Network Contract Direct Enhanced Service (DES)
Draft Outline Service Specifications

Sheffield LMC

Sheffield LMC's Response
January 2020

This is a National DES and, therefore, voluntary for practices to sign up to.

It is important to recognise that the delivery of the 5 clinical specifications within the Network DES for 2020/21 is based on no funding uplift and that NHS England (NHSE) considers the staff provided through the Additional Roles Reimbursement Scheme (ARRS), alongside the £1.76 per head practice engagement and £1.50 per head Primary Care Network (PCN) funding are sufficient to deliver these.

The comments need to be read alongside the document itself:
https://www.engage.england.nhs.uk/survey/primary-care-networks-service-specifications/supporting_documents/Draft%20PCN%20Service%20Specifications%20December%202019.pdf

Section 1: Introduction

1.4 The "phasing in" of specifications to be delivered by PCNs and staff employed under the ARRS does not take account of some PCNs having no access to recruit trained staff. LMC Conference was clear that PCNs had not reduced workload and were unlikely to do so.

1.8 Will use of the Network Dashboard be compulsory and who will develop it?

1.11 This is expected to be delivered solely through the ARRS. "…providing delivery of specs and alleviating workforce pressures". This is actually a lot of extra work that will be partially funded by practices (30% contribution to ARRS + management fees + salaries higher than National expectation).

1.12 Section 1.4 discussed PCNs being at the early stages of development but NHSE are now saying "provided they move swiftly" - these are not compatible.

1.14 Practices are already finding that £1.76 per head engagement is not enough to cover the current management of the PCN let alone the expanded vision here. £1.50 per head for the PCN will not even cover the ARRS contribution and so practices will be expected to pay towards delivery of new services. The Clinical Director (CD) role at 2 sessions per week is not enough to provide leadership currently.

1.15 What are the workload implications to practices to try and attain the funding suggested and is it really achievable?

1.16 This suggests some loss of GP control over some aspects of patient care.

1.19 If Clinical Commissioning Groups (CCGs) are expected to support Standard Operating Procedures, under whose governance regulations would this be implemented? This is primary care and should follow primary care governance. Will Integrated Care Systems (ICSs) really engage with LMCs? They haven't so far.

1.21 This dilutes autonomy further with control of staff being even more distant from practice control.

1.24 By reinvesting Locally Commissioned Services (LCSs) it will detract from the PCN specs. As the PCN DES only provides partial funding for staff, not necessarily the right staff, so removing any funding will affect service provision.

Section 2: Structured Medication Review (SMR) and Medicines Optimisation

2.5 Some areas have been unable to recruit staff so how can the spec be delivered in full by April 2020?

2.6 It suggests SMRs "may" reduce GP appointments but there is no evidence this is the case.

2.8 This will require practices to spend more time searching databases. This activity is not funded through the ARRS and will increase practice workload.

2.9 What guidance is available around reactive referrals and how onerous are they to implement?

2.10 Clinical Pharmacists have to be prescribers and this level of Clinical Pharmacist is not adequately funded through the ARRS. Advanced Nurse Practitioners and GPs are not funded at all through the ARRS to deliver this.

2.12 The practice will need to develop and supervise a recall system. This administrative activity is not funded through the PCN DES.

2.13 Reviewing inhalers because of environmental concerns is not a medical decision and will increase workload.

2.15 A clinical lead that will not be funded by the PCN DES. Who identifies the local criteria - the PCN itself or CCG / ICS?

2.16 Metric 3 might contravene legal obligations to provide prescriptions to patients who need them and ask for them.

2.17 The suggestion here is to perform badly in 2019/20 so that your baseline is poor!

Section 3: Enhanced Health in Care Home

3.5 Significant local spend on Care Home initiatives needs to be maintained / enhanced alongside the ARRS.

3.7/8 There needs to be a clear definition of each organisation's roles and responsibilities otherwise actions will get missed.

3.9 PCNs are not legal entities so it is difficult to see how commissioning could be done at PCN level.

3.13 This seems broader than the Care Home LCS definition and there may be expectation of delivery without any local funding in some cases.

3.16 Again a lead clinician who will have a considerable co-ordinating workload unfunded through the PCN DES. Where is the accountability of different organisations in supporting "The team"?

- 6: Weekly clinician ward rounds led by a GP at least every other week. GPs are not funded to do this through the PCN DES and if CCGs remove local funding this will become unviable.
- 7: Reviews that are unfunded.
- 10: Co-ordinating with the wider healthcare system. GP management engagement that is unfunded through the PCN DES.
- 11: Further GP co-ordinating work that is unfunded.

The targets set in this section are very much about reducing activity in secondary care, rather than primary care targets.

Section 4: Anticipatory Care

4.8 Presumably PCNs can choose their own target populations.

4.9 This requires PCNs to collect data from other organisations to target care. These organisations may not co-operate. This is further unfunded administrative and clinical activity.

4.12. 1: Requires a clinical lead who will have managerial oversight. This is not funded in the DES.

These activities used to be funded through LCSs for Annual Care Programming. This contract provides no funding to deliver a much expanded remit and requires a significant amount of GP clinical lead and management time, alongside administrative workload that is unfunded.

Section 5: Personalised Care

5.4 Information "suggests" this could reduce GP appointments. This "suggests" there is no statistically significant reduction in workload.

5.6 Although there is a phased implementation there is no extra staff or funding to deliver this. If there is a " …required number of social prescriptions" what sanctions are there if you over / under prescribe? 4-8:1000 over how long?

5.7 Again a clinical lead that is unfunded.

How do you identify people in the last 12 months of life? The only accurate way is posthumously!

Who can define further cohort options? PCNs themselves or from CCGs / ICSs / NHSE?

Why is it the PCNs job to promote personal health budgets? They are health care delivery collaborations.

Training will require time and budgets.

5.8.2 How do you measure the "quality" of care and support plans?

5.8.4 How do you measure the "quality" of shared decision making conversations?

5.8.7 Again why is a health care delivery collaboration being measured on personal health budgets?

Section 6: Supporting Early Cancer Diagnosis

6.1 This does not address lead time bias. If we are diagnosing cancer earlier are patients living longer with a diagnosis or are they actually living longer? Does secondary care have the capacity in terms of diagnostics, oncology and psychological support to deal with these extra patients?

6.7 Again clinical leadership is required in a new role to collaborate with other organisations. Again this is unfunded in the DES.

6.11 Safety netting is a further workload on general practice, how will this be remunerated? This will increase clinical liability in primary care. How can you measure safety netting? Who will measure safety netting?

6.12 Another clinical lead that will have significant management role that is unfunded. You can try and invite people in different ways to engage in the National screening programme, but it is their autonomous decision as to whether to engage.

Funding Considerations

"This programme is expected to be delivered by 3 Clinical Pharmacists, 1.5 Social Prescribing Link Workers, 0.5 Physiotherapists and 0.5 Physician's Associates."

The ARRS and £1.50 per head Network fund is wholly inadequate to cover these costs. We are finding it impossible to source Clinical Pharmacists at the NHSE refundable rate, and due to the nature of PCNs these staff can only be employed through third party agencies. This incurs significant management costs and potential VAT implications. Without VAT each Clinical Pharmacist in our area costs a Network £23k to employ, after re-imbursements. Just the Clinical Pharmacists would cost more than the Network allowance, meaning practices are going to have to pay themselves to delivery far more services. The costs of the other staff will inflate this sum significantly.

Clinical Directors (CDs)

Given the hugely expanded remit of PCNs in this proposal CD would need to expand their time dedication to this role. 1 day per week is not nearly enough and the anathema of variable pay due to list size is not lost on our CDs. A CD role will become a full-time commitment for each PCN and will either need to be funded or roles will become rapidly unfilled.

Clinical Leads

Each of the 5 new domains require clinical leads who will not only be responsible for delivery of each area but also liaison with an increasing number of care provider organisations. These are significant new management roles that will be unfunded as currently suggested.

I would envisage these roles will require a senior clinician to spend 1-2 sessions a week co-ordinating these activities. With 5 areas that is 10 sessions of activity that needs to be funded. This is 520 sessions at £100 per hour and 4 hours per session a year or £208k required for clinical management. On top of this is the need for additional non-clinical and administrative support within PCNs. This is nowhere near covered by £1.76 per head to engage with PCNs.

Workload / Workforce

Every aspect of this document encourages increased workload in primary care, some of it clinical, much of it clinical management. Delivery of this increased workload is expected to be partly funded by the clinicians delivering the extra care.

Worst of all it will draw senior clinicians away from frontline, face-to-face, clinical roles at a time when general practice is sorely lacking in clinicians. This threatens the very existence of many practices, the building blocks of PCNs.

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