

## **Consultation Response: Network Contract Direct Enhanced Service – Draft Outline Service Specifications**

National Voices is the leading coalition of health and social care charities in England. We work together to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them. We have more than 160 members covering a diverse range of health conditions and communities, connecting us with the experiences of millions of people.

National Voices has been involved in supporting the development of thinking about PCNs and wider primary care reform. We have been heartened by the genuine efforts from the Primary Care Team to involve us and use our insight. We have also appreciated the generally supportive approach to developing these specifications and requirements, including the opportunity to consult, and are therefore somewhat taken aback by the approach the specifications now take. We recognise that purdah will have had some impact on consultation timescales, but we are nonetheless disappointed that the timings have allowed little time, for example to engage our members with this process.

However, we look forward to continued engagement and have much to offer – our members know how to engage communities, including those far removed from formal services. They also hold data about unmet need, user priorities and user experience that is not reflected in ‘official’ datasets. The sector also holds useful models of facilitating and supporting community engagement with health services. The formal system has much to benefit from working with the VCSE locally and nationally, and we stand ready to help.

### **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?**

We are concerned that the specifications are already **overly prescriptive**. There is a risk that this approach promotes and incentivises box-ticking over the thoughtful, planned development and spread of existing good work. We must not allow existing good work to be destabilised or sidelined.

That said, we expected to see considerably more focus on reducing **health inequalities**, particularly within Anticipatory Care / population health management, and especially as tackling neighbourhood inequalities was originally proposed as one of the included services. Will enhanced funding be made available for PCNs with especially pronounced deprivation and inequalities?

Linked to this, we also expected to see an identified role for **patient and community engagement**. While data analysis and data science can be useful tools for population health management, their success is dependent upon identifying appropriate variables and having sufficient contextual knowledge to understand and interpret the results. We agree that predicting and identifying patients who are at risk of adverse health outcomes requires thoughtful preparation, including the sharing of information between partners (paragraph 4.2). We also agree that general practices “have a unique understanding of the health needs of the communities they serve” (4.9). However, we are unconvinced that centrally-mandated cohorts make sense (though centrally-*suggested* cohorts may be useful). For example, the Newham Central PCN and the West Somerset PCN – the former with a very small and the latter with a very large population of older people – will benefit from a different approach to population segmentation.

As another example, the NHS will not hold much useful data with regard to reducing the adverse health outcomes of violence, such as knife crime, but the local VCSE, schools, police and councils do hold data about the young people at risk. **The DES should focus on PCNs building those relationships** to find appropriate ways of sharing data, segmenting their population and responding to need. But the DES must be realistic about the amount of time it takes to build the relationships necessary to broker this sort of data sharing, as well as to establish the data sharing itself.

Patient and community engagement is an essential part of understanding the needs of PCN populations. It has been an integral part of the personalisation agenda since it began (some decades ago), so it is a surprise to see such **clinically-focused segmentation** and response being proposed – with no indication of asking communities “What matters to you?” The risk is you ‘cold call’ people in a community and tell them about their risk of X (e.g. because it’s often comorbid with their diagnosed condition Y), rather than engaging with people already connected with the valuable community assets of GP surgeries and asking them what would be useful. This proposed model is very **‘doing to’ rather than ‘doing with’** – the antithesis of what the personalisation agenda is about.

We also consider prioritising those “that are at a high risk of their condition progressing or circumstances or needs substantially changing **within the next six months**” (4.12(3)) to be something of an **‘acute’ criteria**. This will not reach people in middle-age who are already affected by multiple long-term conditions or already experiencing expedited effects of chronological ageing, e.g. people living in severe poverty, people who are insecurely housed or people living with an addiction. Through this very acute focus, the specification doesn’t address **inequalities** and their impact on people’s health much further upstream.

Finally, though we believe it’s important that PCNs are able to develop **social prescribing** services that build on their unique infrastructure, assets and relationships, we think it would be helpful to incorporate something about the **essential components of these services** to ensure some consistency in provision. NHS England’s guidance includes a useful summary of these: <https://www.england.nhs.uk/wp-content/uploads/2019/01/social-prescribing-community-based-support-summary-guide.pdf>.

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

Our understanding was that PCNs were proposed as a mechanism to stabilise general practice, so we are surprised and somewhat confused by the **quantity of extra work** described within the specifications. We welcome the injection of funding, but are confused as to how providing 70% of funding for extra roles that will be undertaking extra work is going to address the significant workforce capacity issues within general practice. Rather than introduce additional capacity into the workforce, this approach appears to leave a 30% deficit of unfunded activity, particularly within the first year. We are concerned that an onerous burden of new, under-funded responsibilities will lead to PCNs reverting to their former statuses and opting out of delivering some or all of the specifications. Such variation in provision and quality of provision would be unfair for patients and risks exacerbating inequalities. It will also be a sadly wasted opportunity to extend personalised care in general practice.

We need to see more recognition that for many people with ‘complexity’, the answer is not ‘more or better medicine’, but good care coordination, community support, social connection, and so on. The answer has to be embedded in and generated by communities, the voluntary sector, and in partnership with other local statutory agencies, and so on. The specifications must **avoid conflating problems with medical solutions with those that have non-medical solutions**.

We would welcome clarity as to who will be able to see the **Network Dashboard**. Our members are often challenged by requests and requirements to provide data to GP practices that are not reflexive, i.e. they are unable to see the results of their data collection and therefore to utilise and learn from these.

- Will partners, including those within the VCSE sector, be able to access some or all of the Network Dashboard?
- Will patients be able to access some or all of it?

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

We know there are a lot of good people stepping up into leadership roles for PCNs. It is important that they are supported in these roles, including being able to clearly define and delineate responsibilities in order to be able to grow and up-skill accordingly. The VCSE sector can help with this nationally and locally.

The most important practical implementation support that anyone can give in terms of delivering these service requirements is **time**. As we evidence in our response to Question 5, building functional networks takes time, stability and resource. Things like burdensome governance and unhelpful metrics actively hinder collaboration because they divert so much time, energy, resource and (crucially!) goodwill. Expecting PCNs to “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” by 30th June 2020 (3.16(4)) is unreasonable.

We had hoped the terms of the five-year contract could be agreed from the outset, offering stability to primary care and those it commissions and partners with, including VCSE

organisations and groups. We invariably find the set-up timetables for new services and the scaling timetables for existing services to be to be **underestimated**. We understood the intention was to reduce this level of continual renegotiation, but that does not seem to have been achieved. We welcome the recognition in paragraphs 1.22 and 1.23 that some services will already be commissioned to provide some or all elements of the specifications, but are concerned that, with the specifications set to be renegotiated over a five-year period, the existing good provision will inevitably be destabilised or lost during this process. We stand ready to work with NHS England and partners to try to mitigate this risk.

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

We appreciate that 1.18 recognises the overlap in specifications. There won't be a perfect way of doing this, and phasing is generally more sensible than expecting a 'big bang' launch. We can see some logic in leading with the services that have the greater weight of learning and good practice behind them, but do not feel this necessarily aligns to the evidence about how to implement personalised care.

Asking GPs to start with personalised care and support planning for people living in care homes means asking them to start with some of the people with the most pronounced and complex needs. **Splitting requirements** into shared decision making, social prescribing, segmentation and so on, also risks turning this change into a very **transactional** one. **We question this approach to large-scale culture change**. It ignores the wealth of evidence that many, including NHS England, have invested in to understand the enablers of personalised care, including the **time needed to facilitate teams to build skills, confidence and experience**. This is neatly pulled together in the work led by Sue Roberts on the Year of Care approach: <https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-019-1042-4>. In areas where teams did not have this in place, care and support planning approaches were "difficult to introduce, with poor clinical engagement or culture change; none were sustained". Pushing through specifications that do not allow time to do this groundwork not only threatens the success of these services, but also undermines the whole idea of 'Networks'.

#### **5. Do you have any examples of good practice that you can share with other sites to assist with delivering the suggested service requirements? Please email your examples to [england.contractengagement@nhs.net](mailto:england.contractengagement@nhs.net)**

As well as the Year of Care work (cited in Question 4) – which we assume is well-known within the relevant teams, it might be worth revisiting the work some of the larger National Voices members (Alzheimer's Society, Age UK, Macmillan Cancer Support, Diabetes UK and others) did together with and through the Richmond Group of Charities. It brings together a wealth of information about how to (and how not to) facilitate collaboration between primary care and its community partners.

The key learning points include the importance of:

- 1) Focusing on **outcomes** rather than outputs, because it's outcomes that help everyone understand what they're coming together to work towards, and it's outcomes that people from different organisations and perspectives get **enthused** about.

- 2) Recognising how much **time** it takes to develop truly collaborative relationships. As the Steering Group (including a former Secretary of State for Health and advisors to Number 10) noted: “like most analyses of creating new partnerships, the one obvious issue was needing time and effort to invest” into developing **relationships** across organisations with different cultures and ways of working [<https://richmondgroupofcharities.org.uk/news/tapping-much-greater-potential-help-nhs>].
- 3) Recognising that genuinely **devolving power from the top/centre** reaps greater rewards than restrictive governance [<https://www.nhsconfed.org/blog/2018/03/collaboration-is-not-for-control-freaks>].
- 4) Resourcing. Networks benefit from **bridging organisations** and people who make it their job to connect divergent cultures, language and priorities. They can bring people and organisations together by being ‘middle out’ rather than just top down or bottom up.

We commend the learning in New Philanthropy Capital’s evaluation of the work to you: <https://www.thinknpc.org/resource-hub/tapping-the-potential>. It strongly points to rolling back the requirements and allowing PCNs time in year one for building collaboration and **becoming actual networks**.

**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?**

We are keen to avoid any outcomes and incentives that lend themselves to box-ticking and strongly favour approaches that allow local communities to collaborate on the achievement of good outcomes for people, e.g. not the number of people who are referred to a link worker, but the outcomes of the actual services, facilities and resources that people engaged with. We encourage you to look at the **light touch indicators** Gateshead CCG has pursued for its scaling of personalised care and support planning within primary care.

We are also strongly opposed to metrics that invite and encourage **box-ticking and/or gaming**. PCNs are relatively immature, with some still quite fragile and a wide variation in readiness to implement these specifications. Heavy performance management and steep expectation is not the way to go. For example, tracking the “Number of individuals in the active cohort on the anticipatory care model given a referral to social prescribing service or where social prescribing is declined” (4.13(8)) could be achieved by contacting everyone within the active cohort with a poorly-worded note about social prescribing, yet we know that **people need these services to be clearly and encouragingly explained in order for them to want to engage** [see the research from BritainThinks]: [https://richmondgroupofcharities.org.uk/sites/default/files/field/image/final\\_for\\_website\\_-\\_dtrt\\_-\\_summary\\_of\\_learning\\_about\\_social\\_prescribing.pdf](https://richmondgroupofcharities.org.uk/sites/default/files/field/image/final_for_website_-_dtrt_-_summary_of_learning_about_social_prescribing.pdf)].

There is strong evidence that **ascribing output metrics to personalisation approaches kills ‘the spirit’ of personalisation**. For example, when this was done within Adult Social Care over a decade ago, ADASS was forced to issue an advice note to councils, imploring them to maintain the spirit of personalisation:

“Councils are exhorted to avoid ‘schemes’ to bolster personal budgets numbers at the expense of the wider Putting People First agenda. This includes simply converting existing users’ services to a monetary (£) figure and sending correspondence to say that this amount is now their personal budget. Without changing processes and culture, establishing support services, developing markets and altering commissioning arrangements, it is highly unlikely that real choice and control and better outcomes will result”.<sup>1</sup>

**This is a proven rather than hypothetical concern.** We *must* learn from rather than repeat the same mistakes again. We commend the ambition to accelerate the adoption of personalised and population health approaches. This important work is currently happening in small pockets of excellence and it’s difficult to spread – we struggle with this in the VCSE sector too. It’s a hard problem, for all of us, but we know that ascribing output metrics is not the solution to it. We know that spreading good practice and culture change only happens when people locally own the decisions, metrics and outcomes.

We feel the approach to change adopted in these specifications repeats mistakes made over and over in recent years – if we keep doing the same thing, we will get the same result. Primary care in many places is in crisis, with a demoralised workforce and growing pressures leading to lower satisfaction ratings by service users. If now is not the time to try a different approach to supporting change, then we don’t know when this time would ever be.

We have particular concerns about mandating use of the **PAM** within social prescribing. We understand that significant investment has been made into the PAM by NHS England and others, but **we have struggled to find any support for using it as an outcome measurement tool for social prescribing.** We understand that measuring activation as a concept might be a way to recognise that the choices and actions people take contribute to their outcomes, but the terminology of ‘activation’ is clunky, and the PAM approach to measurement is focused on a medical understanding of health rather than a more holistic understanding of health, wellbeing and social welfare. **The PAM questions focus on medication** rather than a broader view of equipment, physiotherapy and other non-drug therapies. It therefore doesn’t work within social prescribing – something that was emphasised in the discussion during the January 9<sup>th</sup> consultation webinar. **If people overcome social isolation and connect with an activity and people that gives purpose, then the question of whether they have the ‘knowledge to manage their condition/s’ is just utterly irrelevant.** This measure will lead to data collection that is not connected to purpose and therefore increase data burdens without benefits.

Where link workers have told us they’re using the PAM, it’s turned out they are adapting their administration on a case-by-case basis (e.g. selecting which questions to ask). It is not possible to access the calculation the PAM uses to turn a person’s response into a score from 0-100, as the developer will not release it and it is therefore impossible to understand how

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<sup>1</sup> ADASS (2010). *Personal budgets: Council Commissioned Services – Advice Note*. [Issued to Councils January 2010]. Available from: <https://www.yourlifedoncaster.co.uk/Resources/myLife/library/DOH/Council%20Commissioned%20Personal%20Budgets-%20Advice.pdf>

changes to its administration might affect its validation. We cannot see what use it will be if everyone administrates it differently through trying to fit this square peg into a round hole<sup>2</sup>.

There is **heartening recognition** within 3.16(7-8) and 4.12(5-6) that what really matters is the inclusion in plans of **people's personal goals** and the provision of "activities to support the achievement of goals identified as important to the person in their personalised care and support plan, including reasonable efforts to build links with local organisations outside of the home".

*This*, along with shared decision-making and building relationships and networks, is what person-centred care is all about. Monitoring the progress made on these things would be the most useful way to understand the necessary cultural change within primary care.

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<sup>2</sup> If an outcome measure must be adopted, then the Richmond Group of Charities undertook a piece of work on this that brought together learning from their charity members, along with expert views from practitioners, policy makers and academics.  
[https://richmondgroupofcharities.org.uk/sites/default/files/dtrt\\_summary\\_of\\_learning\\_about\\_outcomes\\_measurement\\_for\\_social\\_prescribing.pdf](https://richmondgroupofcharities.org.uk/sites/default/files/dtrt_summary_of_learning_about_outcomes_measurement_for_social_prescribing.pdf). They concluded the ONS Subjective Wellbeing Measure was probably the most useful, valid, reliable, responsive and ethical outcome measure for social prescribing. The Richmond Group's work also explores the possibility of measuring the goals that people set themselves and achieve.