The King's Fund

Ideas that change health care

Consultation response

Network contract direct enhanced service: draft outline service specifications

There is a capacity crisis in general practice, with insufficient available workforce to meet current levels of demand (Beech *et al* 2019). The King's Fund welcomed the five-year GP contract framework published in 2019 but raised concerns about the capacity to deliver its aims: to stabilise general practice; to act as a key link between general practice and the rest of the health and care system; and to deliver key elements of the NHS long-term plan, through a set of new service specifications.

The urgent action needed to stabilise general practice, by addressing workload and workforce issues, raises important questions around the timing, implementation and pace of these new service specifications even though the overall direction they set out is the right one.

The King's Fund, along with other commentators, has cautioned against primary care networks (PCNs) being set up to fail by requiring them to take on too much too quickly. While the consultation document acknowledges this risk and suggests a staged implementation, we believe the tasks required for 2020/21 are undeliverable and will not allow PCNs to focus on stabilising general practice, addressing the pressures that are manifesting in declining patient satisfaction with access to services and issues of retention in the GP workforce.

We have significant concerns that GPs will believe that the demands of the specifications will far outweigh the benefits and, therefore, practices may choose not to sign up for this voluntary contract extension. This has the potential to threaten the future of the otherwise promising PCN model, jeopardising the benefits PCNs may deliver for patients, and limiting their ability to meet challenges identified by the Prime Minister and the NHS Chief Executive of addressing workload and improving patient access to appointments.

We welcome the opportunity to contribute to the network contract direct enhanced service (DES) draft service specifications. Our detailed response below draws on our policy research, including our work on general practice, care homes, community services, social

care and place-based care; and our work providing leadership and organisational development support to PCNs.

Collaborative working and relationship building

Our experience of supporting developing PCNs across England has given us insight into the realities of establishing the effective relationships that are required for these complex collaborations to be successful. While many GP practices were already collaborating in some ways, in many instances PCN relationships are very new and evidence shows that this type of collaborative leadership model needs significant support and time if it is to develop effectively (Timmins 2019; Timmins 2015)

The draft specifications assume that PCNs are already effective and include organisations outside general practice even though our experience suggests that, for most PCNs, active membership only comes from GP practices. This means that in reality it will fall to general practice to lead most areas of the complex system development required by the specifications. The draft standard NHS contract (currently out for consultation) will require providers of community health services to work with PCNs to deliver the specifications but this is not the case for other parts of the health and care system and wider public services. Crucially, there has not yet been adequate time for newly formed PCNs and their complex networks of local partners to build the relationships that serve as the foundation for developing and implementing these services.

Funding

The current draft DES raises serious questions as to whether the funding available to PCNs adequately addresses the full resource requirements required to deliver the specifications. Much of the funding is attached to recruiting new roles, but practices will be required to contribute from their core income to supplement this (apart from social prescribing roles which are fully funded). Estimates of the amount practices must contribute vary but this is likely to equate to more than 30 per cent of the total cost of the new staff because of on-costs, training, supervision and the need to recruit staff at the top of pay bands because of the level of independence and expertise required. Other payments (such as the participation payment) may not, in our opinion, fully cover the costs of practice participation in networks, which includes providing practice manager support, GP backfill to take on clinical leadership roles, support for multidisciplinary teams and the supervision of new staff. This is on top of to the additional workload for general practitioners generated by the service specifications, which we address below.

Many of the specifications also require significant investment in technology, such as mobile technology to document care home rounds, and in estates, which is an issue for many practices that do not currently have the space or IT infrastructure for extra staff. These requirements are not currently funded in the DES.

GPs were enthusiastic about new PCNs and prepared to invest in the new roles and with their own time when the five-year framework was launched, but we are concerned that the additional workload that these specifications require from PCNs, which does not seem equal to the investment allocated, will have significant implications for the success of

PCNs. NHS England and NHS Improvement should be transparent around its rationale and demonstrate clearly how the current allocations will be sufficient to enable PCNs to meet the expectations set out in the DES.

Workforce

Significant additional workforce will be needed to deliver the five service specifications. This is on top of addressing the well-documented workload pressures that exist in general practice (Baird *et al* 2016). We question the evidence that lies behind paragraph 1.12 of the consultation document:

> *Providing that PCNs move forward swiftly to engage new staff and use their additional roles reimbursement entitlement, there will be significant additional capacity within primary care in 2020/21 to deliver the specifications…This would provide more than sufficient capacity to deliver the requirements across all five services with significant capacity remaining for these additional roles to provide wider support to GP workforce pressures by handling appointments or queries that would otherwise have been the responsibly of the GP.*

Our experience and understanding of the current pressures on general practice suggest that new roles funded through the DES may **not** be sufficient to absorb the additional workload, either directly or indirectly, required by these demanding services while also delivering reduced pressure on GPs. This is especially true in the short term as the capacity-releasing benefits from services like anticipatory care will take some time to manifest. Much like on funding, NHS England and NHS Improvement must be transparent around the reasoning and analysis behind its justification and show robustly that it is true.

There also remain questions around whether enough additional staff will be in place by April 2020 to begin delivering these services. For example, our modelling work suggests the number of whole-time equivalent (WTE) pharmacists expected to be in place for the start of the specifications could only, realistically, be expected in general practice from 2023/24 (Beech *et al* 2019). This is backed up by suggestions that some PCNs are struggling to recruit pharmacists, particularly those with the level of qualifications and experience needed. Unless additional qualified and experienced prescribers are in place and able to undertake medications review, meeting the service requirements for 100 per cent coverage from year one will place significant pressure on GPs, especially as structured medication reviews are expected to take considerably longer than the standard GP appointment. With the Medicines Use Review Service no longer being commissioned from community pharmacy from 2021, many PCNs may also face additional pressure from the loss of this service.

While there is a suggestion that clinical commissioning groups can help with recruitment, our modelling suggests that even with this support recruitment will remain challenging.

If PCNs are to make the most of their new staff, multidisciplinary teams will also need time, backfill capacity and support to develop effective ways of teamworking. Relationships and trust need to be built before staff will feel able to delegate and share responsibilities with new team members (Baird *et al* 2018) while premises will need to be

adapted to house them (Beech *et al* 2019). Having staff in post ahead of April 2020 is not enough – teams also need to be ready to work effectively together to deliver these services.

The delivery of the specifications also includes assumptions about workforce capacity in community and mental health trusts that are already under pressure. For example, in *Closing the gap* we, with the Health Foundation and Nuffield Trust, noted the significant decline in WTE numbers of district nurses since September 2009 (Beech *et al* 2019) which limits the work this key staff group will be able to undertake.

Flexibility in priority setting

While recognising that the specifications reflect the ambitions of the NHS long-term plan, they do not allow enough local flexibility for PCNs to set priorities that meet the particular needs of their local population. Evidence has shown that the most successful primary care collaborations have developed over many years, building on shared objectives and allowing innovation, creativity and discretionary effort to flourish to meet the needs of the local population (Rosen *et al* 2017). This might involve improving mental health, managing deprivation, personalised care, social prescribing. We have previously articulated concerns that the lack of flexibility by which roles can be funded through the DES will not allow PCNs to adequately meet local need (Baird and Bell 2019).

A realistic alternative might be to see the specifications as a menu of options for delivery, depending on local need, with the possibility for PCNs, working within local systems, to develop and deliver their own equivalent programmes and priorities, taking into account local population need.

Implementation support

We believe the preparatory work required to deliver these specifications has been underestimated. The vanguard programmes, on which some of the specifications are based, received significant resources, particularly external implementation and project management support, which is not provided under these service specifications. As an example, the requirement to re-register care home patients to align them with a PCN in many areas will require significant work. The structured medications reviews will also require significant groundwork to identify at-risk patients, implement new tools and processes, ensure staff are clear about expectations and skills needed for reviews, and design action plans for reducing prescribing of certain types of medications.

All these specifications are predicated on collaborative leadership across complex systems. These relationships take significant time, leadership and organisational development input to support which is not consistent with the timelines required in these specifications.

Equity

The specifications as written do not explicitly address the inverse care law and there is a risk that unless equity is considered in all service specifications health inequalities will widen. The metrics do not allow for nuanced interpretation of the impact of deprivation on

delivery. For example, the structured medication reviews specification will be particularly challenging in areas of high complexity and deprivation where polypharmacy is more common, but patients are harder to engage. These reviews are likely to be more complex and require more time per individual patient and are likely to require more GP input (rather than clinical pharmacist/advanced nurse practitioners). The proportion of patients with complex needs who would benefit from anticipatory care is also likely to be higher in areas of deprivation, with a greater proactive effort and resource needed to engage people because of language and literacy barriers, and high levels of drug and alcohol dependence and mental health issues.

It is also clear that distribution of care homes is varied across the country, but further analysis is needed to understand this variation so that PCNs in areas with a high concentration of care homes are not disadvantaged.

Metrics

The suitability of indicators, and their usefulness and impact, will depend on clarity about the aims of measurement. This is missing from the service specification, which suggests that these metrics will measure for improvement (for example, benchmarking against peers) and measurement for judgement (for example, access to the improvement and investment fund). Benchmarking metrics can be broader, designed to prompt further investigation and action where needed, and not as a definitive measure of performance in itself. Metrics for judgement require an unambiguous measure of performance where there is no doubt about attribution (Raleigh and Foot 2010). The metrics attached to the service specifications should be adjusted to make clear their purpose and any that are used for judgement must clearly demonstrate a direct link between actions in primary care and the desired outcomes, otherwise general practice may risk being penalised for issues beyond its influence.

Conclusion

We have set out here our concerns that these service specifications will not be deliverable in their current form, with suggestions for how this might be ameliorated. If the ambitions set out within the NHS long-term plan are to be effectively delivered at a time when general practice is under significant pressure, PCNs must be able to focus on stabilising general practice, improving access for patients and focusing on a small number of locally owned priorities. The rate-limiting factor for the maintenance of existing services and even more, the introduction of any new one, is capacity within general practice. While the DES provides resources to help increase this capacity, the workforce needed is not yet in place and the specifications as written, along with the wider ambitions for PCNs, cannot be delivered.

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