUNTANTS?

Q **Cost versus value: my practice manager wants to move to a cheaper non specialist accountant to save money. What can specialists do that non specialists can't?**

A A non-specialist accountant can prepare accounts and complete tax returns, but they may not have sufficient knowledge of:

- What GP practice accounts should look like – so they won't spot problem areas.
- What levels of income should look like – so they won't spot missing income sources or expected changes in income levels.

- Lack of knowledge of 'norms' will mean that they cannot advise on ways to improve the practice or provide any comfort that the practice is doing well compared to others.
- Partnerships and pre-shares of income - these can be complicated and are not always understood.
- The interaction of the NHS Pension Scheme to ensure everything is fair between partners and in accordance with the partnership agreement.
- The NHS Pension Scheme for tax purposes – and risks here include:

1. Incorrect claiming of superannuation relief (we have seen it treated as 'net paid' rather than gross, so that the individual misses out on tax relief).
2. Misunderstanding of the timing of pension contributions and claiming tax relief in the wrong year.
3. No understanding of how to calculate the potential annual allowance charge arising from the NHS pension (with the risk of penalties and interest for an incorrect tax return).
4. No understanding of the Scheme Pays system – and missing deadlines for elections (again with the potential of penalties and interest for an incorrect return).

Even if most of the information needed is learned, non-specialist accountants are less likely to act for a number of practices, which means less experience across the team looking after you and more chance that something gets missed.

Specialist accountants, who are members of AISMA, have not only their own expertise but the collective expertise of around 70 members with

opportunities of training courses/updates on the trickier areas.

AISMA accountants also have the benefit of an annual survey of around 3,000 GP practice accounts to provide very detailed statistics of what the financial performance of a GP practice look like – split by dispensing/non dispensing, contract type, region, by raw patients and by weighted patients.

Cost savings are tempting – but should not be at the expense of expertise. That saving could cost you a lot more in the long run.

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AISMA Doctor Newsline is published by the Association of Independent Specialist Medical Accountants, a national network of specialist accountancy firms providing expert advice to medical practices throughout the UK.
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Hats off to visionary practice managers!

Pushing the practice manager profession forward – **Kay Keane** outlines the impressive development of a new support organisation for her profession

The Institute of General Practice Management (IGPM) was set up in December 2020 by four practice managers who were fed up. I was one of them.

Along with Nicola Davies, Robyn Clark and Jo Wadey I was saddened that we were not considered as professionals by the NHS at large.

We were passed over for opportunities because we did not have a professional register or membership organisations. So as all good activists do, we decided to set one up!

Four years later we have 1,700 paid associate members who are managers in general practice and over 200 who are now accredited members with MIGPM post nominals.

It has been a roller coaster, but we remain passionate about it and will continue to push our profession forward.

Our accreditation programme has been one of our biggest successes. It is based on 10

"Employers can recruit managers who have the postnominals and where they have not, can support them to undertake the accreditation"

domains that we refer to as '10 hats', which is also the name of our monthly podcast.

You may be surprised what it takes to be a manager in general practice:

1 Qualifications and achievements
2 Personal qualities, professional development and working with others
3 Leadership, level of responsibility and accountability, strategic planning, vision and decision making
4 Managing and improving patient services
5 Working with patients
6 Workforce
7 Financial proficiency and practice stability
8 Estate and facilities management
9 Working with other organisations and service providers
10 Probity, legal and compliance, governance.

Managers who have worked in practice for two years can now become accredited. Employers can recruit managers who have the postnominals and where they have not, can support them to undertake the accreditation. The Care Quality Commission (CQC) now looks for this in a well led practice.

Details on the accreditation can be found here **https://www.igpm.org.uk/accreditation**

But it's not just for practice managers. The IGPM is a place for all managers to share knowledge, resources and skills, to support each other and their profession and probably most importantly stand together to be heard.

We were recently successful in getting NHS England (NHSE) to agree that the IIF indicator ACC-008 was not a robust measure and would require significant effort to map locally.

NHSE agreed with us and has confirmed that PCNs will receive 100% of the points available (**https://www.igpm.org.uk/news/203**). We could not do this without our membership and the belief that we can and will make a difference to primary care.

If your practice manager is not a member, or you are a practice manager who is not a member, why not?

Kay Keane is director of the Institute of General Practice Management, https://igpm.org.uk/ and practice manager at the Urban Village Medical Practice, Ancoats Primary Care Centre, Manchester

"Your AISMA accountant can provide a list of claimable expenses, such as subscriptions, indemnity, travel and admin costs"

Topical tips to keep more in your pocket

It's time to consider what you can do to beat the current tax 'freeze'. **Kieran Hancock**[***] shares some ideas that could save you thousands

The cost-of-living crisis has been difficult for many, including medical professionals, over the previous few years.

It is an important time to keep cash in your pocket and making use of simple tips and tricks can make a big difference.

When tax thresholds for individuals, such as the personal allowance and the basic rate band, are frozen for long periods of time, this is known as fiscal drag. As earnings increase, due to inflation, more of the population become taxpayers, or perhaps higher (or additional) rate taxpayers, for the first time.

The concept of fiscal drag has been around for several years and was a trick of the Conservatives to raise tax revenue, without technically raising tax rates. It is also referred to as the 'stealth' tax.

If no action is taken, we will all end up paying more tax.

The tips below provide a useful reminder of what you can do to minimise tax and other liabilities, keeping more money in your pocket:

1 Claiming expenses

A medical professional is likely to incur professional expenses in the course of their employment, or self-employment. Expenses can be claimed against income earned, to reduce tax payable.

For the self-employed, if you have paid for something that you use in your business, even if in part, you can usually claim a deduction from profit.

Expenses for employees are more difficult to claim and the list of what can be claimed is substantially smaller.

Regardless of the value of the expenses incurred, it makes sense to maximise expense claims to reduce tax payable. As you will see from some of the other tips, a small reduction in income can make a big difference in tax payable.

Your AISMA accountant can provide a list of claimable expenses, such as subscriptions, indemnity, travel and admin costs.

2 Pension contributions and gift aid

A personal pension contribution (to a private pension scheme) or gift aid contribution donation will extend an individual's tax bands and reduce income for certain thresholds.

As an example, a personal pension contribution or gift aid donation of £5,000 will

extend an individual's basic rate band by £6,000 (it is grossed up by 100/80 for this calculation). This means they can earn £6,000 more than the usual limit but continue to pay tax at a lower rate.

Their assessable income for things like the personal allowance 'taper' and child benefit clawback is also reduced by that £6,000.

Earning £106,000 and making a £5,000 personal pension contribution would reduce assessable income to £100,000 once the relief is grossed up, maintaining a full personal allowance and perhaps tax-free childcare.

While gift aid donations are lost once paid - the charity receives the cash - pension contributions build up for the individual. This means tax is saved today but the cash is there for retirement. Any growth in the pension throughout the life of an individual is outside the scope of tax.

Utilising these contributions in certain circumstances can prove extremely beneficial, sometimes achieving a better than £1:£1 saving in tax/benefits. There is no limit on gift aid donations and the maximum annual allowance (AA) for tax relief on pension contributions is £60,000 gross, before considering any unused relief from previous years.

"When considering making any personal pension contribution, it is important to seek advice from an independent financial advisor"

If an individual also contributes to the NHS Pension Scheme, they should consider whether an additional personal pension contribution will take them over this limit. For the NHS pension scheme, it is the growth in the member's pension pot over the year which counts towards the AA, not the contributions made. If contributions and/or growth exceed the AA a tax charge could be payable.

When considering making any personal pension contribution, it is important to seek advice from an independent financial advisor.

3 Child Benefit

Child Benefit is paid to parents based on the number of children under 16, or under 20 if in full time education. For a qualifying family with two children this provides an annual income boost of over £2,200.

Historically, Child Benefit started to be clawed back when the highest earning parent's (or person living with the children and acting as one) income reached £50,100 and was lost altogether once income reached £60,000.

In the 2024 Spring Budget, the Conservatives increased these thresholds so that anyone earning under £60,200 would not receive a clawback. Anyone earning over £80,000 would still lose the benefit altogether.

Many families may have opted out of Child Benefit, where earnings exceeded £60,000, to avoid completion of a self-assessment tax return and paying the claim back in full.

As the thresholds have increased now could be a time to review your Child Benefit position.

Earning £70,000 and not claiming for two children could mean you are missing out on over £1,100 of additional income a year.

Relevant earnings for Child Benefit are after the deduction of expenses, pension and gift aid contributions. Maximising those and ensuring a claim is made is certainly a worthwhile exercise.

4 Tax free childcare

The government provides tax-free childcare for qualifying individuals. This is largely those

"For someone receiving a pay-rise to over £100,000, a small contribution to their pension or a charity could help them to save over £7,500 a year in childcare costs"*

earning over £183 a week, who work more than 16 hours a week. There are some other requirements which can be found on the gov.uk website.

Tax-free childcare provides a 25% top-up towards childcare costs. For £8 paid by an individual the government will add £2 to this, allowing payment of £10 to be made to the qualifying childcare facility.

It also provides funded hours when children reach certain ages, ranging from 15 to 30 hours a week.

For those earning over £100,000, the top-up and the free hours are lost altogether. Exceeding the £100,000 threshold can result in extremely high effective tax rates.

Using the tips above for expenses, pension and gift aid contributions can help to maintain tax free childcare claims. Consider what your earnings are likely to be and how these could be kept below £100,000.

For someone receiving a pay-rise to over £100,000, a small contribution to their pension or a charity could help them to save over £7,500* a year in childcare costs.

**Based on a single three-year-old child attending a nursery setting for 24 hours a week, for 50 weeks of the year, at a rate of £8 an hour.*

5 Alternative structures

If you are self-employed as an individual, not a partner, you could consider changing the way your business is structured.

An individual is assessed on all profits generated. This results in a single set of allowances and bands and can end up with high rates of tax.

In certain case, it could be beneficial to set-up a partnership with a spouse. This would allow income to be shared, gaining an extra set of allowances and lowering tax rates.

Taking this a step further, a company arrangement could be put in place. This means multiple shareholders can be introduced and funds could be extracted efficiently.

A company is different to a partnership because income extraction can be controlled. Individuals are only taxed on income extracted from the company once the company itself has settled its tax liabilities. A partnership does not offer control over the amount of income subject to tax.

These arrangements are not for everyone but in the right circumstances they can be extremely beneficial and help maintain take-home income.

Don't forget that specialist advice should always be taken to ensure the appropriate structure is put in place, complying with HM Revenue and Customs (HMRC) rules and requirements. Other considerations are important, such as access to the NHS pension and the availability of the income generated.

Evolving times for PCNs

A clearer understanding of an exciting future for Primary Care Networks (PCNs) has been emerging and is analysed here by **Robert McCartney**

A suite of recent NHS England (NHSE) documents, primarily focused on the PCN Network Contract Directed Enhanced Service (PCN DES), sets out some important issues for practices' consideration.

As I write there has been no published update to the GMS or APMS contracts or the PMS agreement and no amendments to the associated regulations and directions underpinning these.

Consequently, there is clear guidance and expectations on the development of PCNs over this next year but relatively little information about the legislative and contractual changes which may be applied to the core contracts.

Despite this, it is evident that practices must continue to work closely and potentially provide services at scale within the PCN remit.

Four key themes have arisen from changes relating to PCNs:

1 Redefining the role and objectives of the PCN

2 Providing greater flexibility for future development, particularly with the workforce

3 Increased collaboration and integration between the member practices

4 Re-enforcing the requirement to work with other providers including the Integrated Neighbourhood Teams (INTs).

These themes are not new but have been reframed to represent the next stage for PCNs and they are the framework for general practice's future development.

Roles and objectives

There have always been questions about the PCN's role and purpose. The initial version represented a provider and quasi-commissioner role looking at local service development.

The pandemic focused most PCNs onto delivering services at scale. The subsequent recovery period continued this approach but many questions about the future of PCNs were being asked as the initial five-year term they were set up for was due to expire.

Clarification about PCN functions in DES Specification clause 8.1 has been well-received by many clinical directors and PCN management teams. There are four key functions:

a) *co-ordinate, organise and deploy shared resources to support and improve resilience and care delivery at both PCN and practice level*

This ties in closely with other changes in the document about collaborative working. It allows for PCNs to reconsider how they utilise their resources to help their member practices. How much this is implemented will depend on member practices' strategies and by the increased service requirements as commissioner intentions increasingly focus on the delivery of general practice at scale.

> *"The resources will include staffing, finances, equipment, data tools and technology"*

b) *improve health outcomes for its patients through effective population health management and reducing health inequalities*

This has evolved and tools including the data analysis have greatly improved to help PCNs develop strategies and plans to address local health needs.

But there is a query about whether this function exceeds the remit of traditional practice. It requires the input and collaborative working with neighbouring parts of the health and social care system.

PCNs will need to demonstrate they are working on local projects to tackle these inequalities but it is likely to be measured against function (d - see below) and collaboration with INTs to bring large-scale change.

c) *target resource and efforts in the most effective way to meet patient need, which includes delivering proactive care*

This confirms the PCN's role as a service delivery provider or, at the very least, co-ordinator. The resources will include staffing, finances, equipment, data tools and technology. Sharing and allocation of these resources will need good governance systems.

That includes clear decision-making procedures, analysis of effectiveness and ensuring suitable arrangements are in place, including in the Network Agreement, and satisfactory sub-contracts to manage these resources appropriately.

There could be tension between this and function (a) if patient need and proactive care requires resourcing which could be used for other resilience projects.

The PCN management team will need to demonstrate how and when it wishes to prioritise one over the other in a transparent and supportive manner.

d) *collaborate with non-GP providers to provide better care, as part of an integrated neighbourhood team.*

PCNs have intended to expand membership beyond practices since formation but this has increasingly shifted to a commitment to work with others rather than expressly include them.

This is represented by the new express requirement to work with INTs but these are in their infancy and there is no formal guidance or governance about what they are and how to develop them. Several pilots are working on how they may be shaped.

But the principles of collaborative working are not new in the NHS and it would be suitable for PCNs to consider the terms. Will this require additional time or transfer of resources? Could it create a tension between allocating resources to core primary care from wider community services? How would the outcomes be measured and what would success look like?

Greater flexibility

The four functions are expanded upon in clauses 8.1.4 to 8.1.10 of the DES Specification. They can be interpreted as a move towards an outcome focused method of working with reduced level of prescription.

However, the DES Specification has been supplemented with the guidance document *Part A: Clinical and support services* which refers to best practice, coding requirements and other resources which should be used to interpret and implement Specification requirements.

"This provides a mechanism for practices to be creative and develop Multi-Disciplinary Teams to target local issues"

This guidance is a definite change in direction and PCNs have increased flexibility about how they develop their services, such as the workforce.

Previous restrictions on staff numbers recruited through the Additional Roles Reimbursement Scheme (ARRS) have been replaced with only the new enhanced nurse role having a limit. This allows PCNs to restructure services based on the workforce available and their priorities.

They will need to consider how this impacts the existing teams and current employment terms. It is likely to lead to changes to some PCN recruitment strategies.

Clause 7.3.2-A and B include a procedure by which PCNs may now submit business cases to their ICBs to expand the ARRS to other non-GP and non-nurse team members. They must relate to direct patient care and comply with the following:

- be additional to the roles already working within the practices
- be demonstrably different from the other ARRS roles
- have a clear scope of practice and training requirement
- fit with local care pathways and not duplicate existing provision, and
- reimbursement must be at a rate commensurate with its scope of practice.

ICBs may consider the impact of the role and if it is suitable in the wider context of the health economy. This provides a mechanism for practices to be creative and develop Multi-Disciplinary Teams to target local issues.

Increased collaboration

The latest Specification extends the Capacity and Access Programme to incentivise the concept of Modern General Practice Access. This requires

"Practices have an exciting opportunity to redesign their services and help create increased resilience..."

the PCN to provide evidence it has better telephony, simpler online requests, and faster care navigation, assessment and response.

PCNs need to consider how they manage this. Options range from simply monitoring and reporting PCN practices' progress through to fully redesigning access support systems and creating centralised support.

The Specification also refers to shared vaccination and immunisation clinics. Many practices do this for Covid vaccines but this option allows all vaccinations to be delivered likewise.

NHSE has produced seasonal Collaboration Agreements to help define the legal relationship between practices. Many of these have been signed as blank templates rather than fully completed. This creates a significant risk between practices because the legal relationship, including the governance, liabilities and operational specifications, are not appropriately documented.

With any collaborative model the practices must ensure these are addressed in appropriate agreements to avoid uncertainty.

NHSE has added a requirement that any practice using a collaborative model for vaccination clinics should add a new Schedule 8 to their Network Agreement and agree a variation which adds additional clauses to the document's mandatory terms.

This should not be seen as a replacement for a formal collaboration agreement tailored to meet practice needs.

Practices have an exciting opportunity to redesign their services and help create increased resilience but many GPs are concerned it may affect their ability to control core service delivery and their practices' support teams.

Careful planning is needed and final arrangements need to protect participating practices' interests and ensure the quality of patients' services.

Working with providers including INTs

Clause 8.1.8 requires PCNs to contribute to the delivery of multi-disciplinary proactive care for complex patients at greatest risk of deterioration and hospital admission. This 'must be done as part of INTs'.

So PCNs should consider how they will do this, who the partners are within the INT, and what the relationship will be.

Parties are allowed to define what the INT will be and how the different elements will contribute. This should then be the basis to implement a suitable legal structure to formalise the relationship.

It may include collaborative working agreements and/or sub-contracting arrangements but, however they are formed, they must ensure the parties understand their duties and have suitable protections built into them.

Clause 8.1.10 extends the requirement to ensure PCNs work with other PCNs, local community service providers, mental health providers, community pharmacists and other health and social care providers.

NHSE announced funding in May to allow PCNs a community pharmacy primary care network engagement role aimed at helping PCNs integrate with community pharmacists.

As pharmacists increasingly take on some traditional general practice roles this is an essential first step in developing relationships between these providers.

Similar roles could be developed for optometry, dental and other providers in future and could help implement the strategies developed in conjunction with clinical directors.

Each of these four themes support the core message that PCNs are part of the long-term strategy for primary care. The key recurring theme appears to be the need to develop greater integration both in services delivered by practices and with other services.

These changes provide a clearer understanding of the future of PCNs, although it remains subject to a one-year contract and so decisions made after the election may impact the current proposed model.

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