

Network Contract Direct Enhanced Service

Draft Outline Service Specifications

NHS England and NHS Improvement



Version number: 1

First published: December 2019

Updated: NA

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Classification: Official - Draft

Publishing Approval Reference: 001238

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1. Introduction

- 1.1. **In January 2019, NHS England and GPC England agreed *Investment and Evolution***: a five-year GP contract framework which aimed to alleviate the workforce pressures on general practice, secure enhanced investment into primary medical care, and roll out new service models – in collaboration with community services and other providers – to secure major improvements in proactive and preventative care for patients. The GP contract framework, launched in January 2019, commits £978m of additional funding through the core practice contract and £1.799bn through a new Network Contract Direct Enhanced Service (DES) by 2023/24, as part of our wider commitment that, on current plans, funding for primary medical and community services will increase faster than the rest of the rising NHS budget over the next five years. **By 2023/24 spending on these services will rise by over £4.5 billion in real terms** – £7.1 billion in additional cash investment each year by the end of the period.
- 1.2. **A cornerstone of the new GP contract framework is the creation of primary care networks (PCNs) through the new Network Contract DES.** A PCN consists of groups of general practices working together with a range of local providers – including across primary care, community services, social care and the voluntary sector – offering more personalised, coordinated care to their local populations. There has been an enthusiastic response to PCNs across the country: over 99% of practices have signed up to participating in around 1,250 networks, firmly establishing PCNs as a route to greater collaboration across general practice and the wider NHS.
- 1.3. 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

- 1.4. **We recognise that PCNs are at the early stages of development and capacity-building**, and that there are concerns about limiting their chances of success by overburdening them at an early stage with unrealistic expectations for new service delivery. We therefore propose to **phase-in service requirements** in a way that is commensurate with the capacity available to PCNs through the contract and the support available through wider system. Though a combination of the additional workforce capacity within primary care, and the redesign of community services provision to link with and support PCNs, **we expect the Network Contract DES both to reduce workload pressures on GPs and support improved primary care services to patients.**
- 1.5. **The new PCN service specifications are only one part of the wider GP Contract package.** No decisions will be made on individual aspects of the Network DES and the core Practice Contract without considering all aspects in the round.

Developing the outline service specifications

- 1.6 **NHS England and NHS Improvement (NHSE/I) has undertaken a wide-ranging process of evidence-gathering and engagement in order to inform these outline service specifications.** This has included convening expert working groups for each of the five specifications, with representation from patients, working GPs and other clinicians, voluntary sector organisations (such as Cancer Research UK, Macmillan, and Age UK), NHS Providers Community Network, Local Government Association, commissioners, Royal College of General Practitioners, Public Health England and the British Medical Association. The input from these groups has been invaluable in shaping these proposals.
- 1.7 As a result of our engagement to date, we are confident that these specifications are supported by **a strong clinical evidence base** and will enable PCNs to draw upon the partnerships with other providers that are at the heart of the network philosophy. **The service requirements set out in the specifications focus on interventions and cohorts where there is significant scope to improve outcomes and people's health and wellbeing.**
- 1.8 The outline service specifications also illustrate the proposed metrics which – through a new Network Dashboard – will enable PCNs to understand their own position and support peer learning and quality improvement.
- 1.9 NHSE/I will continue to develop and refine the proposals in discussion with GPC England on behalf of general practice through the annual GP contract negotiations, and in response to feedback from patients, clinicians and

organisations with an interest in primary care and the subject areas of the specifications. **The final version of the specifications will be published in early 2020 as part of the wider GP contract package for 2020/21. The final versions will include further detail for each requirement, followed by guidance**, to support PCNs and other providers to deliver the requirements as effectively as possible.

- 1.10 NHSE/I will continue to consider the opportunities and risks arising from these specifications (and primary care networks more broadly) in relation to health inequalities.

Funding and Additional Roles

- 1.11 The Network Contract DES provides funding entitlements worth £552m in 2020/21, rising to £1.799bn by 2023/24. This comes on top of increases to the core practice contract worth £296m in 2020/21, rising to £978m in 2023/24. **Funding is not allocated directly for delivery of the service specifications;** rather, the largest portion of network funding (£257m in 2020/21, rising to £891m in 2023/24) provides reimbursement for additional workforce roles that PCNs can engage to support the delivery of the specifications and alleviate wider workforce pressures. This funding enables the deployment of over 6,000 additional staff by 2020/21, rising to over 20,000 by 2023/24. For a PCN covering a population of 50,000 people, that could equate to around five additional staff in 2020/21 and around 16 additional staff by 2023/24. **This represents a major uplift in the workforce capacity within primary care.**
- 1.12 Providing that PCNs move forward swiftly to engage new staff and use their additional roles reimbursement entitlement, **there will be significant additional capacity within primary care in 2020/21 to deliver the specifications.** 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. **This would provide more than sufficient capacity to deliver the requirements across all five services with significant capacity remaining for these additional roles to provide wider support to GP workforce pressures** by handling appointments or queries that would otherwise have been the responsibility of the GP.
- 1.13 **We will be asking CCGs and ICSs to support PCNs and their community providers to institute shared workforce models** that can help maximise the collaboration between local partners to deliver the specifications and build the wider PCN.

- 1.14 In addition to the funding for additional workforce roles, a typical practice within a PCN will receive funding of £14,000 for participating in a PCN through their PCN participation payment. Each PCN is guaranteed a cash payment of £1.50 per registered patient and 0.25 FTE funding to support its Clinical Director. **Taken together, this provides over £109,000 for a PCN covering 50,000 people.**
- 1.15 Other funding is available to PCNs through the contract agreement, for example through their share of the *Investment and Impact Fund (IIF)* where they make strong progress in delivering the service specifications. The IIF is worth £75m in 2020/21, rising to £300m in 2023/24. **An average PCN could secure funding of c.£60,000 in 2020/21, rising to an additional c.£240,000 by 2023/24.**
- 1.16 Alongside PCNs, **community services providers will also see significant funding increases over the next five years and, under our proposals, will take a significant role in co-delivery in two of the service specs for Enhanced Health in Care Homes and Anticipatory Care** (via the proposed NHS Standard Contract) – enabling the development of an integrated multidisciplinary team to take forward the requirements in the outline specifications as a shared endeavour across different partners. Consultation on the NHS Standard Contract will take place December 2019 – January 2020.

Phasing of service requirements

- 1.17 **NHSE/I is proposing to phase in the requirements over time** in order to ensure that they are deliverable as PCN workforce capacity grows, and as the wider system infrastructure develops to support them. This means:
- implementing the requirements of two of the five specifications (Structured Medication Reviews and Optimisation, Enhanced Health in Care Homes) in full from 2020/21, as agreed in the GP contract framework; and
 - phasing in the requirements of the Anticipatory Care, Personalised Care and Early Cancer Diagnosis specifications over the period from 2020/21 to 2023/24. For these specifications, we have set out a headline trajectory for the requirements over the next four years, with the detail subject to further annual contract negotiations between NHSE/I and GPC England.
- 1.18 **There are also significant overlaps between the requirements of the specifications, as well as with other elements of the wider GP contract package:**

- A significant proportion of the individuals who we propose should benefit from a structured medication review will be care home residents for many PCNs.
- Delivery of the requirements in the Early Cancer Diagnosis specification will support practices' completion of the relevant Quality Improvement (QI) module of the 2020/21 Quality and Outcomes Framework (QOF). Similarly, efforts made by practices and networks to fulfil the Prescribing Safety QI module in 2019/20 will facilitate their ability to meet the elements of the structured medication review and optimisation specification.

Support from the wider system

1.19 **The establishment of PCNs will improve the links between providers of primary and community services, so that general practice feels much more connected and supported by the wider NHS system.** CCGs will be required to play a major role in helping to co-ordinate and support delivery of the specifications, in particular those that involve close collaboration with other partners such as the care homes specification. CCGs will also support PCNs to develop standard operating processes for their partnership, and ensure a clear and agreed contribution to service delivery is made by other system partners within Integrated Care Systems (ICSs) – documented in a local agreement. We will recommend that the Local Medical Committee should be involved in the development of the local agreement.

1.20 Where the outline specifications contain requirements for community services providers, **we intend to incorporate these into the NHS Standard Contract from 2020/21** to ensure they are taken forward everywhere in a reliable way.

1.21 In addition, **where PCNs are struggling to recruit, CCGs and systems should take action to support them.** This may include, for example:

- running shared recruitment processes across multiple PCNs, or supporting PCNs to carry out collaborative recruitment; potentially providing management support to PCNs to help them run recruitment processes;
- brokering integrated workforce arrangements with other providers, for example through rotational posts; and
- working with local representative groups and other stakeholders to match people to unfilled roles.

Relationship with existing locally commissioned services

- 1.22 We recognise that, for some of the specifications, a locally commissioned service may already exist which covers some or all of the proposed requirements set out in this document. **These proposals are in draft: Clinical Commissioning Groups (CCGs) should not, therefore, take final decisions about existing locally commissioned services until the final Network Contract DES for 2020/21 is published.**
- 1.23 Once these specifications have been finalised, **CCGs should work with PCNs, community services providers, Local Medical Committees (LMCs), and other stakeholders to support the transition – and, where required, enhancement – of existing local service arrangements** to meet the new requirements whilst avoiding the unwarranted destabilisation of existing provision. We would expect CCGs to make an assessment of any investment that they continue to make in these areas, recognising that particularly as the expectations of the specifications rise up to 2023/24, it may in the meantime be appropriate for them to maintain delivery of a service where it currently exceeds the national requirements for 2020/21.
- 1.24 **Funding previously invested by CCGs in local service provision which is delivered through national specifications in 2020/21 should be reinvested within primary medical care and community services in order to deliver the £4.5bn additional funding guarantee for these services.** NHSE/I will be collecting data on current spend and discussing how to ensure that the transition to the national specification is manageable and affordable. Further requirements in this respect will be set out at the conclusion of the GP contract negotiations for 2020/21.

2. Structured Medication Review and Medicines Optimisation

Introduction

- 2.1 Structured Medication Reviews (SMRs) are a NICE approved clinical intervention that help people who have complex or problematic polypharmacy¹. SMRs are designed to be a comprehensive and clinical review of a patient's medicines and detailed aspects of their health and are delivered by facilitating shared decision making conversations with patients aimed at ensuring that their medication is working well for them.
- 2.2 Evidence shows that people with long term conditions using multiple medicines have better clinical and personal outcomes following an SMR.² Timely application of SMRs to individuals most at risk from problematic polypharmacy will support a reduction in hospital admissions caused by medicines related harm in primary care. It is estimated that £400 million is wasted in unnecessary medicines related harm admissions to hospital annually.³
- 2.3 Most prescribing takes place in primary care. Through the increased collaboration brought about by the establishment of PCNs, there is a significant opportunity to support the meeting of international commitments on anti-microbial prescribing. Undertaking SMRs in primary care will result in a reduction in the number of people who are over-prescribed medication, reducing the risk of an adverse drug reaction, hospitalisation or addiction to prescription medicines. Better prescribing will also ensure better value for money for the NHS, reduce waste and improve its environmental sustainability, for example by reducing the use of short acting beta agonist inhalers (SABA) and switching to low carbon alternative inhalers.

Existing provision and available support for PCNs

- 2.4 Since 2015, NHS England has funded two pilot schemes to support the establishment of Clinical Pharmacists working in general practice. Significant progress in medicines optimisation has already been made across the country in using the skills of these individuals, and the service requirements to undertake SMRs will be more achievable as a result.

¹ Problematic polypharmacy arises when multiple medicines are prescribed inappropriately, or when the intended benefit of the medicines are not realised or appropriately monitored, potentially due to clinical complexity or clinical capacity.

² NICE Guideline 5 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, 2015

³ Medicines related harm in older adults, Pharmaceutical Journal: <https://www.pharmaceutical-journal.com/news-and-analysis/news/medication-related-harm-in-older-adults-costs-the-nhs-400m-each-year-study-finds/20204894.article?firstPass=false>

- 2.5 The additional roles reimbursement scheme introduced as part of the Network Contract DES in 2019 has made funding available for Clinical Pharmacists to be recruited in all PCNs from April 2019, building upon the existing base from the earlier pilots. This workforce will be key in delivering SMRs, and given this degree of existing capacity and expertise, we believe it is reasonable to expect the new national SMR service requirements to be delivered in full from April 2020.
- 2.6 It is expected that a number of GP appointments may be prevented when individuals have a proactive SMR: supporting the alleviation of workforce pressures on GPs and reducing the risk of harm to patients – an evaluation will be commissioned in year one.

Proposed Service Model

- 2.7 We propose that PCNs identify people who would benefit most from receiving an SMR. The following groups have been identified as being most likely to benefit from an SMR:
- all patients in care homes as per the Enhanced Health in Care Home specification;
 - patients with complex and problematic polypharmacy, specifically those on 10 or more medications;
 - patients who are being prescribed medicines that are commonly and consistently associated with medication errors;
 - patients with multiple long-term conditions and/or multiple comorbidities – in particular respiratory disease and cardiovascular disease;
 - housebound, isolated patients and those with frailty – particularly patients who have had recent admissions to hospital and/or falls;
 - patients who have received a comprehensive geriatric assessment as per the anticipatory care requirements;
 - patients with severe frailty; and
 - patients prescribed high numbers of addictive pain management medication.
- 2.8 A variety of tools have been developed to help clinicians to identify patients with complex and problematic polypharmacy with multi-morbidity, including PINCER, EFACT2, Openprescribing and Eclipse Live. PCNs can select appropriate tools that help them to proactively identify patients from the cohorts outlined above through audit of GP IT systems. Guidance will be published to support PCNs in the identification of patients, including a guide to the selection of these tools.

- 2.9 We propose that PCNs also develop processes for identifying patients who need to be referred for an SMR reactively. PCNs must consider guidance concerning reactive referrals.
- 2.10 PCNs must ensure that only appropriately trained clinicians working within their sphere of competence should undertake SMRs. These professionals will need to have a prescribing qualification and advanced assessment and history taking skills – or be enrolled in a current training pathway to develop these skills – and must be able to take a holistic view of a patient’s medication. This could include:
- Clinical Pharmacists
 - General Practitioners
 - Advanced Nurse Practitioners
- 2.11 We expect that undertaking a SMR would take considerably longer than an average GP appointment, although the exact length should vary. PCNs should allow for flexibility in appointment length for SMRs depending on the level of complexity presenting with individual cases. Clinicians should conduct SMRs in line with the principles of shared decision making, and consider the holistic needs of the patient, providing advice, signposting and making onward referrals where relevant, including new responsibilities to signpost to healthy living pharmacies.⁴
- 2.12 SMRs should be an ongoing process in which an individual appointment or discussion constitutes an episode of care. Regular review and management should be undertaken and SMRs should not be treated as a one-off exercise.
- 2.13 As part of our commitment to a more sustainable NHS, SMRs should also support patients to switch to low carbon inhalers, where clinically appropriate.
- 2.14 Further guidance will be issued on processes to undertake an SMR, built from NICE guidance, the Scottish Polypharmacy model and evidenced best practice.

Proposed service requirements for 2020/21

- 2.15 From April 2020, practices working as part of PCNs will:
- identify a clinical lead who will be responsible across the PCN for the delivery of the service requirements in this section.

⁴ Community pharmacy contractors will be required to become an HLP Level 1 by 1st April 2020 as agreed in the [five-year deal](#) between PSNC, NHS England and NHS Improvement and the Department of Health and Social Care; this reflects the priority attached to public health and prevention work.
<https://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/>

- run locally-defined processes at least twice yearly, on a six-monthly basis, to identify the patients within the practice-registered population that require SMRs. This must include consideration of patients within the cohorts described in paragraph 2.7.
- develop local processes for reactive SMR referrals, adhering to published guidance;
- provide written communication to patients invited for an SMR, detailing the process and intention of the appointment;
- offer SMRs to 100% of identified patients, except in exceptional circumstances where the commissioner agrees that proven capacity constraints (where the PCN had demonstrated all reasonable attempts to ensure capacity had been undertaken) would justify a lower proportion of identified patients to be offered a SMR;
- undertake SMRs and follow-up consultations in line with detailed guidance. CCGs will review variation in the numbers of SMRs undertaken, which will inform the potential development of a standardised requirement in future years;
- use appropriate clinical decision-making tools to support the delivery of SMRs, examples of which will be provided through guidance;
- clearly record all SMRs within GPIT systems, as well as using appropriate clinical codes to signify the reasons for an SMR;
- develop local PCN action plans to reduce inappropriate prescribing of (a) antimicrobial medicines, (b) medicines which can cause dependency, and (c) nationally identified medicines of low priority. This plan will react to guidance specifying how the PCN will deliver against the guidance;
- work with community pharmacies locally to ensure alignment with delivery of both the New Medicines Service (to support adherence to newly-prescribed medicines) and developing medicines reconciliation services (to support effective transfers of care between hospital and community);
- ensure delivery of SMRs and medication optimisation aligns to the work of medicines optimisation teams within CCGs local to the PCN.

Proposed Metrics

2.16 Proposed metrics to monitor the success of the service are set out below:

	Metric description
1.	The number of individual SMR episodes undertaken, including: <ul style="list-style-type: none"> • The number of SMR processes undertaken (number of individual patients given one or more SMR appointment) • The number of SMR follow-up appointments
2.	Outcome measurement to monitor impact of SMR
3.	Prescribing rate of nationally identified medicines of low value that should not be routinely prescribed
4.	Prescribing rate of low carbon inhalers
5.	Prescribing rate of medicines that can cause dependency
6.	Prescribing rate of anti-microbial medication

2.17 Reducing unwarranted prescribing spend in particular areas is likely to be one early focus of the Investment and Impact Fund, with progress expected to be measured against baseline levels of performance in 2019/20.

3. Enhanced Health in Care Homes

Introduction

- 3.1 One in seven people aged 85 or over permanently live in a care home. People living in care homes account for 185,000 emergency admissions each year and 1.46 million emergency bed days, with 35-40% of emergency admissions being potentially avoidable⁵. Evidence suggests that many people living in care homes are not having their needs assessed and addressed as well as they could be, often resulting in unnecessary, unplanned and avoidable admissions to hospital and sub-optimal medication regimes.
- 3.2 People living in care homes should expect the same level of support as if they were living in their own home. This can only be achieved through collaborative working between health, social care, the voluntary sector and care home partners.
- 3.3 In 2016, the New Care Models programme developed and tested the Enhanced Health in Care Homes (EHCH) Framework⁶ to improve health and care provision for people living in care homes. In implementing the EHCH service, local areas showed how to improve services and outcomes for people living in care homes and those who require support to live independently in the community⁷.
- 3.4 Given the efficacy of the model, the Long-Term Plan and GP Contract Framework made a commitment to implementing the clinical elements of EHCH nationally during 2020/21. Implementation of the EHCH service is a national priority for primary and community care-based service integration, and we will be expecting all ICSs/STPs and CCGs to prioritise supporting full and successful delivery.

Existing provision and available support for PCNs

- 3.5 There is evidence of substantial existing enhanced primary and community provision to residential and nursing homes. Data collected from CCGs for 2018/19 suggests that there is already significant local spend on such services. In combination with additional support described below, we believe that this existing capacity and expertise will enable implementation of this specification at a faster pace than other services.

⁵ <https://www.longtermplan.nhs.uk/online-version/chapter-1-a-new-service-model-for-the-21st-century/1-we-will-boost-out-of-hospital-care-and-finally-dissolve-the-historic-divide-between-primary-and-community-health-services/#ref>

⁶ <https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf>

⁷ <https://www.health.org.uk/publications/reports/emergency-admissions-to-hospital-from-care-homes>

- 3.6 We have drawn on evidence from these service models as well as evaluations of the New Care Models to design the service requirements below, and to inform forthcoming guidance for implementation, which will include advice on collaborative service redesign with other providers such as community services.
- 3.7 Delivery of this specification must happen in partnership between general practice and community services. The proposed Standard Contract requirements will ensure a contractual basis for the requirements attributable to community service providers, and CCGs will oversee local agreements between providers within a PCN to ensure that primary and community care are supported in delivery by relevant partners being held to account.
- 3.8 We anticipate CCGs will also support delivery of this service by holding a list of care homes in the area and agreeing the responsibilities of PCNs in relation to each home, including making sure that each care home is aligned to a single PCN. An approach to the reinvestment in primary care of existing expenditure by CCGs in this area of work and the potential for uneven distribution of care homes between PCNs will be discussed as part of contract negotiations. CCGs can also support improved joint working between PCNs and social care their established relationships with social care commissioners in local authorities.
- 3.9 We acknowledge that the geographical distribution of care homes means that PCNs will be affected differently by the service requirements in this specification. We are considering this issue further, alongside the potential economies of scale provided by the opportunity to provide enhanced support to care homes at a network level rather than through individual practices.

Proposed Service Model

- 3.10 The EHCH service will focus on national roll out of the first four clinical elements of the EHCH framework: enhanced primary care support; multidisciplinary team support; reablement and rehabilitation; and high-quality end-of-life care and dementia care. The service requirements are shared across both PCNs and other providers (particularly community services) who will work together to deliver the model.
- 3.11 In implementing this model nationally, we expect to:
- Improve the experience, quality and safety of care for people living in care homes, their families and their carers;
 - Reduce avoidable ambulance journeys, A&E attendances and emergency admissions to hospital for people living care home residents;

- Improve sub-optimal medication regimes in care homes; and
- Support more people living in care homes to die in a place of their choosing.

3.12 Given the significant progress already made across the country in implementing these model elements, we expect this service to be delivered, in full, during 2020/21. In future years we will consider whether and how to bring out of hours provision under the authority of PCNs, to ensure more effective and coordinated out of hours support for care homes.

In scope population

3.13 All people who live permanently in care homes (both residential and nursing) are eligible for the service. This includes people living in residential and nursing homes that deliver specialist support (such as specialist learning disability and dementia units) but does not include people living in secure units for mental health.

3.14 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.

3.15 For the purposes of this document, the term ‘care home’ encompasses all types noted above.

Proposed service requirements:

3.16 During 2020/21, practices working as part of PCNs and working with providers of community services, will:

	Practices, working as part of PCNs	Other providers of community services, including mental health
1	By 30 June 2020, identify a clinical lead who will be responsible across the PCN for the delivery of the service requirements in this section.	
2	From no later than 30 June 2020, ensure every person living permanently in a care home has a named clinical team, including staff from the PCN and relevant providers	Work alongside PCNs and care homes to ensure delivery of the multidisciplinary elements of the service model described below

	of community services, who are accountable for the care delivered through the EHCH model.	
3	<p>From no later than 30 June 2020, ensure every care home is aligned to a single PCN, and its multidisciplinary team (MDT), which is responsible for supporting that care home and delivering the EHCH service for people living in that home that are already registered with a practice in the PCN or choose to register with a practice in the PCN.</p> <p>By 30 June 2020 each PCN will agree the care homes for which it has responsibility with its CCG. People entering the care home should be supported to re-register with the aligned PCN and have the benefits of doing so clearly explained.</p> <p>Where people choose not to register with a practice in the aligned PCN, requirements 4-9 below should be delivered by their registered practice, either directly or through local sub-contracting arrangements.</p>	
4	<p>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.</p>	<p>By no later than 30 June 2020, co-design with the PCN, and thereafter participate in, a multidisciplinary team (MDT) of professionals, to work in close collaboration with care homes to develop and monitor personalised care and support plans.</p> <p>Attend MDT meetings and manage delivery of the MDT if agreed locally.</p>
5	<p>From no later than 30 June 2020, establish protocols between the care home and wider system partners for information sharing and shared care planning, use of shared care records</p>	<p>From no later than 30 June 2020, support the establishment of protocols between the care home and wider system partners for information sharing and shared care planning, use of shared care records</p>

	and clear clinical governance and accountability	and clear clinical governance and accountability.
6	<p>From no later than 30 September 2020, deliver a weekly, in person, 'home round' for their registered patients in the care home(s). The home round must:</p> <ul style="list-style-type: none"> • be led by a suitable clinician. On at least a fortnightly basis this must be a GP. With local agreement the GP can be substituted by a community geriatrician. • involve a consistent group of staff from the MDT. • focus on people identified for review by the care home, those with the most acute and escalating needs or those who may require palliative or end-of-life care. 	<p>From no later than 30 September 2020, deliver, participate in or prepare for home rounds as agreed with the PCN and provide initial triage of people living in care homes who have been flagged for review.</p>
7	<p>From no later than 30 September 2020, own, and coordinate delivery of, a personalised care and support plan with people living in care homes based on relevant assessments of needs and drawing on assessments that have already taken place where possible and:</p> <ul style="list-style-type: none"> • ensure that this plan is developed and agreed with each new resident within seven days of admission to the home, and within seven days of readmission following a hospital episode. Review the plan when clinically appropriate and refresh it at least annually; 	<p>From no later than 30 September 2020, deliver, as determined by the MDT, elements of holistic assessment for people in care homes across five domains; physical, psychological, functional, social and environmental, drawing on existing assessments that have taken place where possible.</p> <p>Provide input to the person's care and support plan within seven working days of admission to the home, and within seven working days of readmission following a hospital episode.</p>

	<ul style="list-style-type: none"> ensure the plan is developed with the person or/their carer, and reflects their personal goals; ensure the plan is tailored to the person's particular needs (for example if they are living with dementia) and circumstances (such as those people approaching the end of their life). 	<p>Deliver palliative and end of life care, as required, to care home residents 24 hours a day.</p>
8	<p>From no later than 30 September 2020, coordinate, alongside community providers, one-off or regular support to people within care homes, based on the needs defined in the personalised care and support plan and those identified by care home staff.</p> <p>Directly deliver or support delivery of elements of this support where appropriate, including:</p> <ul style="list-style-type: none"> structured medication reviews (SMRs), delivered according to the requirements of the SMR specification. 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. 	<p>From no later than 30 September 2020, provide one-off or regular support to people within care homes based on the needs defined in the personalised care and support plan and those identified by care home staff.</p> <p>This support must include, but is not limited to:</p> <ul style="list-style-type: none"> community nursing tissue viability falls prevention, advice and strength and balance training oral health speech and language therapy including dysphagia assessment and support dietetics hydration and nutrition support continence assessment and care (urinary and faecal) psychological therapies e.g. via IAPT services or local older people's mental health services cognitive stimulation or rehabilitation therapy and reminiscence therapy for people with dementia
9	<p>From no later than 30 September 2020, provide, through the MDT, identification and assessment of</p>	<p>From no later than 30 September 2020, support the identification and</p>

	<p>eligibility for urgent community response services</p>	<p>assessment of eligibility for urgent community response services and:</p> <ul style="list-style-type: none"> • deliver urgent community response services (which include provision of crisis response within two hours and reablement within two days of referral); • deliver specialist mental health support in cases of mental health crises and challenging behavioural and psychological symptoms of dementia <p>Where the above would help a person to remain safely and recover in their care home as an alternative to hospital admission or to support timely hospital discharge.</p>
10	<p>Provide support and assistance to the care home by:</p> <ul style="list-style-type: none"> • supporting the professional development of care home staff by identifying opportunities for training and shared learning; • working with the care home and wider system partners to address challenges the home is facing in coordination with the wider health and care system; • delivering relevant vaccinations for care home staff, in line with the provisions set out in the seasonal influenza DES. 	<p>Make opportunities for training and shared learning available to care home staff, drawing on existing continued professional development programmes for staff working in community services.</p>
11	<p>From no later than 30 September 2020, working with the CCG to establish processes that improve efficient transfer of clinical care between residential homes, nursing homes and hospices and between</p>	<p>From no later than 30 September 2020, support the development and delivery of transfer of care schemes.</p>

	care homes and hospitals, as described by NICE guidance ⁸⁹ . Facilitate and support local and national initiatives to support discharge from hospital and psychiatric inpatient units, such as trusted assessor schemes.	
12	From no later than 30 September 2020, establish clear referral routes and information sharing arrangements between care homes, PCNs and out of hours providers and providers of a full range of community-based services including specialist mental health, dietetic, speech & language therapy, palliative care and dementia care.	From no later than 30 September 2020, support the development of clear referral routes and information sharing arrangements between the care home and other providers.

Proposed Metrics

3.17 Potential metrics to monitor the success of the service include, but are not limited to:

	Metric description
1.	The rate of emergency admissions for people living in care homes.
2.	The rate of urgent care attendances for people living in care homes.
3.	The proportion of people living in a care home who have a personalised care and support plan in place.
4.	The number of people living in a care home who receive an appointment as part of the weekly care home round
5.	The number and proportion of people living in a care home who receive a structured medication review.
6.	The number and proportion of people living in a care home who receive a delirium risk assessment.

⁸ <https://stpsupport.nice.org.uk/transfer-of-care/index.html>

⁹ <https://www.nice.org.uk/guidance/ng27/chapter/Recommendations#supporting-infrastructure>

4. Anticipatory Care

Introduction

- 4.1 Anticipatory care helps people to live well and independently for longer through proactive care for those at high risk of unwarranted health outcomes. Typically, this involves structured proactive care and support from a multidisciplinary team (MDT). It focuses on groups of patients with similar characteristics (for example people living with multimorbidity and/or frailty) identified using validated tools (such as the electronic frailty index) supplemented by professional judgement, refined on the basis of their needs and risks (such as falls or social isolation) to create a dynamic list of patients who will be offered proactive care interventions to improve or sustain their health.
- 4.2 It supports the focus on prevention in the [Long-Term Plan](#), and the ambition that people can enjoy at least five extra healthy, independent years of life by 2035.
- 4.3 The service has three key aims:
- Benefitting patients with complex needs, and their carers, who are at risk of unwarranted health outcomes by enabling them to stay healthier for longer, with maintained or improved functional ability and enjoy positive experiences of proactive, personalised and self-supported care.
 - Reducing need for reactive health care for specific groups of patients and supporting actions to address wider determinants of health.
 - Delivering better interconnectedness between all parts of the health system and the voluntary and social care sectors
- 4.4 These aims will be achieved through a combination of:
- population segmentation, followed by risk stratification and clinical judgement, to identify people who would benefit most; and
 - multi-disciplinary primary and community teams, including social care and the voluntary sector working together.
- 4.5 Anticipatory care is intrinsically linked to population health management models developing and already in place in systems across the country. The service focuses on the “rising risk population”, comprising those with multiple long-term conditions and/or frailty, who may have underlying risk factors like unhealthy

lifestyles, behavioural risks, social isolation or poor housing. Addressing many of these risk factors will require non-clinical interventions and strong working relationships with local voluntary, community and civic groups, as well as system public health teams.

- 4.6 In future years we will establish a standardised approach to the identification of individuals to receive the service. There is a range of approaches currently in place across the country, and the evidence base is still developing. 2020/21 therefore represents an opportunity to build and embed ways of working and service models which will expand and develop in future years. We will continue to monitor outcomes from different local approaches, and would welcome submissions of evidence where these have been successful.

Existing provision and available support for PCNs

- 4.7 Population health management (PHM) tools that can support risk stratification are already in place in a number of areas across the country. They are usually hosted by ICSs but drawing on data from MDTs based across PCNs and community service providers. PHM tools will predict and identify patients who are at risk of adverse health outcomes, and the particular interventions that would support them to remain healthy.
- 4.8 The first year of the service is predominately a preparatory year, with target populations to be agreed by the PCN through discussion with their CCG and their ICS/STP. CCGs and ICSs will support PCNs by sharing information and access to risk stratification tools successfully in use that could be used by PCNs
- 4.9 General practices already have a unique understanding of the health needs of the communities they serve. By joining together health and social care information with other information from wider public sources like housing and education, and applying predictive modelling techniques, PCNs have the opportunity to draw on deeper intelligence to better understanding which people in their areas might benefit from more targeted and proactive care.

Proposed phasing of objectives from 2020/21 to 2023/24

- 4.10 By 2023/24, we expect all PCNs and community service providers – working together – to offer an Anticipatory Care model based on the following components:
- **Identification of specified key segments of the PCN's registered practice populations who have complex needs and are at high risk of unwarranted health outcomes.**

Population health management tools – hosted by ICSs but drawing on data from MDTs based across PCNs and community service providers – will predict and identify patients who are at risk of adverse health outcomes, and the particular interventions that would support them to remain healthy.

Over time, as population health management tools are validated for increasing cohorts, this will mean a reduction in the need for additional manual segmentation and stratification of the identified patients. By 2023/24, PCNs and community service providers will access, interrogate and filter a list of which individuals are most likely to benefit from different health and care interventions.

- **Maintenance of a comprehensive and dynamic list of identified individuals who would benefit from anticipatory care, based on the outcome of the population segmentation approach above.**

This list will be dynamic: it will be maintained and updated in real time based on population health intelligence.

- **The delivery of a comprehensive set of support for those individuals identified as eligible through the anticipatory care list, through an MDT based across PCNs and community service providers.**

The available support provided to each individual will be based upon each their personalised care and support plan, but support offers will include a broad range of primary and community services support via the MDT. Establishing this support infrastructure is a key component of the 2020/21 requirements.

4.11 Complex population cohorts require the skills of different healthcare professionals working together as a multidisciplinary team. For MDTs to achieve their goal, PCNs and other health and care partners must share relevant patient information and develop whole system data sharing and data processing agreements, drawing on national guidance. In time, this data will be sourced from Local Health and Care Records.

Proposed service requirements for 2020/21

4.12 During 2020/21, practices working as part of PCNs and working with providers of community services, will:

	Practices, working as part of PCNs	Other providers of community services, including mental health
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1	<p>From no later than 30 June 2020, present a coherent local Anticipatory Care model by:</p> <ul style="list-style-type: none"> • identifying a responsible clinical lead for delivery of the model; • assisting with the development and improvement of system-level population health management approaches to identify patients with complex needs that would benefit from anticipatory care; • working with others to develop and establish, clinical accountability and governance arrangements to manage the model, through shared design with providers of community services and mental health care, engaging with social care and voluntary services, drawing on existing system-level programmes where possible; • taking a leading role in coordinating the care and support of people as patients begin to be treated by Anticipatory Care - building links and working across the system to facilitate development of a wider model of integrated care for individuals living with complex needs. 	<p>From no later than 30 June 2020, assist with the development and improvement of system-level population health management approaches to identify patients with complex needs that would benefit from Anticipatory Care.</p> <p>Support the coordination of the care and support of people being treated by the Anticipatory Care model, building links and working across the system to facilitate development of a wider model of integrated care for individuals living with complex needs</p> <p>Work with others to develop and agree delivery, clinical accountability and governance arrangements with practices working as part of a PCN, engaging with other providers of community services, mental health care, social care and voluntary services.</p> <p>Work with the CCG, PCN, providers of social care and voluntary sectors and patient representative groups to co-design and clearly set out how and where the range of support service offers described below (which will be recurrently available through MDTs for those receiving anticipatory care) and other support services will be delivered.</p>
2	<p>From no later than 30 June 2020, with CCG support, work with others to develop and sign data sharing agreements between practices and with providers delivering community and mental health services, local acute hospitals voluntary sector organisations and social care to support the operation of MDTs and</p>	<p>From no later than 30 June 2020 work with others to develop and sign data sharing agreements with practices and with other providers delivering community and mental health services, local acute Trusts, voluntary sector organisations and providers of social care to support the operation of MDTs and the</p>

	<p>the development of population health analytics data sets.</p> <p>Support the development of system-level linked data sets to build population health analytics capabilities, including the extraction of anonymised, patient level data.</p>	<p>development of population health data sets.</p> <p>Support the development of system-level linked data sets to build population health analytics capabilities, including the extraction of anonymised, patient level data.</p>
3	<p>From no later than 30 June 2020, identify a priority list of patients who are at rising risk of unwarranted health outcomes, based on the CCG standard approach where applicable.</p> <p>Prioritisation should focus upon:</p> <ul style="list-style-type: none"> • individuals with complex needs: including multiple long-term conditions and/or with frailty. • those that are amenable to improvement through multi-disciplinary intervention and • those that are at high risk of their condition progressing or circumstances or needs substantially changing within the next six months. 	<p>From no later than 30 June 2020, support the prioritisation of a target cohort of patients based on professional judgement and/or validated tools.</p>
4	<p>From no later than 30 June 2020, establish and manage an MDT, to meet regularly to coordinate and manage the care of the cohort of people on the Anticipatory Care list.</p>	<p>From no later than 30 June 2020, align relevant community nursing and therapy staff to the local PCN and identify other professions that may need to be involved in the MDT discussion.</p> <p>Attend and participate in the MDT discussion – using available information to plan and co-ordinate the care of patients discussed.</p>
5	<p>From no later than 30 June 2020, co-ordinate and deliver comprehensive needs assessments, targeted needs</p>	<p>From no later than 30 June 2020, co-ordinate and deliver constituent parts</p>

	<p>assessments or care co-ordination reviews for the people in this cohort, recording this activity and the person's individual goals in a personalised care and support plan.</p>	<p>of comprehensive and targeted needs assessments with the PCN.</p> <p>Develop or add to care and support plans for the individuals which the MDT identifies should be supported by community health professionals</p>
6	<p>From no later than 30 June 2020, coordinate the delivery of support offers as identified by the needs assessment and the patient's personal goals. Via the responsible lead, retain overall clinical responsibility for the delivery of this plan.</p> <p>The available support offers must include (not exhaustive):</p> <ul style="list-style-type: none"> • medicines optimisation to address problematic polypharmacy, in line with the process established in the SMR specification • social prescription using a broad range of community assets to support well-being and address loneliness and isolation • carer identification and signposting to local support • annual comprehensive or targeted needs assessment for other validated cohorts with complex needs. • annual care coordination review for other validated cohorts with complex needs. • adoption of patient activation measures • non-medical interventions from the personalised care and support plan 	<p>From no later than 30 June 2020, co-ordinate support offers if locally agreed.</p> <p>Deliver relevant support offers as identified in the patient's needs assessment and care and support plan, to include (not exhaustive):</p> <ul style="list-style-type: none"> • fall risk assessment and intervention including bone health management and strength and balance training • rehabilitation services • continence services • tissue viability service • care co-ordination • mobility assessment • continence assessment (urinary and faecal) • carer identification and signposting to local support • annual comprehensive or targeted needs assessment for other validated cohorts with complex needs. • annual care coordination review for other validated cohorts with complex needs. • relevant outreach services for hard to reach groups and those with protected characteristics. • mental health assessment and interventions to identify and

		<p>manage depression and anxiety, including IAPT</p> <ul style="list-style-type: none"> • cognitive assessment (to identify dementia and delirium risk) and post diagnosis dementia support (including cognitive stimulation therapy and cognitive rehabilitation therapy). <p>Deliver annual review of those patients actively supported by community health providers (especially those patients who are housebound)</p>
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Proposed metrics

4.13 Potential metrics to monitor the success of the service include, but are not limited to:

	Metric description
1.	Number of individuals in receipt of the Anticipatory Care model
2.	Number of needs assessment carried out for individuals in receipt of the Anticipatory Care model.
3.	Number of individuals in the active cohort of the anticipatory care model with a personalised care and support plan.
4.	Number of individuals in the active cohort of the anticipatory care model receiving a falls risk assessment.
5.	Number of individuals in the active cohort of the anticipatory care model receiving a delirium risk assessment
6.	Number of SMRs for the active cohort on the anticipatory care model
7.	Number of SMR follow-ups in the active cohort on the anticipatory care model
8.	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

5. Personalised Care

Introduction

5.1 Chapter one of the NHS Long Term Plan (LTP) makes personalised care business as usual across the health and care system as one of the five major, practical changes to the NHS service model. Personalised care means people have choice and control over the way their care is planned and delivered, based on ‘what matters’ to them and their individual diverse strengths, needs and preferences. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families and communities in delivering better health and wellbeing outcomes and experiences.

5.2 *Universal Personalised Care: Implementing the Comprehensive Model*¹⁰ is the delivery plan for personalised care, published by NHS England in January 2019 following the LTP. The Comprehensive Model builds on the success the NHS has had in implementing personalised care in a variety of settings and locations across the country. The experience and evidence thus far (and as set out in *Universal Personalised Care*) has shown that benefits include:

- improvement to people’s experiences of care and their health and wellbeing, including for people who face the greatest health inequalities; and
- more effective use of NHS services, including reduced crises that lead to unplanned hospital or institutional care.

Existing provision and available support for PCNs

5.3 There is substantial existing provision and support available to PCNs through the personalised care national programme, and its regional networks. This includes:

- Dedicated clinical support tools are available via GPIT systems to support professionals in having shared decision making conversations with cohorts where this is a service requirement in 20/21; and
- Well-developed social prescribing in many areas – often occurring at a scale that already exceeds the 2020/21 requirement. Building on this success, there will be free training provided by HEE available to all

¹⁰ <https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf>

social prescribing link workers, as well as access to regional support networks.

- 5.4 Evidence from existing social prescribing schemes and clinical expertise suggests that GP appointments can be prevented when individuals receive a social prescribing intervention, and onward referral to appropriate services. Delivery of this service (which will be mostly be carried out by staff funded in full via the Network DES) has a clear potential to reduce GP burden at a local and national level.

Proposed Service Model

- 5.5 The Comprehensive Model for Personalised Care brings together six evidence-based and inter-linked components, each of which is defined by a standard, replicable delivery model. The six key components are¹¹:
1. Shared decision making
 2. Personalised care and support planning
 3. Enabling choice, including legal rights to choose
 4. Social prescribing and community-based support
 5. Supported self-management
 6. Personal health budgets (PHBs) and integrated personal budgets.

Proposed phasing of service objectives from 2020/21 to 2023/24

- 5.6 To achieve the benefits of personalised care the Comprehensive Model needs to be delivered in full. For example, social prescribing is more effective when it is delivered with a complementary approach to shared decision making. Over the four years of Network Contract DES, we will phase in increasing levels of activity across the six component areas as summarised below:

2020/21	<p>Personalised Care and Support Planning Requirement of personalised care and support plans to be in place for at least 5-10:1000 weighted population. This must include:</p> <ul style="list-style-type: none"> • All people in last 12 months of life • All individuals eligible in the Anticipatory Care and Enhanced Health in Care Homes cohorts <p>Promotion of Personal Health Budgets Requirement to promote of Personal Health Budgets for:</p> <ul style="list-style-type: none"> • People with a legal right to a Personal Health Budget
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¹¹ Further detail of each of the six components can be found in the [Universal Personalised Care: Implementing the Comprehensive Model](#).

	<ul style="list-style-type: none"> • Any other cohorts identified as eligible for a Personal Health Budget within the CCG local offer <p>Shared Decision Making Priority shared decision-making clinical situations, to include at least:</p> <ul style="list-style-type: none"> • MSK: Back pain, hip pain, knee pain and shoulder pain (led by physiotherapists) <p>Training and shared learning Prioritise the following roles for training:</p> <ul style="list-style-type: none"> • Team members undertaking personal care and support planning conversations • Clinical pharmacists hosting Structured Medicine Reviews • MSK practitioners • Social prescribing link workers <p>Social prescribing Required number of social prescribing referrals at least:</p> <ul style="list-style-type: none"> • 4-8:1000 weighted population. <p>Supported self-management PCNs to use the Patient Activation Measure (PAM)¹² for the following cohorts:</p> <ul style="list-style-type: none"> • People living with newly diagnosed Type 2 diabetes • People referred to social prescribing link workers
2021/22	<p>Personalised Care and Support Planning Requirement of personalised care and support plans to be in place for 10-15:1000 weighted population.</p> <p>Promotion of Personal Health Budgets Continue to promote as per 2020/21, and develop offer to directly provide Personal Health Budgets for specific cohorts</p> <p>Shared Decision Making Priority shared decision-making clinical situations, to include at least:</p> <ul style="list-style-type: none"> • MSK: Back pain, hip pain, knee pain and shoulder pain • Reducing stroke risk in people with AF <p>Training and shared learning</p> <ul style="list-style-type: none"> • Further staff cohorts to be confirmed

¹² The PAM is a tool designed to measure the level to which people feel engaged and confident in taking care of their condition. Further information is available here: <https://www.england.nhs.uk/personalisedcare/supported-self-management/patient-activation/pa-faqs/>

	<p>Social prescribing Required number of social prescribing referrals:</p> <ul style="list-style-type: none"> • 8-12:1000 weighted population. <p>Supported self-management</p> <ul style="list-style-type: none"> • PCNs to use the Patient Activation Measure for additional cohorts to be confirmed.
2022/23	<p>Personalised Care and Support Planning Requirement of personalised care and support plans to be in place for 15-20:1000 weighted population.</p> <p>Promotion of Personal Health Budgets Continue to promote as per 2020/21, and begin to offer Personal Health Budgets directly for specific cohorts</p> <p>Shared Decision Making Priority shared decision-making clinical situations, to include at least:</p> <ul style="list-style-type: none"> • MSK: Back pain, hip pain, knee pain and shoulder pain • Reducing stroke risk in people with AF • Additional clinical situations to be confirmed. <p>Training and shared learning</p> <ul style="list-style-type: none"> • Further staff cohorts to be confirmed <p>Social prescribing Required number of social prescribing referrals:</p> <ul style="list-style-type: none"> • 12-16:1000 weighted population. <p>Supported self-management</p> <ul style="list-style-type: none"> • PCNs to use the Patient Activation Measure for additional cohorts to be confirmed.
2023/24	<p>Personalised Care and Support Planning Requirement of personalised care and support plans to be in place for 20-25:1000 weighted population.</p> <p>Promotion of Personal Health Budgets Continue to promote as per 2020/21, and have in place a clear offer of Personal Health Budgets directly for specific cohorts</p> <p>Shared Decision Making Priority shared decision-making clinical situations, to include at least:</p> <ul style="list-style-type: none"> • MSK: Back pain, hip pain, knee pain and shoulder pain • Reducing stroke risk in people with AF

	<ul style="list-style-type: none"> • Additional clinical situations to be confirmed. <p>Training and shared learning</p> <ul style="list-style-type: none"> • Further staff cohorts to be confirmed <p>Social prescribing</p> <p>Required number of social prescribing referrals:</p> <ul style="list-style-type: none"> • 16-22:1000 weighted population. <p>Supported self-management</p> <ul style="list-style-type: none"> • PCNs to use the Patient Activation Measure for additional cohorts to be confirmed.
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Proposed service requirements for 2020/21

5.7 From April 2020, practices working as part of PCNs will:

- Identify a clinical lead who will be responsible across the PCN for the delivery of the service requirements in this section.
- increase the number of personalised care and support conversations and plans for identified cohorts across a PCN, in line with the standard replicable model, so that at least 5:1000 weighted population receive a PCSP. In 2020/21 the required cohorts are:
 - People in last 12 months of life
 - Individuals eligible in the Anticipatory Care and Enhanced Health in Care Homes cohorts

Further cohort options to consider include:

- People with multiple long-term conditions and/or at high risk of hospital admission
- People with a diagnosis of Cancer
- promote personal health budgets across a PCN to enable delivery of legal rights to a PHB and any other cohorts identified as eligible within the CCG's local offer.
- deliver shared decision making for different clinical situations using available decision support tools. The priority cohorts for 2020/21 are patients with musculoskeletal conditions such as back pain, hip pain, knee pain and shoulder pain. These conversations will be led by trained physiotherapists

- facilitate relevant training, shared learning and quality improvement for staff in PCNs. For 2020/21 PCNs should prioritise the following roles for training:
 - Team members undertaking personalised care and support planning conversations
 - Clinical pharmacists hosting Structured Medicine Reviews
 - PCN MSK practitioners
 - Social prescribing link workers

- support the delivery of effective social prescribing so that at least 4:1000 weighted population receive a referral.

- use Patient Activation Measure to enable more personalised support for people with different levels of knowledge, skills and confidence. For 2020/21 the required cohorts are:
 - People living with newly diagnosed Type 2 diabetes
 - People referred to social prescribing link workers

Proposed metrics

5.8 Potential metrics to monitor the success of the service include, but are not limited to:

	Metric description
1.	The number of personalised care and support plans delivered (including measure of delivery rate for required cohorts)
2.	The quality of personalised care and support plans
3.	The number of shared decision making conversations completed (including measure of delivery rate for required cohorts)
4.	The quality of shared decision making conversations
5.	The number of social prescribing referrals made
6.	The number of patient activation measurement assessments undertaken (including measure of delivery rate for required cohorts)
7.	The number of Personal Health Budgets

6. Supporting Early Cancer Diagnosis

Introduction

6.1 The NHS Long Term Plan (LTP) sets an ambition that, by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around half now to three-quarters (75%) of cancer patients. Achieving this will mean that, from 2028, 55,000 more people each year will survive their cancer for at least five years after diagnosis.

6.2 Primary care has a vital role to play in delivering this ambition, working closely with wider system partners including Cancer Alliances, secondary care, local Public Health Commissioning Teams and the voluntary sector. Through the requirements in the Network Contract DES, primary care networks will:

- Improve referral processes across GP practices, including by introduction of locally agreed standardised systems and processes for identifying people with suspected cancer, referral management and safety netting¹³.
- lead and coordinate the contributions of practices and the PCN to efforts to increase the uptake of existing National Cancer Screening programmes among their local populations.
- Improve outcomes through reflective learning and collaboration with local partnerships

6.3 An average PCN will have around 250 new cancer diagnoses each year. Moving from around one half to three quarters of these getting a diagnosis at stage one or two would mean around 60 more people being diagnosed early, increasing their likelihood of survival.

Existing provision and available support for PCNs

6.4 The service requirements support and further embed the clinical best practice detailed in NICE Guideline 12: *Suspected cancer: recognition and referral*. All practices are already implementing the NICE guidelines and the development process for this specification has shown that much of general practice is already engaged in the actions set out in this specification to improve referrals, screening uptake and reflective practice

¹³ Safety netting is defined for these purposes as ensuring attendance at appointments following urgent referrals for suspected cancer the results of investigations are received and acted upon appropriately and reviewing people with any symptom that is associated with an increased risk of cancer but who do not meet the criteria for referral or other investigative action.

6.5 PCNs will be supported by local system partners in the delivery of the specification and the ultimate improvement of local early diagnosis rates:

- Improving early diagnosis is a strategic and delivery priority for the 20 Cancer Alliances across England and they will support and work with PCNs to deliver the outcomes in this specification.
- The [Public health national service specifications](#) set out programmes for supporting early diagnosis for breast, cervical and bowel cancers and regional public health commissioning teams and Cancer Alliances will work with PCNs on local screening improvement plans.
- Voluntary organisations also have a defined local support offer which includes training, communities of practice with expert cancer GPs and practice nurses, and advice on population-level data to help drive service improvement.

6.6 The implementation of wider Long Term Plan commitments will also support PCN implementation of this service. National Screening Programmes are being modernised and the development of a new referral pathway for people with serious but non-specific symptoms through Rapid Diagnostic Centres (RDCs) starting in 2019/20 will provide support faster diagnosis through more efficient diagnostic pathways and a clearer route for those with unclear symptoms.

Proposed Service Model

6.7 Over the four-year period, PCNs should provide a leadership, enablement and support function across their component practices to deliver the service requirements and ensure the highest standards across its practices. By 2023/24, all PCNs will be expected to be undertaking a range of activity to contribute to realisation of their local Cancer Alliance target for number of people diagnosed at stages 1 and 2, set through the LTP planning process.

6.8 Through the PCN Dashboard, PCNs will have access to a variety of data allowing them to understand and explore trends in cancer presentation and diagnosis locally. National data sets will also enable comparison with other areas and encourage PCNs to learn from one another. Working with partners, such as Cancer Alliances, local public health commissioning teams and voluntary organisations, offers an opportunity for PCNs to leverage available support, guidance and training.

6.9 It is anticipated that the scope of activity undertaken by PCNs will increase year on year, as PCNs become more established and are able to build on what is learnt through audit and exploration of data and significant event analysis in the

early years. The proposed trajectory for this is set out in more detail in the table below, with specific requirements to be determined in future years.

6.10 The requirements for 2020/21 complement the content of the *Quality Improvement QOF domain – Early diagnosis of cancer*, which includes activity on improving referral practice and increasing screening uptake. Where practices take up this Quality Improvement QOF Domain, PCNs will ensure that associated learning and best practice is shared. Delivery of some parts of this specification will also contribute to Continued Professional Development requirements for practice and staff working in the PCN.

Proposed phasing of service objectives from 2020/21 to 2023/24

6.11 The requirements in this specification will be phased over time, as capacity both within PCNs and the wider pathway for cancer diagnosis and treatment increases. The table below summarises the expected phasing of objectives from 2020/21 to 2023/24:

2020/21	<p>Improving referral practice</p> <ul style="list-style-type: none"> • Enable and support practices to improve the quality of their referrals for suspected cancer (including recurrent cancers), in line with NICE guidance and making use of new RDC pathway for people with serious but non-specific symptoms where available. • Introduce safety netting approach for monitoring patients referred for suspected cancer and those who have been referred for investigations to inform decision to refer. • Ensure patients receive high-quality information on their referral. <p>Increasing uptake of National Cancer Screening Programmes</p> <ul style="list-style-type: none"> • Building on existing practice-level actions, lead and coordinate practices' contribution to improving screening uptake. • Develop a PCN screening improvement action plan for 2021/22 that contributes to delivery of the local system plan (shared with Public Health Commissioning team and Cancer Alliance) <p>Improving outcomes through reflective learning and local system partnerships</p> <ul style="list-style-type: none"> • Develop a community of practice across the PCN and encourage practices' engagement with local system partners, in particular the Cancer Alliance, to enable delivery of the service requirements.
2021/22	<p>Improving referral practice</p> <ul style="list-style-type: none"> • Increase the proportion of people diagnosed at stages 1 and 2 by identifying and referring suspected cancer early, contributing to delivery of local CA target for improvement

	<ul style="list-style-type: none"> • Continue to review and improve referral practices, building on 2020/21 learning and activities, including through Significant Event Analysis and peer to peer learning and further analysis of local population data • Expand safety netting to include monitoring of patients with non-specific symptoms where the GP has a significant clinical concern but are not immediately referred for suspected cancer.¹⁴ • Continue to ensure patients receive high-quality information on their referral (for all future years) <p>Increasing uptake of National Cancer Screening Programmes</p> <ul style="list-style-type: none"> • Deliver agreed actions from their 2021/22 PCN screening improvement action plan, in line with Public Health Commissioning and Cancer Alliance plan. Update plan for 2022/23 <p>Improving outcomes through reflective learning and local system partnerships</p> <ul style="list-style-type: none"> • Working with local system partners (including patient groups), PCNs to proactively engage the local community to promote healthier lifestyles, awareness of signs and symptoms and availability of support.
2022/23	<p>Improving referral practice</p> <ul style="list-style-type: none"> • Increase the proportion of people diagnosed at stages 1 and 2 by identifying and referring suspected cancer early, contributing to delivery of local CA target for improvement • PCNs continue to review and improve referral practices, building on 20/21 learning and activities, including through Significant Event Analysis and peer to peer learning <p>Increasing uptake of National Cancer Screening Programmes</p> <ul style="list-style-type: none"> • Update & implement local screening improvement action plan. <p>Improving outcomes through reflective learning and local system partnerships</p> <ul style="list-style-type: none"> • Working with local system partners, PCNs proactively engage the local community to promote healthier lifestyles, awareness of signs and symptoms and available support. This includes identifying people at higher risk of developing cancer.
2023/24	<p>Improving referral practice</p>

¹⁴ NG12 recommends considering a review for people with any symptom that is associated with an increased risk of cancer where the GP has a concern, but who do not meet the criteria for referral or other investigative action. The review may be planned within a time frame agreed with the person or patient-initiated if new symptoms develop, the person continues to be concerned or their symptoms recur, persist or worsen. GP IT systems are structured to enable this practice.

	<ul style="list-style-type: none"> • Increase the proportion of people diagnosed at stages 1 and 2 by identifying and referring suspected cancer early, contributing to delivery of local CA target for improvement • All patients are receiving high-quality information about their referral. Those that are deemed to require additional support for their referral are signposted to the PCN social prescribing link workers. • Continued implementation of a consistent approach to safety netting across the PCN, and all people with serious but non-specific symptoms into Rapid Diagnostic Centres. <p>Increasing uptake of National Cancer Screening Programmes</p> <ul style="list-style-type: none"> • Subject to success of pilots, Targeted Lung Health Checks are scheduled for national roll out. PCNs should help practices to encourage participation in the programme for those who could benefit. <p>Improving outcomes through reflective learning and local system partnerships</p> <ul style="list-style-type: none"> • Working with local system partners, proactively engage the local community to promote healthier lifestyles, awareness of signs and symptoms and availability of support. This includes identifying people at higher risk of developing cancer.
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Proposed service requirements for 2020/21

6.12 From April 2020, practices working as part of PCNs will:

- identify a clinical lead who will be responsible across the PCN for the delivery of the service requirements in this section.
- 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 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

undertaken to exclude the possibility of cancer ('safety netting') in line with NICE Guideline 12. This should build on relevant approaches already in place in constituent practices and drawing on evidence.

- ensuring that patients receive high-quality information on their referral including why they are being referred, the importance of attending appointments and where they can access further support.
- increase uptake of National Cancer Screening Programmes. This will be done by:
 - leading and coordinating constituent practices' contribution to a local screening uptake improvement plan, working with the local Public Health Commissioning team and Cancer Alliance. PCNs should identify actions relevant for their particular populations that they will take forward.
 - building on actions already underway across practices to agree and deliver with practices any 2020/21 improvement activity identified.
 - standardising processes across the PCN to encourage the uptake of National Cancer Screening Programmes.
 - working with local system partners to agree a 2021/22 Network-level action plan for improving uptake of cancer screening programmes across the PCN.
- improve outcomes through reflective learning and local system partnerships. This will be done by:
 - developing a community of practice among practice level clinical staff that will inform Network-level improvement action plans
 - investigating historic referral diagnosis data to identify trends and opportunities for proactive work across the PCN to improve referrals and early diagnosis, and to identify cases which should be used for peer to peer learning and significant event analysis (including patients who presented many times before diagnosis and those diagnosed late).
 - facilitating and supporting constituent practices to conduct Network-wide Significant Event Analyses and peer to peer learning sessions, taking advantage of the broad range of cases across a PCN.

- facilitating and encouraging practices' engagement with local system partners, including Patient Participation Groups, secondary care, the relevant Cancer Alliance and Public Health Commissioning teams, to inform ongoing improvement activity.

Proposed metrics

6.13 Potential metrics to monitor the success of the service may include, but are not limited to:

	Metric description
1.	The proportion of cancers diagnosed at early stage (stage 1 and 2) – progress towards local Cancer Alliance target
2.	PCN-level participation in breast, bowel and cervical screening programmes
3.	Proportion of urgent cancer referrals that were safety netted
4.	The number of new cancer cases treated that have resulted from a two week wait referral (the 'detection' rate)
5.	The number of two week referrals resulting in a diagnosis of cancer (the 'conversion' rate)
6.	Number of cancers diagnosed via emergency presentation