



## NEW NHS ALLIANCE'S RESPONSE TO CONSULTATION ON THE PCN SERVICE SPECIFICATIONS

15 January 2020

### **About New NHS Alliance**

New NHS Alliance is a UK-wide cross-sector movement of professionals and local people working as equal partners to address and reduce health inequalities.

Our mission is: *to increase the number of years people live in good health in every community.*

Members are people who want to see this change happen across our health and care systems. They are drawn from the NHS, local authorities, housing, the voluntary and community sector and people with lived experience of disadvantage and poor health. Collectively we know a huge amount about what makes and keeps people well and how build a 'social model of health' that would serve disadvantaged communities much better. They join the New NHS Alliance for free and become part of the movement: <https://www.nhsalliance.org/associate-members/>.

Through our movement we aim to unlock that knowledge and support spread and implementation know-how across our systems.

### **General comments about the specifications**

We are struck by the task-focused nature of all the specifications which don't embrace the shift to 'population health'. We don't think is the right way to go.

We had hoped that the argument about the need for outcome measures that focus on the actual outcomes for patients (what happens as a result of the treatment or intervention and responding to the 'what matters to me' question) was starting to be won. However, the focus in these specifications is on the number of tasks that primary care undertakes (what they do to people) with little reference to outcomes for people or indeed for the system. We know that tasks and outcomes don't correlate so this is disappointing. The specifications/metrics as they stand will continue to feed the 'tick-box' approach to meeting the specifications – they give an illusion of impact but they only count activity. They are at odds with an initiative that aspires to change relationships and bring quality to life

We sense that GPs and primary care want this to change because they want to be able to do more for their patients and for their jobs to be more fulfilling than this.

We would prefer to see many more outcome metrics that demonstrate engagement with patients, communities and local partner and a commitment to listening and responding to them. These will necessarily have some qualitative aspects to them.

In addition to outcome-specifications (and not instead of) there is a need to ensure that primary care are making changes for the most disadvantaged patients (with local partners). Could there be a way of overlaying the outcomes against the Index of Multiple Deprivation (IMD) so that we can see the trend over time across the range of 'deprivation' geographies? This will help to measure how the gap in health outcomes across the range of geographies is changing over time. ScotPHO has recently published a useful document on 'indicator specifications' for equality indicators that could provide some useful insights (there is a section on primary care):

<http://www.healthscotland.scot/media/2919/health-and-social-care-indicator-specifications.pdf>

While we understand that the purpose of these specifications is the DES Contract and not to measure inequality per se, these specifications will drive what gets done in primary care. If we are to have a stronger focus on prevention and reducing health inequalities in primary care (as per the 7<sup>th</sup> service specification) then we need the DES Contract to drive the right actions and they need to be outcome-focused. So, it is essential that these DES specification are outcome-focused.

We note that there is no mention of a social model of health, Health Creation, nor of how well general practice is connecting with the community or with local partners. All of these are essential if primary care is to stand a chance of contributing to a reduction in health inequalities.

## **Q1. Are there additional requirements we should consider for inclusion which have delivered benefits in your area?**

- **Encouraging a broader mix of skills – for community engagement, relationship building**

The statement in 1.1.2, that '*Recruitment decisions by PCNs will depend on their priorities but an average PCN could – indicatively – engage around 3 WTE clinical pharmacists, 1.5 WTE social prescribing link workers, 0.5 WTE physiotherapists and 0.5 WTE physician associates from April 2020*' is unhelpful because it directs attention to existing NHS-funded roles rather than assisting PCNs to think more widely about the roles they might fund.

Through our work, we are aware of one instance in which skills held by Community Development workers are being used by a PCN (Modality) to transform General Practice, enabling better connections and trust-building between practices and the populations they serve.

PCNs also need to employ people with relationship-building and negotiation skills to make the **'shared workforce models'** (mentioned in 1.1.3) actually work for all local partners; these things don't happen without some dedicated resource. Community Pharmacy is another type of role and Patient Champions could also be employed to do valuable community-connecting work.

There is a need for a much broader mix of skills than is featured in the list above in order for general practice and primary care to draw on the immense resources of local partners and within local communities. This was a strong message at our event on 'How can PCNs succeed in reducing health inequalities' – see this event report here:

[https://www.nhsalliance.org/wp-content/uploads/2019/10/PCNs-conference-report\\_3.0.pdf](https://www.nhsalliance.org/wp-content/uploads/2019/10/PCNs-conference-report_3.0.pdf)

We would like to see Community Development, Cross-sector relationship builders, Community Pharmacy and Patient Champions also listed alongside the other roles in order to make PCNs think more widely about the roles and skill mix they require.

- **Building on existing activity of local partners rather than starting from scratch**

For many elements, there are non-NHS local partners already some way down the road to 'delivering' some of them and their efforts would work much better if general practice is engaged. It's important that the PCNs don't feel that they're starting from scratch, nor that they have to lead all of this – rather that they are expected to contribute to, help shape, build from and progress initiatives that are already underway in their local area.

Just one example is one of the metrics for Enhanced Health in Care Homes says ... *"From no later than 30 June 2020, establish and manage a multidisciplinary team (MDT) of professionals, working across organisational boundaries to develop and monitor personalised care and support plans, and the support offers defined in them, for people living in care homes."* This assumes that there is no pre-existing support plans already in place and that GPs will be starting from scratch.

A better alternative wording might be *'Establish the status of existing support planning activity and, working in partnership with professionals from across organisational boundaries, develop a multi-disciplinary process for developing and monitoring personalised care and support plans containing both social and clinical elements, for people living in care homes'*.

This is also happening in relation to social prescribing. There are already a range of 'community navigators', 'local area coordinators' and other similarly named roles being undertaken in communities to help people to identify, find and connect with the activities that would be of most help to them. This role is very similar to the new NHS-funded Link Workers. It is really important that the Link Workers work alongside the existing practitioners – for example building on locality asset-mapping that has already been done – rather than starting from scratch.

These specifications need to expect general practice to build relationships and work in partnership with local partners and communities and they need to describe ways of doing this. These need to be seen to be THE way to deliver the specifications (which need to be on a reasonable timescale). If sufficient time is not given then PCNs will be overwhelmed and community and non-NHS partners will feel pushed-aside.

- **Basing practice on Health Creation**

There is good evidence that Health Creation, especially through community strengthening, has a positive impact on health generally.

In poor communities and excluded groups, the biggest drivers of poor health are disconnectedness, hopelessness, despair. To be well, people need sufficient of the ‘3Cs of Health Creation’; Control over the circumstances of their lives, meaningful and constructive Contact with other people, Confidence to take action with others to make improvements. The route to improving their health is to support them to increase their levels of Control, Contact and Confidence. (See here for more information on the 3 Cs and 5 features of Health Creation: <https://www.nhsalliance.org/health-creation/> )

There are examples from across the country of these approaches improving engagement of communities and clinicians in better understanding of the underlying causes of poor health and what some of the solutions might be. These interventions may be particularly useful in PCNs in deprived areas, with literacy, language, poverty and other problems. The Alvanley Practice in Stockport, the Grantham Practice in Stockwell London, Hope Citadel in Oldham and – along with many others – are all practicing in health creating ways with their communities and getting good outcomes (ie. improvements in population health).

We would like to see these approaches reflected in the metrics and incentivised. These and other practices that practice Health Creation need to be at the forefront of designing these Service Specifications.

## **Q2. Are there any areas where we could clarify the service requirements further?**

- **Enhanced health in care homes**

Paragraph 3.1 says that ... *‘Supported living environments and extra care facilities are not currently in scope for this service but may be covered by other services to be delivered through the network contract DES, including anticipatory care, medications reviews and personalised care’.*

We would suggest that Extra Care Schemes should be seen as ‘phase 2’ of this – to be worked on at a later stage where this is not already being offered within extra care already. The reason is that the trend is towards building more extra care and to prevent escalation towards the requirement for full scale residential or nursing care. In some

places, residential and nursing homes are over-used and people are going into them before they need such a high level of support; many of those areas are looking at alternative less intensive ways of providing accommodation based support for older people such as extra care.

- **Anticipatory Care**

We understand that there is some speculation as to whether this specification could be removed from this year's Specification.

We hope this is not the case because some elements of 'Anticipatory Care' are already being practiced to some degree by non-NHS partners in many places – through development from Making Every Contact Count (that is now practiced quite widely across sectors) and 'Early Help' models that have emerged from the Troubled Families Initiative. Some areas have 'Healthy Homes' and similarly-named schemes already in operation – named this because most people spend most time in their homes (not in health institutions).

Work on 'risk stratification' being undertaken in general practice and elsewhere is badly needed because anticipatory care needs to be based on good data. The key thing here is sharing and interpreting data from a wide range of sources and coordinated cross-sector approaches to dealing with the problems that arise. It is important that the valuable work of community groups is recognised and built into this approach. A shift to Multi-disciplinary Team working should be paving the way for general practice to be more central to this way of working in a locality because this can go a long way towards addressing health inequalities.

Working in this way requires a commitment to working in partnership and we know that these take time to develop. We would like to see primary care make progress in developing the necessary local relationships (as set out above) and for this Specification to be brought back in a much better form at a later date.

New NHS Alliance would be pleased to lead a project to develop a better set of Metrics around Anticipatory Care.

- **Cancer Diagnosis**

While we have not done any direct work on cancer diagnosis, a project NNHSA undertook with Leeds Hepatitis C infected Sex Workers showed a seven-fold increase in the number of women diagnosed and cured of hepatitis C over 12 months (from 1 in previous 12 months to 7 now). This was achieved by employing the '5 features of health

creating practices' with local partners (See: <https://www.nhsalliance.org/health-creation/>).

We believe that a similar approach could also work with diagnosis and treatment of other 'diseases of inequality' as well as cancer and diabetes 2. A fundamentally different way of thinking about the role of Service Specifications in enabling the primary care workforce to become equipped with skills in Health Creation, including to aid early diagnosis with partners, is needed.

- **Personalised care**

While 2 of the 7 specifications here focus on 'quality' they nevertheless are pretty much numbers-based. We are concerned that there is not specification on the 'quality' of social prescribing nor on what 'good social prescribing' might look like.

Evidence is emerging from a number of universities that are undertaking research into social prescribing, that it is not achieving the outcomes hoped for. We know that there are some good models of SP that do lead to better outcomes and some less good ones that are transactional in nature and that the most disadvantaged people can't make use of. These latter versions do little to meet the stated desired outcomes of the UPC programme.

We need measures that are more nuanced and that can differentiate between the 'good' SP and the 'bad' SP ... just measuring the numbers referred is a long way from doing this. It is purely about activity it tells us nothing about where people went, what their needs were, what difference this "prescription" made to their lives and what costs the referral placed on others such as the community or the voluntary sector.

One suggestion for an alternative being put forward by Prof Mark Gamsu, a professor in local democracy and health inequalities, is set out below:

*"I suggest that Instead every primary care network is required to hold a yearly workshop with people who have received "social prescriptions" local community organisations and local voluntary sector. This meeting should discuss the difference that social prescribing made, the challenges that it faced and the actions that need to be taken to improve it.*

*The report from this meeting should go to the practices in the PCN, the CCG and to NHS England. The National Academy for Social Prescribing should be required to analyse these and produce recommendations back to DHSC and NHS England".*

We also believe that PCNs should take into account the emerging research findings on the effectiveness and impact of social prescribing within this process.

### **Q3. What other practical implementation support could CCGs and Integrated Care Systems provide to help support implementation of the service requirements?**

New NHS Alliance would be happy to work with CCGs, ICSs and NHSE to develop and support, insights, collaborative workshops to explore how PCNs could implement the Health Creation and community strengthening aspects of these specifications. We understand there is some way to go before it is 'business as usual', however, we have access and contacts with a wide variety of places doing this kind of work and can bring insights from other sectors who could be great local partners to general practice. For example, we could arrange cross-PCN visits and links between those places finding aspects hard and those who seem to be managing them better. This can be and is being done; we want to support the spread of this work.

#### **Q4. Is the proposed approach to phasing in service requirements appropriate?**

It is a big ask of newly-formed PCNs to be taking all these on so swiftly. There appear to be a range of difficulties, including recruitment problems and a sense that these specifications impose a set of centrally structured demands that, in some places, may shrink the ability of PCNs to follow the paths they feel they need to tread.

#### **Q5. What good practice are you able to share with other sites to assist with delivering the suggested service requirements?**

We already share good practice through our diverse membership, at our events and through our publications. We would like to do more of this and would be very happy to work with NHS England and NHS Improvement to build our capacity to do so.

#### **Q.6 Of the set of metrics proposed for each service, which individual metric best represents of successful delivery of the specification?**

Some metrics are worded better than others eg. 'Outcome measurement to monitor impact of SMR' gives a sense that outcomes are important but the lack of an explanation as to how this will be done leaves many questions.

#### **Finally ...**

New NHS Alliance would like an early discussion on the nature/structure of the 7<sup>th</sup> Service Specification on 'delivering locally agreed action on health inequalities' so that we can proactively assist NHSE in shaping the content of that specification. We suspect that this specification might be quite different and it is a theme that we will be exploring further with partners at our events on 'PCNs and health inequalities' during February and March.

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