



## COMMUNITY NETWORK RESPONSE TO PCN DES DRAFT SERVICE SPECIFICATIONS, JANUARY 2020

### INTRODUCTION

The community network is the national voice for NHS community services in England. Established by NHS Providers and NHS Confederation, the network brings together and represents NHS and not-for-profit organisations providing NHS community health services.

We appreciate the opportunity to feed back on the draft service specifications, and were pleased to see that representatives from the community health services sector were involved in the working groups that preceded them. This response reflects feedback from the network as well our observations from the wider engagement process. We have focused on anticipatory care and enhanced health in care homes as the key areas for community providers, and assumed that what is set out in and accompanies the specifications will apply to community services provided by community interest companies and social enterprises as well as NHS trusts and foundation trusts.

### OVERALL COMMENTS

While the specifications are clearly well-intentioned and represent the right direction of travel, there are currently a number of issues which warrant further refinement. The service specifications must avoid overloading Primary Care Networks (PCNs) or destabilising trusts and other partners, instead focussing on developing local partnerships and supporting existing good practice. More clarity is necessary on how funding flows will function, and on some of the practical detail – for example, if the DES is voluntary, what would happen in a neighbourhood if the PCN or a number of its practices chose to reject it?

During the webinars that informed the engagement process there has been ongoing confusion about whether the purpose of PCNs is primarily to stabilise and support the primary care system, or whether it is more focussed on bringing primary care providers together with the full range of local partners to deliver integrated care to local communities. It would be helpful if NHS England and Improvement were to articulate the relative weighting of these twin objectives clearly and consistently, reminding local partners that they are expected to meet both (if indeed this is the case).

For example, the draft service specifications document states that the establishment of PCNs will improve links between providers of primary and community services ‘so that general practice feels much more connected and supported by the wider NHS system.’ We would suggest that PCNs should aspire to create an environment where all providers in a neighbourhood– whether primary, community, mental health or other – feel equally supported by the wider NHS system.

## TIMESCALE AND FUNDING

As the draft specifications were released just before Christmas with a deadline for response of 15 January, we are concerned that providers and others who are crucial to their delivery will not have had sufficient time to engage in detail and provide a fully considered response. With the refined specifications themselves due to be taken forward into further negotiations with GPs, the status of the engagement exercise - and therefore the opportunity for respondents to influence eventual outcomes - is unfortunately unclear.

During the webinars that have taken place as part of the engagement exercise, we have also picked up on concerns from a range of stakeholders about whether the timescale for change is realistic. NHS England and Improvement has helpfully acknowledged that PCNs are at varying stages of maturity, and yet national deadlines have been suggested which may not be attainable for some. We also wonder what would happen in a situation where a locally-developed service was delivering good outcomes but not in line with the models proposed – presumably it would be forced to change, which seems out of kilter with the wider drive for locally-developed solutions to population health issues.

CCGs are being asked not to take final decisions about existing locally commissioned services that cover some or all of the areas covered by these specifications until the final Network Contract DES for 20/21 is published. We are concerned that, with the final contract unlikely to arrive until shortly before the beginning of the new financial year, this approach will leave some local areas uncertain about their immediate future. The document states that 'it may in the meantime be appropriate for them (CCGs) to maintain delivery of a service where it currently exceeds the national requirements for 2020/21' - in practice, we wonder what the incentive would be for a CCG to do this.

The pace of change must match, rather than precede, funding growth over the course of the next four years. The back-loaded nature of growth money for community services means that next year's addition may barely cover ongoing demographic growth and service pressures, let alone the implementation of new specifications.. Furthermore, agreeing protocols, pathways and MDT processes with all the PCNs in their footprint (86 in one example we are aware of) on a one to one basis will be a huge change management task for community providers. This task will require resourcing, but most of the growth funding will not flow until years three and four.

## WORKFORCE

We share concerns with others about the potential workforce implications of the new service specifications. The engagement document notes that the additional roles represent 'a major uplift in the workforce capacity of primary care' but that is only the case if sufficient new staff can be recruited and trained without depleting teams elsewhere in the local area or disrupting recruitment plans. There are costs to employing new members of staff that are not covered by salary – such as training and appropriate supervision.

There are already examples of good partnership work in this area - for example an ambulance trust agreeing to employ paramedics on behalf of local PCNs. PCNs could work in partnership with trusts and others to help create opportunities for more creative and flexible careers within a local health

economy, but there is an immediate risk that their efforts to recruit risk disrupting an already overstretched workforce with a limited pool of applicants particularly if PCNs are able to recruit more flexibly above the agenda for change offer. It would be helpful to have more detail about how the workforce needed to achieve the specifications has been modelled. It will take time to recruit and train sufficient staff, which needs to be reflected realistically in the timescales.

## MODELS AND METRICS

We also wonder whether setting out relatively prescriptive service models with activity-based metrics on a national basis is in conflict with the principles that PCNs should be developing services that meet the needs of their local population – for example, setting a fixed ward round regularity for everyone rather than allowing PCNs to set their own more flexible models. As some colleagues pointed out during the engagement process, some PCNs include very few care homes.

We are concerned that as many of the metrics are activity- rather than outcome-based, this may create perverse incentives and risk distracting from the goal of providing integrated care across multidisciplinary teams in order to deliver better patient outcomes. It is important that the need for some transactional measures does not obscure the vision for better outcomes, achieved through partners working together effectively. These measures must also reflect the reality of working in primary and community services today, in what can be a very stretched and challenging environment.

More work will also need to be done to ensure that people working across PCNs have access to information technology that allows them to deliver and report on the specifications, such as shared care records and integrated systems. NHS England and Improvement will need to support the delivery of this technology so there is national consistency around reporting templates and capability for example by working with providers of digital systems.

## ENHANCED HEALTH IN CARE HOMES

On enhanced health in care homes, the focus on frail older people is welcome. However, this should not be to the detriment of older people living with frailty on their own homes. It's reassuring to see that the specification covers aspects of both physical and mental health.

There is wide variation in distribution of care homes. The specification acknowledges that this is an issue for GPs and PCNs to be addressed in contract negotiations. However, it is not addressed for community service providers. Whilst the specification acknowledges this for GPs and PCNs as an issue to be clarified in the contract negotiations this isn't addressed for the community service providers. When numbers of care homes can vary dramatically between areas, how will CCGs with relatively high numbers of care homes be able to commission services from community providers unless their allocation of funding is weighted to reflect this? We would also appreciate more detail on how the implications of the new specifications on social services budgets and activity have been explored, and how any concerns from social care leaders have been addressed.

We are also concerned that encouraging each care home to align to a single PCN may conflict with the principle of patient choice, especially where people have longstanding relationships with their current healthcare professionals. Should patients choose to reregister with a new PCN, it would be good to see more detail on how arrangements would be made for EHCH activities to be delivered by their registered practice. It would also be helpful to see in more detail the rationale between 'home rounds'

being delivered by a GP, and in person. This is one area where technology may offer more flexible solutions.

## ANTICIPATORY CARE

Although the focus on anticipatory care in the Ageing Well programme is understandably on older patients living with frailty, it's important that this approach and learning is extended more widely, including to mental health and children's services. We would also appreciate more detail on the tools that will be available/approved for population segmentation.

**Contact:** We would be happy to discuss our response further, and to facilitate further engagement with the community network. Please contact: Rebecca Owen-Evans, Community Policy Manager, [rebecca.owen-evans@nhsproviders.org](mailto:rebecca.owen-evans@nhsproviders.org)