Draft Outline Service Specification – NHSE&I Engagement

The draft service specifications are subject to an engagement approach. The full documentation can be accessed here. The following is included in the introduction of the document.

The GP contract framework set out seven national services specifications that will be added to the Network Contract DES: five starting from April 2020, and a further two from April 2021. **The purpose of this document is to provide PCNs, community services providers, wider system partners and the public with further detail of – and seek views on – the draft outline requirements for the first five services, as well as how we plan to phase and support implementation. Feedback we receive will shape the final version of the service requirements for 2019/20, as well as guidance for implementation. The five services are:**

- Structured Medication Reviews and Optimisation
- Enhanced Health in Care Homes (jointly with community services providers)
- Anticipatory Care (jointly with community services providers)
- Personalised Care; and
- Supporting Early Cancer Diagnosis

JD FINAL
15 January 2020

Oxfordshire CCG response to PCN DES draft specifications

1. Is there anything else that we should consider for inclusion as a requirement in this service? For example, are there approaches that have delivered benefits in your area that you think we should consider for inclusion?

The CCG welcome the opportunity to provide feedback on the draft specifications. We value having consistent specifications across the county which over time will deliver benefits to our patients. However our practices and PCNs have expressed strong concerns to us regarding the complexity of the specifications and the tight time scale for delivery. Our suggestion would be that the specifications are phased more slowly with some of the additional roles funding being redirected to delivery of the specifications whilst maintaining some underlying principles:

- The specifications should not just be delivered by GPs but a multidisciplinary approach should be taken
- Care Homes and Anticipatory care should, as proposed, be jointly delivered by community services Trusts and PCNs to promote and strengthen further integration
- Specifications would remain directed at Network level (and not revert to practice)
- PCNs and Commissioners could choose which specifications to deliver first in response to population health need rather than a one size fits all approach
- Milestones should remain but the full specification should be delivered over a much longer time period by year 4
- Consideration should be given to the impact on the sustainability of individual practices in terms of delivery of the specification
- Clinical governance around delivery will need to be explicit

It should be remembered that the preface of PCNS was to

- To stabilise general practice
- To encourage ground-up development of plans according to local need; this in turn is likely to have a knock-on system benefit

The specs in their current form do not appear to support these important principles. This makes them harder to sell to practices and other local providers.

We understand and welcome the reference to Community Trusts in the draft specifications as well as in the NHS Standard Contract from 2020/21 which is out for consultation. However, if would be beneficial if this was a little more flexible as some of the services referenced might currently be provided by acute trusts and ISTCs e.g. re-ablement services and Ambulatory outreach provided by acute Trust and MSK by a third party provider.

Below is some feedback from the CCG which is specific to individual services especially where we have experience of local delivery.

Generally we feel that the specifications would benefit from

- links to the vanguard projects and areas which has already taken this approach (this was done well in the Long Term Plan)
- more clarification on the Impact and Investment Fund (IIF) and how this would link with the service specifications
- clarification on the governance approach to be taken to support multidisciplinary multi organisation working and delivery of the specifications
- Specific focus on addressing inequalities in each component
- The ability to have one Clinical Lead across multiple PCNs so as to make best use of the resource. Clarification should be provided that the Clinical Lead does not need to be a doctor
- Funding is not allocated directly for delivery of service specifications (funding is via additional staff). Funding is available up front for staffing but how will effective delivery/VFM be assessed?
- Funding for 100% of the roles with management on costs which decline over time
- The specification has a significant number of requirements for the PCN to deliver, but the document is not specific on how it should be achieved. This may lead to a variation in delivery within a CCG area, so the impact of services may be variable across the area.
- Clinical governance around delivery will need to be explicit

Specifically for:

Structured Medicines Reviews and Optimisation

- The intention of the proposed specification is really positive and does present a great opportunity for clinical pharmacy to effectively support primary care. However it could go further to support joined up working across CCGs and acute Trust medicines teams. There is a real danger in the way it is described in this current proposal that we will lose the opportunity to embed this properly especially given the lack of current resources currently in place to deliver.
- Aims are positive to directly tackle over-medication of patients including inappropriate use of antibiotics, supporting the government's antimicrobial resistance strategy, withdrawing medicines no longer needed and through NHS England led-programmes such as low priority prescribing, as well as support medicines optimisation more widely.
- Elderly population are highlighted as the patient group most likely to benefit from SMR. This is aligned with the AHSN Medicines Optimisation priority re Polypharmacy that is being rolled out nationally to CCGs/PCNs via local AHSN teams and should be more closely aligned with this work and the metrics that have already to support it.
- However some of the priority aims in the intention above ie antimicrobials and LPP will be prescribed in a much wider population therefore other strategies already in place through CCG Medicines Optimisation teams will need to continue/ be aligned to retain focus on these important elements of evidence based cost effective

prescribing. These should be separated out from this proposal as they are separate initiatives

Enhanced Health in Care Homes

- We would suggest clinical governance meetings at least twice a year for MDT specifically including senior care home staff/manager. Should cover incidents, falls, admissions, deaths not in preferred place of care etc.
- Include something about how flu outbreaks could be managed.
- Specify how PCN will work with Thames Valley PHE e.g. outbreak management & infection control.
- Is there an opportunity to include social care as part of the MDT.

2. Are there any aspects of the service requirements that are confusing or could be better clarified?

Generally

- links to the vanguard projects and areas which has already taken this approach (this was done well in the Long Term Plan)
- more clarification on the Impact and Investment Fund (IIF) and how this would link with the service specifications
- clarification on the governance approach to be taken to support multidisciplinary multi organisation working and delivery of the specifications
- Specific focus on addressing inequalities in each component

Structured Medication Review and Optimisation

- Some elements of meds optimisation work being included within the proposed metrics– LPP, AMR and medicines that cause dependency do not align with the SMR/polypharmacy intention. They are however national meds optimisation priorities and being worked on through other routes.

Enhanced Health in Care Homes

- Fee for care homes should not be flat based but based on a per bed formula
- Clarify responsibilities for training Care Home Staff as this is not an NHS responsibility (i.e. homes themselves or local authority?)
- Provide examples of personalised care plans – minimum requirements?
- More detail about the urgent response/crisis management service – particularly the nursing element into residential homes which seems to go beyond the District Nurse role – will CCGs have to commission this as a new service?
- More detail should be provided on the value of risk assessment for developing delirium? Is there any primary care related evidence for using the tool?
- How is the management of the MDTs intended to happen given that PCNs have very little management resource allocated? The role of the clinical lead is vague,

and the experience/background of this person is not clear. A clarification of the role and who can cover this would be appreciated.
- The 2 hour/2 day requirement is the same as Staying Well requirements and there is confusion of whether this sits in the EHCH specification or the community specification, as well as the funding for these services

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

Generally

- 100% of the additional roles funding with management on cost provided in the first two years of role release to promote and support uptake
- More workforce flexibility to allow interchangeability of some roles
- Greater resources to support transition phases – each of vanguard exemplar sites were afforded this resource investment to establish their new models of care
- Workforce plan from HEE that demonstrate that there will be sufficient new roles within in the market as it has been demonstrated that demand for workforce outstrips the supply
- Support for how to manage the market

Structured Medication Review and Optimisation

Action	Comments and proposals where CCG could support
Locally defined processes at least twice yearly on a six month basis	Need to standardise approach and develop template search for practices to identify patients
Need to set up template for practice search of patients as defined above once final specification published	CCG to produce or could this be done nationally by the IT providers
PCNs also need process for identifying patients who need to be referred for SMR reactively	Priority group should include eg following admission/fall. ? Good practice all discharge summaries to be reviewed on discharge by clinical pharmacist and also to identify patients for SMR referral.
Need to be offered to 100% of identified patients. Provide written communication to patients invited for SMR detailing process and intention of SMR	Proposal that practices/ PCNs send batch invite to patients – letter or text (CCG could develop template letter for PCNs to use) Will practices need to use locally agreed patient identification process? Could be a lot of variation on achievement if not.
Switch to low carbon inhalers where appropriate	This needs a managed approach as not appropriate for all patients. Patients need most appropriate/clinically appropriate inhaler. Patient choice/ decision aids can be used to support conversations. Guidance on this being produced as part of update of Oxfordshire respiratory guidelines. Patient decision aids to support patient conversations and choices eg NICE https://www.nice.org.uk/guidance/ng80/resources/inhaler

	s-for-asthma-patient-decision-aid-pdf-6727144573
Utilise best practice and clinical decision making tools to support SMRs	CCG could develop a best practice reference portal via webpage– e.g. NICE patient decision documents and Scottish Polypharmacy model. – 7 steps medication review approach which includes resources for patients and health care professionals
Develop PCN action plans to reduce inappropriate prescribing of antimicrobials, medicines that cause dependency (need to define) , and medicines of low priority in line with NHSE LPP.	CCG could develop draft action plans/audits and monitor through prescribing dashboard
Work with community pharmacy to ensure alignment with new medicines service and medicines reconciliation service	Need to link with community pharmacy PCN links – CCG to follow up with LPC to confirm names. Need to avoid duplication between services and improve communication/transfer of information between community pharmacy and PCNs/practices. Close working with LPC required.

Enhanced Health in Care Homes

In a large rural county, there is not an even distribution of care homes across PCNs. In Oxfordshire there are three PCN areas which have just over one third of the care homes and care home residents. The demands upon these PCNs will be significant.

- There needs to be guidance on how CCGs/ICSs should support the development of the partnership aspect of the PCN and community services, and how the clinical lead should oversee the delivery of services. The issue of governance between the parties is not sufficiently covered and needs to be strengthened.

Supporting Early Cancer Diagnosis

Action	Comments and proposals where CCG could support
PCNs need to identify clinical lead	Most practices have an assigned clinical cancer champion through cancer initiatives already taking place but significant resource to identify clinical lead for each element for every PCN. Could this be at network of network level?
Improve referral practice for suspected cancers, including recurrent cancers. This will be done by: - using local data including practice level data to explore local patterns in presentation and diagnosis of cancer. - enabling and supporting practices to improve the quality of their referrals	Need to standardise approach and develop template search for practices to identify patients Implementation of C the Signs and REGO systems to help with clinical decision support and referral

for suspected cancer, in line with NICE guidance and making use of Clinical Decision Support Tools and the new RDC pathway for people with serious but non-specific symptoms where available. - introducing a consistent approach to monitoring patients who have been referred urgently with suspected cancer or for further investigations	management Help with standardising process – I.T infrastructure to be put in place to help facilitate safe monitoring

4. To what extent do you think that the proposed approach to phasing the service requirements is manageable in your area?

We do not think that the specification as described is deliverable. We think that significant change is needed if primary care is to remain sustainable. This is related to phasing and the amount of resource available for implementation. Vanguard learning has demonstrated that implementation of major service change takes significant time and funding

More time should be allowed for:

- PCN Clinical directors and members of MDTs who will need training to deliver the new services. Time should be allowed for this to be commissioned and to ensure members have capacity to be trained.
- Those CCGs who already commission services similar to the specifications will need to allow sufficient time to safely transition from existing service to the new specification.
- PCNs to establish a local population health needs approach which would be lost with the number of requirements within the draft specifications

Structured Medication Reviews and Optimisation

- The new Structured Medication Review requirements should be directly enabled by the expansion of clinical pharmacists working in networks however PCNs are at different stages of recruitment of clinical pharmacists with varying competency, skills and knowledge. Some are part of the CPPE training programme. PCNS are unlikely to have workforce to fully deliver in 2020/21 & given the investment required directly from practices/PCN to fully recruit to additional roles this is a huge risk to sustainability of practices and PCNs.

- There is an expectation within the draft that SMRs are implemented in full in 2020/21 this seems unreasonable given the sustainability and workforce challenges and an approach to phase in of this full service requirement needs to be considered to manage this implementation successfully.
- Clarification has been sought as to whether there is an expectation that SMRs can only be undertaken by a prescriber however this would put further limitations on the resources currently available (& during 2020/21) to deliver this service as many clinical pharmacists have not yet completed the prescribing qualification.

Enhanced Health in Care

- The phasing is very short, and requires the EHCH provision to be fully operation by September. With a large number of PCNs, care homes and community services, the change programme will be significant, and in areas with larger population of care homes and care home residents there is a risk of delay.
- Given the significant numbers of vacancies for GPs and other clinicians (pharmacists, ANP, ECPs) in Oxfordshire there is a risk to delivery due to lack of capacity. The Community provider also has high levels of vacancies.
- Concerned about the need for systems & infrastructure to support shared records and information sharing – N3 connections, NHS Mail in care homes etc. may not be available in tight timescales.
- Turnover of care staff in care homes and high levels of vacancies means that implementing changes will be challenging. It will be particularly difficult where homes are struggling with quality issues identified by CQC.

Anticipatory Care

- Difficult to stratify patients which will take time
- Difficult to establish an MDT to look after cohorts identified for anticipatory care by June given current vacancies and pressures and even harder to deliver required interventions to timescales.

Supporting Early Cancer Diagnosis

We feel that the timeline for delivery of these specifications is too tight because

- There is a significant lack of access to communications training at all levels. A number of the areas of delivery require a whole practice approach and upskilling training is required for all levels of staff within the practices/PCNS in order for this to effective. This also extends to pharmacists and social prescribers. This is difficult to facilitate without additional funds.
- With regards to screening – Until the improvements are seen in terms of accessing up to date data from the screening hubs it is very difficult to proactively manage improvements in uptake. Practices require prior notification lists from all programmes and notices of those who have not attended/responded in a timely way so that they can effectively make an impact.

5. Do you have any examples of good practice that you can share with other sites to assist with delivering the suggested service requirements?

Oxfordshire CCG have a number of examples of good practice including

Structured Medication Reviews and Optimisation

Alignment with AHSN and CCG polypharmacy initiatives and resource to support delivery of structured medication review (AHSN Action Learning Sets on structured medication review as developed through Wessex AHSN)

Wessex AHSN: Medicines Optimisation

Enhanced Health in Care Homes

Oxfordshire CCG has separately commissioned a proactive GP service and a specialist nursing service, which covers 80% and 100% of care homes respectively. The outcomes for care home residents are good, and this is based upon a relationship which has developed between GPs, specialist nurses and the care home managers and nurses over a number of years. Oxfordshire care homes' performance, as measured by the CQC, rates Oxfordshire highest in terms of minimal impact upon the acute hospital sector.

Our locally commissioned service specification can be found at https://www.oxfordshireccg.nhs.uk/professional-resources/documents/primary-care/Locally-Commissioned-Services-2019-20/Proactive-GP-Support-to-Care-Homes-Service-LCS-2019-20.pdf

Although note we currently fund at £250/bed/pa. This ensures those with greatest number of beds are fairly renumbered.

Support early cancer diagnosis

The Oxford SCAN Pathway

The Cancer Quality Award Scheme currently being piloted implemented through the TVCA

The Quality Improvement Scheme implemented through the TVCA

Thames Valley Strategic Clinical Network

6. Referring to the 'proposed metrics' section of each of the services described in this document, which measures do you feel are most important in monitoring the delivery of the specification?

Structured Medication Reviews and Optimisation

- It is difficult to understand how the metrics will reflect and quantify impact of SMR on high risk (likely to be elderly/frail) cohort of patients as identified from the proposed.
- Given the cohort of patients identified as those who would most benefit SMRs it is not clear how the metrics described above would reflect the impact of SMR on the elderly/frail/those with complex polypharmacy cohort of patients. Perhaps alternative metrics should be similar to those on EPACT 2 dashboards eg

polypharmacy number of patients over 65 on 10 or more medicines, reduction in drugs with anticholinergic burden, anticoagulant plus antiplatelet, measures related to increase bleeding risk etc which may be a more informative indicator of impact of clinical medication review.

- Metric 1: need to know the number of patients offered SMR (in line with group considered to most benefit SMR as described within spec and expectation that 100% are offered SMR)
- Metric 2: Not SMART - how we will define this?
- Metric 3: ?NHSE low priority for prescribing metric available via Openprescribing at practice level for all 25 measures. Liothyronine is the main priority on this. For the majority of the rest Oxfordshire is well below average. Liothyronine has been a continued area of focus for a number of years to manage prescribing and RMOC guidance is now available which has been adopted locally. This metric is unlikely to be impacted by review of complex/frail elderly patients through SMR & something we (within Meds Opt CCG teams) are tackling anyway.
- Metric 4: It would be useful to clarify with a national list of low carbon inhalers as we understand that different MDIs have different propellants within differing carbon footprints. We acknowledge dry powder inhalers (DPIs) are likely to feature in the answer but unless we know the complete cradle to grave carbon footprint for all inhalers, I think this is difficult to measure meaningfully although agree the propellant in any pressurised device is likely to have the largest greenhouse gas impact. It is impossible/not appropriate to switch completely from MDIs. Patients need the most clinically appropriate product and patient factors need to be considered when considering such a change with discussion with patient. Useful patient resources available – NICE and will also include advice within local guidance (currently in development) Also important to note that any switch from SABA (certainly salbutamol) MDIs to DPIs will have a financial impact.
- Metric within Open prescribing at CCG and practice level for *MDIs prescribed as a proportion of all inhalers in BNF Chapter 3, excluding salbutamol.* This metric is unlikely to be impacted by review of complex/frail elderly patients through SMR & something we (within Meds Opt CCG teams) are tackling anyway.
- Metric 5: again, any national list? Or are we going with the 5 classes of drug named in the report to be found here:
- https://www.gov.uk/government/publications/prescribed-medicines-review-report ? there are a number of metrics within the EPACT2 medicines safety dashboard that could be used re benzodiazepines, z drugs, opioids, gabapentin/pregabalin and antidepressant usage is monitored through EPACT2 Mental Health dashboard. This metric is something meds opt teams are trying to address and covers a wider piece of work than the SMR review on complex frail elderly patients.
- Metric 6: monitoring anyway in line with national priority and local quality incentive scheme – EPACT2 antimicrobial stewardship metrics. This metric is unlikely to be impacted by review of complex/frail elderly patients through SMR & something we (within Meds Opt CCG teams) are tackling anyway.

Support cancer early diagnosis

- Metric 2: PCN-level participation in breast, bowel and cervical screening programmes – Not SMART how will this be defined?