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NHS England and Improvement (NHSE/I):
Consultation on Primary Care Network (PCN) Service Specifications

1. The Royal College of General Practitioners (RCGP) welcomes the opportunity feed into the NHSE/I consultation on the service specifications that will be attached to the Network Contract Directed Enhanced Service (DES)

2. RCGP is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 53,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. The College is an independent professional body with expertise in patient-centred generalist clinical care.

3. We are supportive of the principles that have guided the establishment of PCNs across the country. We believe that, if given the chance to develop properly, PCNs will bring benefits to practices and the patients they serve. The creation of PCNs encourages collaboration between providers across an area, helping them to pool resources, enhance services and ensure funding reaches the frontline delivery that needs it most. The success of this policy depends on frontline clinicians being able to use their professional judgement, and knowledge of the population that they care for, to develop services from the bottom-up that reflect the needs of their patients and the assets available to them.

4. The purpose of the service specifications is to guide the work of PCNs in some areas that have been identified as a priority at a national level. The College has significant concerns about the process by which these service specifications have been developed for blanket implementation across all networks, particularly in light of the variability that is inherent to network structures and assets. We would like to see more time given to allow for wider consultation with the profession at large, to give GPs the opportunity to properly shape these specifications and ensure that the end result has been properly co-produced with the workforce that are going to be asked to deliver them. This must include strong input from patient groups. This is the best way to ensure networks are empowered to deliver the place-based care that was envisioned when the Network DES was launched

5. The College would also like NHSE/I to reconsider the extra workload that these specifications would entail in a very short space of time. The success of PCNs relies on practices collaborating in new ways, which requires strong relationships and professional trust. These vital elements take time to develop while practices are still working to deliver routine services in a time of unprecedented demand. Most networks have been operational for less than a year, and overloading networks with unrealistic expectations will draw focus away from the organisational development work that lay build the foundations necessary for the ongoing survival of a successful network. A co-production exercise with the wider workforce will ensure the requirements of the service specifications are realistic and relevant across all networks.

The consultation process for the service specifications

6. The RCGP recognises the intention of NHSE/I to consult with GPs, and other stakeholders across primary care, on the content of these service specifications. We recognise the challenges faced by NHSE/I in relation to meaningful engagement as a result of the restrictions imposed by purdah, the general election and the Christmas break. It is unfortunate that this has coincided with a strict contract timetable that requires the consultation to close on 15 January 2020 in time for the NHSE Board meeting to approve contract details prior to implementation in April.

7. The consequence of a rushed consultation period has been to remove the possibility for GPs and other stakeholders to shape the content of these specifications. This is contrary to the aims of primary care networks as a whole. The success of established networks will rely on their bottom-up development, led by frontline staff working to meet the needs of their populations.[1] The College would like to see a substantive two-way engagement process that would co-produce service specifications with the organisations that are being asked to deliver them.

8. These five service specifications were developed by relatively small expert working groups prior to this public consultation. While this has ensured expert input and a good amount of evidence in some areas, it must be used as a starting point for discussions of what is realistic for general practice and would add value in a local setting. PCNs represent a new approach to primary care, collaborating at scale and adding value at a system level in a time of unprecedented demand.[2] This requires a new approach from NHSE/I in developing specifications to build shared goals and create something that can be used to stabilise primary care provision in the face of growing demand. It is an opportunity to do something different with the development and implementation of these service specifications, and it must be grasped with both hands.

9. Prior to this consultation, the College has conducted some qualitative research with a number of clinical directors and practice support staff to ascertain how PCNs have been received by working GPs. The view of the PCN policy as a whole was a sense that PCNs are being "done to GPs" rather than with them, as there was very little wider engagement with GPs before PCNs became national policy. This was the perception before this consultation exercise was launched, and during a period of implementation when NHSE/I was explicitly pursuing a strategy of giving PCNs space to develop. Implementation of the specifications in this form will worsen the concerns that PCNs are not owned by the professionals being asked to put them in place for their local population. A key element to

[1] Bowen, P, 2019, *Primary Care Networks: the importance of ground up partnerships* https://napc.co.uk/the-importance-of-ground-up-partnerships/ (accessed 13/01/2020)
[2] Prof F D R Hobbs et al, *Clinical workload in UK primary care: a retrospective analysis of 100million consultations in England, 2007–14*, The Lancet, 2016

success for primary care networks is that they are built on relationships and shared vision – if GPs do not feel a sense of buy-in to the new organisations it will make it difficult for PCNs to realise the aims of the policy overall. More engagement with the wider profession on these specifications would provide valuable insight from PCNs on the ground, as well as help to secure buy-in from the workforce that will be tasked with delivering these services.

Unrealistic timescales for organisational development and service implementation

10. The RCGP considers that the implementation timescales for these specifications to be unrealistic. Practices need more time to develop the strong relationships and networks that will enable PCNs to deliver the service improvements that the contract envisages. Some elements of these specifications will be required of PCNs that have been operational for less than a year. These new organisations are just beginning to understand how their network is going to operate and have been focusing on the projects that add value in their community. Overly ambitious timelines for implementation will result in bureaucratic implementation that adds little clinical value to services.[3]

11. Many of networks have started on projects related to chronic diseases that have resulted in practice working well together to build the foundations of a good network. The College is concerned that these service specifications will needlessly undo good work in these networks, demoralising the workforce, taking valuable skills and resources away from developing the foundation of a strong network and hampering delivery of network objectives further down the line.

12. These specifications outline new work that is expected to be supported by new staff employed as part of the dedicated funding for the new roles in networks. However, the specification and the timescales do not take account of the different stages of networks across the country. In some networks, the new roles are yet to be recruited. Staff that have been recruited may not have a lot of experience in practising in a primary care setting. This may be because they are newly qualified, or they are coming from elsewhere in the health service. The personal development of this new group of clinicians will take time, as they learn to use their skills in a new service. Workload that cannot be undertaken by the wider practice team will inevitably fall to overburdened GPs. The service specifications must flexible so that service providers can take into account the different assets available across networks, and not pile an unrealistic workload on staff that are yet to be properly embedded across the networks.

13. We have particular concerns relating to the workload and timescales outlined in the Structured Medication Review. Enhanced Health in Care Homes and Anticipatory Care Service Specifications.

Inherent variability in bottom-up development of networks

14. The initiation of PCNs in 2019 was permissive, specifying only that a network must nominate a lead practice to receive funding, cover a geographically contiguous area and a population between 30,000 – 50,000, with flexibility to ensure networks made sense locally. The aim of the programme was to enable local autonomy to create a network that worked with the population and assets available to them, to build a strong organisation from the bottom up. Some areas have networks that are very mature and organisations that can support some level of organisational development and collaborative service delivery; most are quite new and all have only officially been in place since 1 July 2019.

[3] Hallsworth, M. *Policy Making in the Real World* Institute for Government, 2011 www.instituteforgovernment.org.uk/publications/policy-making-real-world

15. A challenge of this inherent variability in PCNs is how to create a centrally mandated service model that guides service provision in all networks[4]. In order to be successfully adapted in varied localities, with different service assets and population needs, service specifications cannot be overly prescriptive. For example, the care home specification requires a GP to visit to the care home every two weeks, regardless of the assets/services in the locality. This may be appropriate in an area where the wider practice team is relatively inexperienced in their role in primary care. However, there are many areas with established care home services that successfully deploy advanced nurse practitioners to care homes. These services would have to unnecessarily restructure a successful service to fit the centrally mandated specification. Instead, it could be made less prescriptive by including only broad objectives that networks can incorporate, tailoring their services according to their local workforce availability and population priorities, and using the professional judgement of the local workforce to shape the best service for their patients.

16. PCNs that are less mature will struggle to implement the changes that are being suggested, as will PCNs without the extra resource provided by new workforce. This will widen the gap between the more mature networks that have already have capacity and a well-developed organisational culture, and those that do not. They will lag behind and if they engage at all they will do so in a compliance focussed fashion rather than through a process of meaningful change that will improve patient care. This will be a lost opportunity in the reimagining of primary care across the country.

The consequence of unrealistic expectations and a lack of meaningful consultation

17. General practice is facing unprecedented workload pressures, the effect of an ageing population and a reduction in the number of full-time equivalent GPs per 100,000 people.[5] GPs are working to meet the demands placed upon them by patients and the wider system, but they are working over and above full capacity. Primary care networks are an opportunity to ease some workload pressures by bringing dedicated new resources into primary care, and this contributed to the success of getting practices to sign up to the Network DES and achieve the 100% coverage that NHSE/I currently have. These service specifications should not ask primary care to take on more work until the current workload pressures have begun to be reduced. Practices will no longer sign up to the Network DES if they feel they will be held responsible for delivering on unrealistic expectations of extra workload. The RCGP has already seen evidence of this across the country, as different organisations recommend that practices hand back the contract for their network.[6]

18. The RCGP is concerned that the additional work that is outlined in these specifications will hinder GPs ability to deliver the acute care required of them, outside of the Network DES, in the GMS contract. Additional requirements in some services, particularly when specified to be delivered by the GP, will divert the key skills of this finite workforce and may impact negatively on patient access to general practice overall at a time when there is a focus on improving access for patients more generally.

19. The College is concerned that the development of primary care networks as organisations in their own right will be hampered, as practices that decide to continue to participate in the Network DES are driven towards tick-box implementation. Emerging networks will be overloaded as they attempt to build trust within their networks while also trying to understand how to implement services that have been developed in relative isolation. The

[4] Matland, R *Synthesizing the Implementation Literature: The ambiguity-conflict model of policy implementation* Journal of Public Administration Research and Theory, 5(1995):2:145-174
[5] P Johnson, E Kelly, T Lee, et al *Securing the future: funding health and social care to the 2030s*, Institute for Fiscal Studies and The Health Foundation, 2018
[6] http://www.pulsetoday.co.uk/news/pcns-and-more-lmcs-urge-practices-to-withdraw-from-network-contract/20039972.article

development of the networks will be overshadowed by the requirements outlined in the specifications, making it difficult for them to mature in the way they would be able to without this kind of top-down pressure. Practices that are overloaded will not be able to engage with the wider cultural changes that networks offer, which will lead to a less meaningful implementation of the policy, and failure to achieve the laudable objectives outlined in each service specification.[7]

20. The College believes that these resources would be better used in helping PCNs develop their workforce/shared vision that they have been working on in the last year, while a two-way engagement exercise is undertaken to allow the profession to properly shape the service specifications. This would mean that they reflect the reality of general practice on the ground, make the workforce feel bought in to the end result, and ensure that networks address the issues that are important to them. This will go some way to ensuring success of PCNs further down the line and will ultimately benefit primary care and the patients that it serves.

The Service Specifications

Structured Medication Review

21. The RCGP supports the overall objective of the structured medication review (SMR) specification, which is aligned to one of this year's QOF QI programmes. The aim for PCNs to use recognised tools to stratify their patients and implement an SMR for patients most at risk of harm from their polypharmacy is appropriate and laudable. However, the document requires more clarity in the guidance on how to achieve this objective. The specification confuses the patient safety focus in an SMR with other objectives related to reducing certain types of prescriptions across the system. This must be more clearly separated within the document.

22. The specification makes recommendations for a number of different tools to assist in identifying patients who will benefit from a SMR. The College would like to see the specification recommend only tools that have been shown to be effective at identifying patients without creating a list that is too long to be properly managed. EPACT2 identifies patients who are deemed to be at risk from harm from problematic polypharmacy and compares Practice/ PCN position to CCG, Regional and national picture. This has been shown to identify a reasonable number of patients, can be tailored by each network to address prescribing issues within a locality, and allows for national comparisons.[8]

23. The metrics for this specification are confusing, given their focus on elements of prescribing that should not be the focus of SMRs. The RCGP would like to see these metrics simplified and more clearly aimed at measuring the successful implementation of SMRs. This could include qualitative monitoring of the processes used to identify the patients who would benefit from a SMR. Metrics such as the prescribing rate of low carbon inhalers, or the rate of anti-microbial medication should be removed from this specification.

Enhanced Health in Care Homes

24. RCGP supports work that improves the care for people living in care homes and the broad objectives of this specification. In order to make progress to achieve this aim, this specification must be subject to an extended and more in-depth development process. This will help to develop a specification that adds value to work that is already being done in this area in different places.

[7] Prof F D R Hobbs et al, *Clinical workload in UK primary care: a retrospective analysis of 100million consultations in England*, 2007–14, The Lancet, 2016

[8] https://www.hsj.co.uk/the-hsj-awards/hsj-awards-2019-patient-safety-award/7026233.article (last accessed 13/01/2020)

25. The College has had a lot of feedback from members regarding the services that are subject to local enhanced service agreements. These services have taken a long time to develop and are funded separately. The proposed blanket implementation of this service model will have a destabilising effect on the work that is already going on, as commissioners and providers look to ensure services are not double funded. There have already been recommendations from some areas to not sign up to the network contract DES on this basis, as it will set back significant gains across care home health in many different areas.[9]

26. The EHCH specification has been developed from evidence produced from the Vanguard project. This evidence identifies a number of different factors that contribute to the success of a service, including co-production. This service specification has not been subject to co-production with patient groups and the workforce that are being asked to deliver it, which has led to the creation of a specification that is excessively prescriptive.[10] The inherent variability in care home services across the country will make meaningful implementation of this service model almost impossible, as it cannot be adapted to local requirements and populations.

27. There are other factors that have been identified in evaluating the vanguard sites, but not all of this learning can be generalised to all localities where conditions are different. For example, significant funding was dedicated to the vanguard sites to specifically develop in these areas, and these systems chose to focus on these services.[11] This is not the same as requiring systems to make these changes alongside four other specifications, while developing a team and a new organisation. More time must be given to allow systems to consider the care home services they are already running, consider the evidence that the EHCH has to offer and apply the most relevant aspects to add value at a local level without destabilising work that is already underway as part of local enhanced services.

28. The specification as it stands represents extra work required of GPs who are already under pressure from excessive workload and risks diverting GPs and other clinical staff from managing requests from patients for improved access. This will be exacerbated in networks with more care homes than others and the workload requirement cannot be fully understood until networks can be sure of how resources will be fairly divided. We also have concerns regarding the capacity of wider multidisciplinary teams to meet the increased workload, particularly if they are new to primary care and are taking time to build their skills in a new area.

29. The RCGP considers the timescale for the implementation of this specification to be unrealistic, given the amount of time that is required to build the foundations needed to run an effective network. Good team working across organisations takes time and must be supported by digital and physical infrastructure, but the current specification does not take into account these hurdles. The deadline in this document of 30 June 2020 for many elements of this specification is less than a year since all primary care networks went live. The RCGP would like the timescale for implementation of any EHCH service specification to be revised to ensure it is realistic and achievable.

Anticipatory Care

30. The RCGP supports the aims of the anticipatory care service specification as a means to support patients to be healthier for longer. General practice has a long tradition of working to understand and treat the whole patient and a model to proactively help patients

[9] https://www.easterncheshireccg.nhs.uk/Downloads/News-Events/BGS%20Poster%20-%20version%205.pdf (last accessed 13/01/2020)
[10] https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf (last accessed 13/01/2020)
[11] https://www.research.manchester.ac.uk/portal/files/103375904/Interim_report_of_the_NCM_external_evaluation_final_v1.pdf (last accessed 13/01/2020)

contributes to that aim. However, as with other specifications, this service model has not been subject to enough consultation across the sector and has unrealistic expectations in relation to timescales.

31. The RCGP would like to see broader requirements in the national specification. The current draft outlines the patient groups that networks should focus on. This reduces the impact that professional judgement, local patient stratification exercises and local priorities can have in shaping the service. This will ultimately hinder the success of this programme. Prioritisation should not be dictated by NHSE/I; it should be decided upon by the network based on the outcomes of the population stratification exercise and the professional judgements of the clinicians involved.

32. The development and implementation of a successful anticipatory care model is also highly dependent on having the right staff from a variety of organisations, building relationships amongst that team, and reaching a shared understanding of the model. This must happen while also continuing with business as usual. The RCGP call on NHSE/I to reconsider the timeframe and service requirements of this specification to create a service specification that is more realistic and will truly add value for patients.

33. The RCGP would like to see a reconsideration of the proposed metrics in this area. This is a challenging area to evaluate with quantitative measures, and the current metrics will lead to extra bureaucratic work that adds little value to patient care. NHSE/I could consider establishing a more qualitative monitoring process for services such as anticipatory care that would be locally applicable and relevant.

Personalised Care

34. The RCGP is strongly in favour of investing in and promoting the personalised care agenda, and the aim of this specification is laudable. We would like to see more consideration of how the objectives of this specification can be aligned with the requirements in some of the other areas in this document, in particular the EHCH and Early Cancer Diagnosis specifications. This is particularly important as networks are attempting to understand the different objectives across the requirements on PCNs and how they fit together. More engagement is required with the professions to ensure all specifications are internally consistent in their aims and to ensure that the content is full aligned with the work programme of the yet-to-be-established Personalised Care Institute.

35. The Universal Personalised Care programme shows that individuals are better able to self-manage with access to health coaching, amongst other interventions.[12] The current draft document does not mention health coaching at all, even in plans for future years. Health coaching is an intervention with a strong evidence-base in supporting self-management, improving health outcomes, and optimising healthcare usage and a continued plan for supporting implementation of health coaching would be a useful addition to this programme.

36. A measure of meaningful implementation is embedding this into the practice of the workforce across the system, and we are not convinced that quantitative methods are functionally capable of measuring the quality of these discussions without reducing measurements to a tick box. The College would like to see more information on how a quantitative metric can be developed that records the quality of personalised care conversations with validity. It would be more useful to measure the training and support being offered to networks to embed these practices. This would ensure that staff have a detailed understanding and appreciation of the way that person centred care enhances the quality of health care, patient experience and health outcomes. Systems and networks

[12] https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf (last accessed 13/01/2020)

should then be encouraged to qualitatively evaluate their implementation of these principles in every day work over time as part of their professional responsibilities.

Supporting Early Cancer Diagnosis

37. This objective of early cancer diagnosis in patients whose outcomes would benefit from early detection of cancer is again an ambition that the RCGP supports. The implementation of the service specification in its current form will not be able to meet that objective, particularly if it is to dovetail with the implementation of the personalised care agenda. The RCGP calls for more engagement with the profession to co-produce a service specification that will meet the objective, supporting patients to make an informed choice regarding cancer screening and investigations.

38. There is a body of evidence that demonstrates the risks of overdiagnosis for patients encouraged into screening without adequate information on the outcomes in screening programmes.[13,14,15] Overdiagnosis subjects patients to unnecessary interventions, needless stress for patients and loved ones, and contributes to resource and workload burden within the system. The RCGP would like to see more consideration of the risks of overdiagnosis as part of this specification.

39. The proposed metrics for this specification, similar to the metrics in the other specifications, cannot measure the value of the implementation of the early cancer diagnosis service model. Blanket measurements of patients undertaking screening, regardless of risk or personal circumstances, will be a perverse incentive to screen patients in direct contradiction to the aims of the personalised care specification. The RCGP would like to see more consideration of how to measure the early diagnosis of cancer in patients who have made an informed choice to be screened/investigated.[16,17]

40. The RCGP would like to see metrics aimed at supporting reflective practice and improving referral pathways, especially for those patients with serious but non-specific symptoms. However, feedback from members is that improving access to diagnostic services and especially imaging will be required and in particular removing some of the current barriers that prevent general practitioners accessing MRI and CT scanning in particular.

[13] Independent UK Panel on Breast Cancer Screening "The benefits and harms of breast cancer screening: an independent review 2012 *The Lancet* 380(9855) 1778-1786

[14] Kalager, M et al. "Overdiagnosis in Colorectal Cancer Screening: Time to Acknowledge a Blind Spot" 2018 *Gastroenterology*, 155(3) 592-595

[15] Bulliard, J. & Chiolero, A., Screening and overdiagnosis: public health implications. *Public Health Rev* 2015 **36(**8)

[16] Smith SK et al. "A decision aid to support informed choices about bowel cancer screening among adults with low education: randomised controlled trial" 2010 *BMJ* 341;c5370

[17] Lillie SE, Partin MR, Rice K, et al. Washington DC: Department of Veterans Affairs (US); 2014 Sep.