Somerset Local Medical Committee Commentary
Network Contact Direct Enhanced Service. Draft Outline Service Specifications

This was published by NHS England & NHS Improvement (NHSE&I) on Dec 23rd with a deadline for comments to be submitted via a survey by Jan 14th a fact which I intend to pass over without comment. The introduction rehearses the five year GP contract agreement "Investment & Evolution" which aimed to alleviate workforce pressures, secure investment into primary care through Primary Care Networks (PCNs) and to encourage new service models working with other providers to improve preventive and active care for patients. Despite what one commentator has called "industrial" primary care and others "organised" primary care the ambition is to preserve what is best about traditional primary care by offering more personalised and better coordinated care to local populations. To help achieve these local needs there were seven national service specifications with five starting in April and two more in 2021. The five are:

- Structured Medication Reviews (SMRs)
- Enhanced Health in Care Homes (EHCH),
- Anticipatory Care
- Personalised Care
- Supporting Early Cancer Diagnosis.

This paper is to set out the outline of the first five specifications and to obtain feedback to shape the final version. The survey asks for comments in the form of free-text in various domains and so one has to wonder how NHSE&I will collate thousands of responses in time for the April start date? Nevertheless the LMC is encouraging colleagues to make their views known and hopes that this commentary will help.

NHSE&I say that they recognise the early stages of PCN development and concerns about overburdening them with unrealistic expectations and so propose to phase-in the requirements. However it should be noted that these delays really only amount to a few months with June and September this year featuring heavily in what then follows. NHSE&I say they expect the PCN DES will not only improve services to patients but reduce the workload on primary care. One can only assume that this reduction will also be phased-in. Key to all of this will be the recruitment of new health care professionals (HCPs) through the Additional Role Reimbursement Scheme (ARRS) and joint working with community providers. The ARRS could provide three whole time equivalent (WTE) clinical pharmacists, 1.5 WTE social prescribers, half a physiotherapist and half a physician associate FROM April 2020 and so "[t]his would provide more than sufficient capacity to deliver the requirements across all five services with significant capacity remaining for those additional roles to provide wider support to GP workforce pressures…" What will happen if PCNs cannot recruit is not specified but it must be understood that the aims in this paper is for HCPs enlisted through the ARRS to do much of the work although there are also specifications for GP leads and face-to-face ward rounds in care homes, for example (see below). Quite what impact a 0.5 WTE physio could make to 30,000 patients is not speculated upon but CCGs and Integrated Care Systems (STPs) will be "asked" to support PCNs and community providers to institute shared workforce models. The £1.50 per registered patient is expected to be used for this work and (surprisingly to this reviewer) the 0.25 FTE funding to support the clinical director of each PCN is also factored in. The so far mysterious Impact & Investment Fund will also be available to PCNs "making strong progress" and could be worth £60k to an average PCN in 2020-21. Community services are also promised more cash over the next five years which they will expected to use for co-delivery of EHCH and Anticipatory Care. It must also be acknowledged that there is considerable overlap between the five services which will

tend to benefit many of the same people. CCGs will be expected to coordinate and support local delivery and to help PCNs get value for money documented in local agreements. The LMC will have a role in brokering these deals although this latter point is so far only a "recommendation" which Somerset LMC will be insisting upon making an essential. It is also acknowledged that where funding for similar, existing schemes is through LESs these are likely to cease unless they exceed the national requirements. LMCs will be involved with the CCG in any transition period. Existing CCG LES spending will have to be reinvested in primary care rather than spent on deficit reduction.

SMRs are introduced with a recommendation from NICE together with a more dubious estimate of how much money could be saved if admissions from the adverse effects of "unnecessary medications" were avoided. Low carbon alternative metered dose inhalers (MDIs) also get a surprisingly high priority. Pilot schemes have shown the importance of clinical pharmacists in undertaking SMRs. Given that clinical pharmacists have been available for PCNs to recruit from April 2019 NHSE&I expect this service to be fully delivered from April 2020.
Those eligible for a SMR form a very wide group including everyone in a care home, anyone with polypharmacy, those with multiple LTCs, those prescribed high numbers of pain management medicines, the frail, the housebound and those recently admitted after a fall. Tools such as Eclipse Live can be used to find these people.
SMRs will be conducted by HCPs able to prescribe and with advanced assessment and history taking skills or those in training to do so. An SMR will take "considerably longer than an average GP appointment…" SMRs will not, however, just be a one-off exercise but will be expected at least once a year. For stable patients, attending for LTC reviews for example, the expectation of a formal SMR would increase workload.
From April each PCN must identify clinical lead, run locally-defined searches at least six monthly to find the SMR population and provide "written communication" to each patient. We can only hope that this will include email and text messaging. SMRs must be offered to 100% of those eligible unless the CCG is persuaded that there are capacity constraints when all reasonable attempts to recruit had been made.
Each PCN will develop action plans to reduce antibiotic, medicines of low priority and potentially addictive drugs. It might be easier if the middle group was simply blacklisted centrally?
There is a rather simplistic list of metrics including the number of SMRs, those areas listed above and also the low carbon MDIs.

EHCH starts with a statement on the number of people living in care homes and how many emergency bed days they generate. Not said is the obvious fact that the very last place a person should be admitted to hospital from is a care home. Yet it is admitted that residents often get poorer LTC and medication reviews. Implementation is a national priority and so NHSE&I will be expecting "all STPs and CCGs to prioritise full and successful delivery." It is a massive amount of work and the mind-set in community services that district nurses etc. cannot go into nursing homes will be the first challenge. On the other hand, are not the fee-payers already paying for equivalent services in care homes? Community services are, of course, also being provided by outreach services to care home such as the LARCH team from TST. There is also a wide variation in concentration of care homes – all are included except for psychiatric secure units. There are, for example, 19 each of the Burnham-on-Sea and Minehead areas, 16 in Yeovil but only 14 in the Taunton area although some there will be very large. (Health warning - these figures include supporting living units which are not included in the ECHC.)

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By the end of June each PCN should have a clinical lead and a named clinical team for every resident. Each care home should be aligned with a single PCN and new residents "supported" to re-register with a practice in the aligned PCN. Shared care records and data sharing with governance and accountability should be established.

From the end of September there should be a weekly "in person" "home round" led by a Professional who will be a GP at least once a fortnight (a consultant geriatrician may be substituted) and the group of staff attending should be "consistent." Every resident should have a mutually agreed care plan within seven days of being admitted and it should be reviewed within seven days of each hospital discharge. Controversially – but probably desirably – the PCN is expected to support care home staff in shared training and learning. Will care home owners be expected to contribute to costs? Communications between hospitals and community-based services are expected to be streamlined with better data sharing.
The metrics here are also unsophisticated including emergency admissions and urgent home visits, the number of appointments that result from a home round and the number of SMRs. Rather more esoterically the number of delirium risk assessments made will also be measured.

Anticipatory Care risks reheating the old Avoiding Unnecessary Admissions DES but we can only hope "lessons have been learned." In fact one can begin to see at this point how this melds with the first two. It is good to see the words "clinical judgement" used in this section at least. Nevertheless a standardised approach to identify worthy recipients of a care plan will be developed in the future from early experiences using care record and public health data.
From the end of June there should be the inevitable clinical lead to support development of the data but to start with a list of higher risk patients. An MDT needs to be formed to coordinate their care. This will include offering SMRs to those not otherwise eligible (hard to envisage), social prescribing, signposting, needs assessments and doing patient activation measures (PAMs) to see what impact all this might have. All these will be metrics.

Personalised care is designed to be "business as usual" in the NHS in the first chapter of the NHS Long Term Plan to give people choice and control over the way care is planned and delivered. Cynics have added "as long as they agree with us." Social prescribing is seen as the beginning of this process leading to community-based support and self-management and ultimately personal health budgets (PHBs).
In 2020-21 personal care and support plans are expected for at least 5-10:100 weighted population including those in the last 12 months of life and all those in the Anticipatory Care and EHCH cohorts. PHBs are to be encouraged. Shared decision making should come into physiotherapy led consultations for joint pains. Social prescribing is also allocated a "required number of referrals" of 4-8:1000 weight population (never mind the quality…?) but PAMs will be taken those referred and from newly diagnosed Type 2 diabetics.
In 2021-22 and subsequent years all these areas will be expanded as the ARRS gets bigger.

Supporting Early Cancer Diagnosis is the final section with an ambition that by 2028 cancers diagnosed at stages 1 and 2 will be 75% of cases rather than 50% now. This will involve primary care working with local Cancer Alliances and secondary care. PCNs will standardise the identification, referral and safety-netting of people with suspected cancers.

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Predictably another clinical lead is needed this year. But referral from practices must be improved in line with NICE guidance and using a new Rapid Cancer Diagnosis pathway for those with vague symptoms. (In a separate document on RCD centres it is stated that 8% of such patients may have a cancer but one cannot help wondering if that refers to 8% of those referred bearing how ubiquitous certainly transient "vague symptoms" can be.) As the years go by the ante is progressively upped with some sort of standardisation of safety-netting (surely more than the habitual, "if things don't get better, or you are concerned, come and see me again"? but surely not another routine appointment "just in case"?) and local screening uptake action plans.

In conclusion it has been remarked that this could indeed be described as representing the "industrialisation" rather than "organisation" of primary care. Whether the holy grail of demand reduction will be achieved and GP workload reduced will be a matter of faith. Papers like this which are created after speaking to experts never hesitate to add to workload of other people and so everything becomes a priority: this is a paper which starts with an acknowledgement of this risk of overburdening embryonic PCNs. However, it is also worth recalling that GPs and practices are not being expected to undertake this massive amount of work (or anything like it if "consultation" does mean anything?) alone but together with other community providers which nowadays include hospital trusts. The EHCH scheme in particular is mandated to require the support of ICSs (STPs) and CCGs to encourage working across boundaries. How private care home owners and staff will be integrated will be interesting.

We are encouraged that LMCs are to be involved in transition arrangements like winding up of existing LESs and that the funding must be recycled. We remain anxious that acting on all these good intentions will not "bolster" existing primary care as PCNs were supposed to do at first. The number of clinical leads needed alone risks the whole thing failing.

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