

NHS Clinical Commissioners' response to the NHS England and Improvement consultation on the Primary Care Network - Direct Enhanced Service Draft Outline Service Specifications

15th January 2020

Introduction

NHS Clinical Commissioners (NHSCC) is the membership body of Clinical Commissioning Groups (CCGs). Established in 2012, we have around 90% of CCGs in membership. We offer a strong national voice for our members on specific policy issues and support them to be the best they can to commission services effectively for their local populations.

We have decided to provide our response to the above consultation in this format (as opposed to the online survey) because we wanted to highlight the overarching concerns and feedback from our members at a national level. We know many of our members are responding on the specifics in the specifications at a local level so to avoid repeating them we wanted to share a broader themed response which represents them all. Our response to this the above consultation has been informed by the views of our members, including Clinical Chairs, Accountable Officers, Primary Care leads and Medicines Optimisation leads.

The commissioner view on the draft specifications is critical for future delivery and success. As we know PCNs are at varying stages of maturity across the country. CCGs are heavily involved in their development and are critical partners in ensuring the DES specifications support practices to develop new ways of working but also give practices what they need now to meet public demand.

Our members have fed back several areas of concern which we've grouped into themes and share below. **Please note we developed our response before the HSJ Exclusive on the 14th Jan which highlighted that significant changes to the specifications were to be made.**

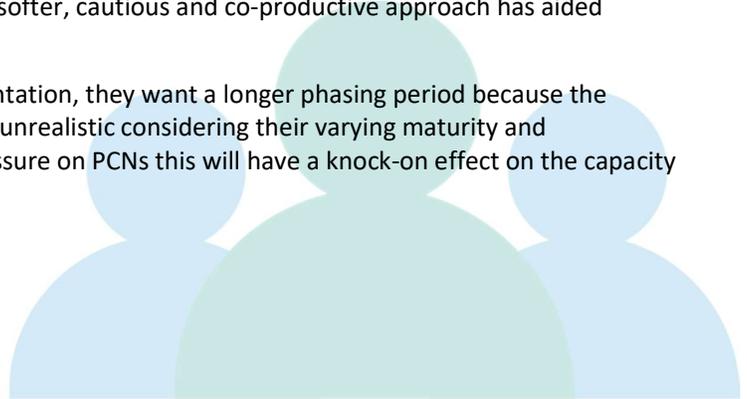
Moving too fast – further phasing is needed in 2020/21

For CCGs the draft specifications were intended to set strong ambitions and clinical direction for primary care, they are still very supportive of that aspect. They are also supportive of the flexibility provided in the proposals for PCNs to allocate roles and finance within their contextual areas, reflecting where they have pressures.

However, the overall feedback from our members suggests that with the current draft there is considerable work to do to help it land well in primary care at a local level. We know there is a strength of feeling amongst GPs and PCN Clinical Directors that the specifications are moving PCNs into scaled up delivery too quickly and risks destabilising the current capacity of general practice services.

It must be recognised that PCNs are currently going through a phase of connectivity between practices, so delivering a place-based methodology as proposed here will require further time i.e. to embed a level of collective change. For CCGs, provider ownership and delivery are key, and with the current model of general practice being so individually driven we know a softer, cautious and co-productive approach has aided delivery so far.

While our members support a phased implementation, they want a longer phasing period because the expectation on PCNs in 2020/21 is too high and unrealistic considering their varying maturity and development, and they fear that by putting pressure on PCNs this will have a knock-on effect on the capacity



of CCGs to support.

Risk of destabilising the PCN model

A number of our members have expressed their concern that the specifications are asking for too much from an already stretched service. They feel the pace of change is not in keeping with the current maturity and capability of PCNs to deliver at the suggested scale. It also doesn't recognise that PCNs are in some places already under strain to deliver the asks of the current contract and its DES requirements so undertaking the workload described in the draft specifications feels unrealistic.

The consultation proposals as outlined are also affecting GP morale locally, with even the most resilient of GPs expressing concern at what is being asked of them by the specifications. This may not be true of the whole country (i.e. where GPs/localities have previously engaged and/or have services already in place through initiatives like the Challenge Fund, Better Care Fund or Vanguard etc) but is certainly reported by the majority of CCGs that responded.

Most worrying is that they feel the enthusiasm, local achievements and engagement that CCGs have undertaken to date is at risk of being undermined, including early plans of service delivery or locally led best practice. They are looking to keep some level of local flexibility in the specifications which doesn't seem clear in the current draft. For example, some CCGs have commissioned care home specifications which are fully funded and working well, this consultation suggests their practices will lose funding and drop the current service level. This is not good for the CCG, PCN and most importantly the population. How do we balance the differing priorities of local and national specifications?

On another level consistency is important to CCGs to ensure PCNs receive the same level of support nationally. A number of our members therefore ask what contribution is expected of CCGs when *"playing a major role in helping to co-ordinate and support delivery of the specifications ..."* Will there be national standard operating manual/guide rather than each CCG inventing something similar locally? This clarification would be helpful.

Investment and Funding

Our members have also expressed a need for further clarification on the funding position, as it has implications for CCGs.

- In the introduction of the document it suggests that by 2023/24 spending on the service areas will rise by over £4.5 billion in real terms (£1 bn through the core contract and £1.8 bn through the DES) but where is the other £1.7 bn to come from? Is this going to flow to CCGs to uplift the community services contract, if so, what is the funding trajectory? If it is - how will the redesign of community services provision be funded to do this? Or will this cost pressure fall to CCGs?
- Similarly, section 1.24 the document says that previously invested funding by CCGs in local service provision which overlaps with the national service specifications should be reinvested in primary medical care and community services. While CCGs would always want to support Primary Care appropriately should it also be clear this is not delegated funding?
- Commissioners welcome the use of current services that could support the delivery of the specifications, but there is some concern to note around QIPP. Where it is possible, current services can be adapted to deliver the specification requirements, but as some services were sporadic and only covered small areas, these are or have been decommissioned to support QIPP in anticipation of universal specification coverage. So, if it is expected that the CCG baseline spend will provide certain services (as above), then this will be another cost pressure for the CCGs.
- There are also a number of requirements on the CCG to support services labelled in sections as '...must include' which may not be available locally. The implication is that this could lead to another cost pressure on CCGs i.e. having to build up the 'must have' areas.

- It would also be good to get some clearer steer on the use of the practice PCN participation funding i.e. £1.50 per registered patient, is it believed that this should be used to support the delivery of the new specifications?

CCG capacity and wider workforce issues

While members felt it was good to see clear support for system working there were clear concerns about current GP and CCG capacity, recruitment and funding for additional staff (where it may not exist).

- Overall members felt the expectation around activity is high, but the workforce to deliver it is low in capacity. For example, the Enhanced Health in Care Homes Specification calls for weekly ward rounds. A PCN with a list size of 42,000 would need to see over 150 patients every 2 weeks, which even at 10mins per patient would equate to 5 GP sessions a week. The difficulty is the number of GPs wont dramatically change in the short term, and yet there still seems to be enormous reliance on GPs doing the work within the specifications, rather than using a wider skill mix. How do CCGs support PCNs where the workforce does not exist?
- Similarly, the specifications require a clinical lead who will be responsible across the PCN for the delivery of the service requirements. The timescales are not realistic, even if there were clinical leads coming forward to take up this role (which does not have any additional funding attached to it). Clinical leads would need protected time and some funding to enable them to undertake the lead role effectively.
- On recruitment the document says that *where PCNs are struggling to recruit, CCGs and systems should take action to support them. This is positive but* this can be time consuming, as many PCNs (early in development) are struggling to agree what they want, and many want each practice involved. So this has implications for CCGs and our members would like clarity on what support they will get too. Please note that CCGs have to achieve a 20% running cost reduction by April 2020 - how will they create the capacity to support this.
- Staffing PCNs from a small talent pool (as outlined in the consultation) is a major risk to delivery for CCGs, PCNs and the system. This is especially the case when the current PCNs are taking resource from local hospitals, trusts and Practices, leaving them with similar difficulties and so leading to system difficulties. A combined approach is supported, although the limiting factor remains the input and output from universities of appropriately trained talent. CCGs felt delivery as currently outlined in the specifications required major workforce transformation which is system level and cannot be addressed by CCGs or PCNs alone.
- The specifications seem to inflate senior managerial capacity at PCN level to both deal with the basic understanding of the specification, its delivery, engage with other providers and the local authority, at a local and system level. This has not always been the case and may need further thought as the engagement with commissioners of 10-20 PCNs wanting something slightly different will be difficult to manage.
- There is also an issue around primary care estates, new staff will need facilities and the space to work. Will additional funding be provided to CCGs to support this? If not, how will facilities be made available?

More of a focus on outcomes

Members have also highlighted that overall, the service specifications are not ambitious when it comes to a population or outcome focus. They felt the specifications were targeting older people with multi-morbidity who are frequent users of emergency care and are concerned the specifications will miss out a significant range of younger people with complex needs – including those with mental health problems, who could benefit from healthcare delivery provided via PCNs.

In terms of the metrics they feel very activity driven – given all services have been tested or piloted through various means and have an evidence base. It would be preferable to have more outcome measures as these will be useful for identifying impact. This is particularly important for commissioners and their priorities when working at population level in the context of integrated care.

The engagement process and pace of this consultation

Our members feel that the consultation would have benefited with much more lead in time for feedback, while they appreciate there was a general election period which delayed this, they do not feel they have been given enough time to engage and respond to the draft specifications in the detail they want to and that they have not been given the time to explore their implications with practices within their localities. This would they feel have negated some of the strong feeling that has been shared by PCN CDs in recent NHSE webinars and wider surveys.

Members of the NHSCC CCG medicines optimisation reference group were particularly disappointed that CCG medicines teams who have been commissioning Structured Medication Reviews from practices for many years were not duly engaged in drawing up the service specification. This would have been of help both in drawing up a spec with more detail, and so providing a clearer picture of the workload involved (this was a key and recurrent question in the webinar on the 8th Jan); and in beginning to formulate the metrics.

Specific points from the five specifications

Below we represent some specific themes raised by our members that have come up from the five draft specifications.

Structured Medication Reviews and Optimisation

Our CCG medicines optimisation reference group have highlighted the following areas:

- **Identifying patients suitable to have an SMR:** More clarity is needed on the likely number of patients per 100,000 in a typical practice. It is crucial to consider a baseline indicating the minimum number of patients who should be receiving an SMR under this service spec. In addition, references to housebound, isolated, and frail with recent admission – how will this cohort be consistently identified? Similarly with severe frailty – thresholds of frailty or criteria should be made clearer. Lastly, the same applies to the definition of addictive pain medications – a definition is necessary to ensure fairness, consistency and appropriateness.
- **Capacity constraints:** The service spec requires PCNs to offer 100 per cent of eligible patients an SMR unless there is exceptional circumstance where the commissioner- i.e. NHSE- agrees there are capacity constraints. This tremendous challenge in allocating sufficient pharmacist capacity to meet this high demand cannot be overstated. Often there is only one pharmacist per PCN and within a CCG medication review team it will be near impossible to undertake the volume of SMRs being suggested. One CCG has told us that with their current workload as a medication review pharmacist team covering a population of 1.30million, reviewing patients on ten or more medications will take the CCG 7.5 years to do. Even with additional capacity in place, the work required to transform the system to support this proposed SMR relies heavily on GPs , rather than employing the use of a multidisciplinary team or wider skills mix.
- **Proposed metrics:** as above, the number of SMR processes and follow ups needs to include reason for SMR to ensure appropriate patient groups are being targeted and that follow ups are consequently appropriate. Prescribing rate of medicines of low priority, antimicrobials and medicines that can cause dependency should also include a baseline rate as this spec requires PCNs to have local action plans and so its implied that rates will improve but a baseline is crucial to be able to judge this rate of change.

A few areas came up for clarification:

- **Section 3.8** discusses aligning PCNs to Care Homes. Where this has been done in the past, alignment of care homes to single/joint Practices has taken approximately six months of engaging, working and agreeing the requirements with General Practice. Apart from the timescales, specific CCG headroom will be required to enable this to be delivered, hence capacity pressure in CCG. Additionally, there will be capacity issues to enable many PCNs delivering 'joint working' between PCNs and social care in this period due to local government priorities.
 - Similarly, if one practice registers all residents in a care home, but the PCN is responsible for delivering the EHCH specification, how does the practice who has registered the patients from the care home share the capitation fee they get for registering those patients with the PCN so that the PCN can benefit from the capitation fee and collectively deliver the service?
- **Section 3.12** - This may undermine the new 111 contract that has a dedicated care home line. It also differentiates one cohort for Out of Hours care
- **Section 3.13** discusses the types of homes to be covered. Specialist LD and some other high intensity units are not managed by General Practice and are more CCG or Local Authority commissioned, so this will need to be stated.
- **Section 3.15** mentions 'the term care home encompasses all types noted above.' It is felt this is best removed as it only confuses the definition stated in 3.13.
- **In Section 3.16** proposed service requirements (point 8 in the table), several support areas stated say that they 'Must include' the following. Apart of the timescales being unrealistic, some of these services may not be available to the PCNs across the system, hence putting commissioner pressure to 'level up/create' these services to meet the specification. The comment should be changed to 'Should include' and timescales delayed allowing for the change.
 - In the same section, the proposed service requirements (point 10 in the table) states PCN support to Care Homes for training. It has been feedback that this cannot be justified as this is a requirement on them as an independent organisation; similarly, their staff can have Influenza injections from their GP. From a commissioner perspective, although the system improvement is clear, this area of improvement should really be within the Care Homes Contracts via Local Authorities, rather than PCNs/CCG?
- **Metrics:** The metrics being recommended in the specification are system metrics in the main (inc. improve the experience, quality and safety of care for people living in care homes, their families and their carers) and thus system should share the risk. How do we ensure that there aren't penalties to the primary care element of the PCN DES because the system doesn't work together?
- **Weekly 'ward round'** - As mentioned earlier, this proposal will exacerbate existing capacity issues – having a GP or Community Geriatrician at this frequency is not realistic. The wider workforce in the MDT would need to be the first line to care homes – escalating where they feel the need. This type of work could also be driven by technology (GP being called via a video platform). CCGs also need to understand what percentage of patients will require a review on a weekly basis i.e. residents who are not stable, this will then help to understand the cost of providing this service. Currently without any additional funding for the GP element of this specification, it does not appear realistic to think the capitation payment for these patients will be enough to cover this additional cost. How does NHSI/E believe this element will be funded?
- **Medicines Optimisation in Care Homes (MOCH)** There needs to be greater guidance on how the current MOCH teams are integrated into these new arrangements. There is a mismatch as such teams have been set up and funded through the Pharmacy Integration team with a focus on working at scale across STPs. There is no separate funding for the delivery of the EHCH service spec and as the PIF funding is time limited it is difficult to see how the staff resource and expertise gained through this project will be retained under the new arrangements- which are principally network/practice rather than locality (place) or STP based. Consideration should be given to continuing an element of centralised funding to support the transition of MOCH teams into the new working landscape.

- **Inequity for the frail elderly living at home.** The spec creates a two-tier model of care where the frail elderly living in their own homes who are far more “at risk” than those being cared for in nursing or residential homes, will be overlooked in order to attempt to achieve an unnecessary level of input to care homes

Anticipatory Care

A few areas came up for clarification/change:

- **Section 4.12** (item 1 in table), apart from what has already been stated around lack of capacity/resource to enact the model so quickly, the cost pressures of asking community services to make the changes suggested could be prohibitive from a capacity, resourcing and funding point of view for commissioners.
- **Section 4.12** (item 6 in table) has a similar comment to 3.16. The table discusses the support ‘Must’ include which could be direct and significant cost pressures to CCGs. If this can be replaced with ‘Should’ please.
- **Metrics** – the metrics recommended in the specification will need to flex with the cohorts being supported, can this be clarified.

Personalised Care

A few areas came up for clarification/change:

- **Section 5.3** discusses support provided via the national programme, but these services may not be consistent across all areas. If they are required as part of delivery, could there be a potential cost pressure as well as capacity problems in establishing the services for CCGs (even if available nationally, due to timing of delivery, national capacity and local delivery capacity may not match).
- **Section 5.4** states that GP appointments can be saved. This is also mentioned earlier in the specification document, it would help commissioners if a reference is applied to this point so that evidence of actual improvement from pilots/elsewhere can be used in discussions between CCGs with PCNs, enabling engagement and support of model.
- **Section 5.6** (item 2020/21 in table) has a similar comment to 4.12 and 3.16. The table discusses the support ‘Must’ include which could be direct and significant cost pressures to CCGs. If this can be replaced with ‘Should’ please.

2.4 Supporting Early Cancer Diagnosis

- **Members are supportive of the ambition** – but this requires a system wide approach and responsibilities held by all providers along the patient pathway.
- Again, our members raised an issue of **unrealistic timescales**, workload requirements and unmatched resource and capability for PCNs.
- There is a **CCG managerial pressure** due to lack of capability of PCNs.

For more information

If you would like any further detail on our response, please do not hesitate to contact Julie Das-Thompson, Assistant Director – Policy and Delivery, NHSCC at j.das-thompson@nhsc.org