British Geriatrics Society
Improving healthcare
for older people

Network Contract Direct Enhanced Service

Draft Outline Service Specifications

Response from the British Geriatrics Society

Executive summary

The NHS Long Term Plan identifies the care of older people living with frailty as one of its priorities, something that the British Geriatrics Society welcomes. This further aligns to the Government's Industrial Strategy and the 2019 Public Health England-led Consensus Statement on Healthy Ageing. We know that we have a growing ageing population and that failure to appropriately meet the needs of this population is a major contributor to the problems that the NHS faces.

We believe there is much to be welcomed in these draft service specifications and they represent a positive direction of travel for the care of older people in England. The specifications provide a key opportunity to build on existing NHS work focused on meeting the burgeoning health and care needs of older people, especially the most vulnerable who are known to live with frailty and multiple long-term conditions. However, we do have concerns about the specifications as written, as it appears that the focus on older people and healthy ageing that was such a crucial element of the NHS Long Term Plan has been diluted. This is particularly concerning at a time when Primary Care Networks are taking on responsibility for the healthcare of their local populations and would benefit from clear support from a dynamic Ageing Well programme. Much of the content of these specifications falls directly under the Ageing Well workstream of the Long Term Plan. However, there is currently no clear line of sight from the aspirations of the NHS Long Term Plan through the Ageing Well programme and these specifications to improved health outcomes for the people they aim to serve.

In this document we have provided what we hope is constructive feedback and suggested ways in which these specifications could be fine-tuned to make them more achievable and ensure that they work towards improving healthcare for older people.

Introduction

The British Geriatrics Society (BGS) welcomes the opportunity to comment on the draft Outline Service Specifications for a new Network Contract Direct Enhanced Service (DES). We see the national consultation as a positive step in creating a shared vision and hope this becomes the norm in future.

The British Geriatrics Society is the membership association for professionals specialising in the healthcare of older people across the UK. Founded in 1947, we now have over 4,000 members, and we are the only society in the UK offering specialist expertise in the wide range of healthcare needs of older people. Our members cover a broad range of healthcare professionals involved in the care of older people including GPs, geriatricians, nurses and allied health professionals. In addition, we have sixteen Special Interest Groups which include a range of sub-specialisms from movement disorders to community geriatrics. Our Special Interest Groups serve as the Society's source of clinical innovation, developing and maintaining high standards of clinical care, and disseminating specialist knowledge. Many of our members have considerable experience of policy, practice, research and innovation in healthcare for older people and are considered world leaders in their respective fields. BGS members stand ready to support NHS England and NHS Improvement in developing these specifications further and we hope that you will recognise how invaluable this support will be as NHS England and NHS Improvement work to deliver an ambitious, world leading and evidence-informed Ageing Well programme as a key component of the NHS Long Term Plan.

BGS members and officers have reviewed the draft specifications and this response reflects the feedback we have received, including 42 detailed responses from our online survey of professionals working in primary, community and acute care. Our views reflect current evidence on reducing demand and disability associated with frailty and multimorbidity and our experience of introducing new models of primary care and community services across the UK.

We have structured this document in what we hope is a helpful order, firstly providing some context about why this matters to older people and the evidence underpinning our assertions. We have then provided overall feedback on the service specifications followed by specific feedback on the three specifications that are particularly relevant to the care of older people – structured medication reviews, enhanced health in care homes and anticipatory care. Lastly, we suggest some clear, positive and implementable changes that could be made to the specifications, that will build capacity in primary care and the community to deliver excellent, joined-up care for older people.

Context

Older people are the main users of health and social care services with nearly two thirds of those admitted to hospital aged over 65.[1] Older people can have different patterns of disease presentation and are more likely to experience frailty – a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves[2]. The BGS mission is to improve healthcare for older people and we believe the health system is currently not sufficiently geared to their needs.

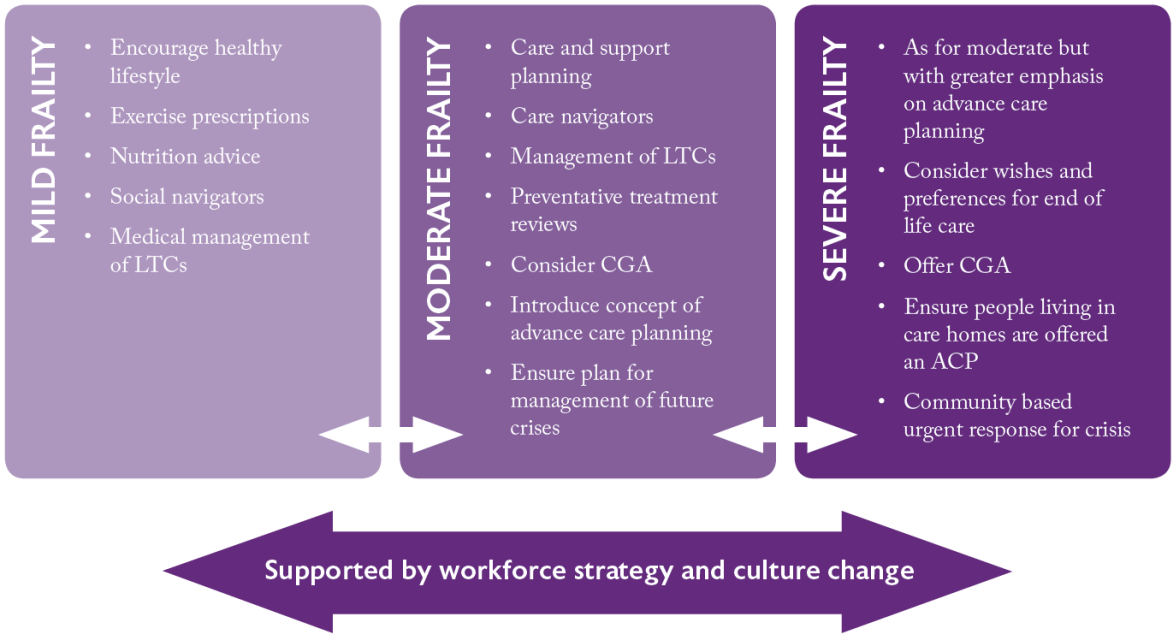
The NHS Long Term Plan acknowledges the impact that our ageing population is having on the NHS and social care and promotes the concept of frailty as a long-term condition. Work in recent years to improve healthcare for older people has been significant and it is essential that the specifications build on the evidence for new ways of working. For example as demonstrated by the Vanguards and Enhanced Health in Care Homes[3]. We need to ensure that primary and community care provision works for people who already have frailty, as well as those at risk of developing frailty. Recent evidence suggests having four or more long term conditions in mid-life is strongly associated with frailty and that the presence of frailty - even after adjustment for the number of long-term conditions, sociodemographics, and lifestyle - is associated with higher mortality[4,5.]

Advantage JA recently published *Promoting Healthy Ageing through a Frailty Prevention Approach*[6] – evidence-based guidance supported by 22 member states across Europe. The Frailty Prevention Approach (FPA) comprises screening to identify individuals at risk, comprehensive geriatric assessment (CGA) and care and support planning, tailored interventions such as exercise (particularly strength and balance training), adequate nutrition, avoiding inappropriate polypharmacy, reablement to promote independence and recovery after illness, and care planning that considers treatment preferences and wishes around end of life care. The elements of the FPA are mutually reinforcing. Individual elements are more effective when implemented together and in an integrated model by multi-disciplinary teams positioned at the heart of age-friendly communities – rather like the promise of Primary Care Networks.

The role of the GP as expert medical generalist is a precious asset in the NHS. GPs have expertise in holistic, person-centred practice, and are skilled at managing risk and uncertainty when dealing with undifferentiated presentation in primary care. We welcome the potential for additional funding to enable GPs to have more time to manage people who have complex care and support needs or complex social circumstances. This refocusing of the GP role will require some tasks currently carried out by GPs to be undertaken by members of a wider multi-disciplinary team within the Primary Care Network (PCN).

The introduction of PCNs and joined-up working with community services marks a turning point in place-based care and population health management. Both have local expertise in the communities they serve and local assets in the area. Providing them with freedom, resourcing, support, and headspace, will enable them to align and deliver services that support older people to lead happy, healthy, and independent lives.

Frailty is expensive to the NHS – using 2013/14 reference costs, extra annual cost to the healthcare system per person was £561.05 for mild, £1,208.60 for moderate and £2,108.20 for severe frailty[7]. As such, efforts should focus on the early identification of frailty, particularly mild frailty as early intervention is more likely to reverse frailty or prevent/delay progression. BGS advocates the following approach to the management of frailty in primary care, as set out in our position statement on primary care for older people.[8]



General comments on the Service Specifications

BGS welcomes the new investment to enhance primary care workforce through the *Additional Roles Reimbursement Scheme (ARRS)*. We are encouraged that the services in the DES should either directly benefit older people and their carers, at home or in a care home, or address acknowledged risk factors for frailty and multi-morbidity. BGS strongly supports the advice on developing information sharing agreements, shared records and collaborative working across provider organisations. We agree with the overall areas that the specifications have prioritised and our members feel that the overall direction of the specifications is positive.

However, overall the DES has a very wide scope with many areas of overlap and duplication between the elements in the five specifications. There seems to be little recognition of the need to carefully phase their introduction in terms of system readiness and the requirement to address important interdependencies to optimise value. Our members therefore have significant concerns about the DES overall, as well as each of the individual specifications.

Stability in primary care

Stability in primary care is paramount; primary care is the first point of contact for most patients seeking healthcare. Every year 307 million patients are seen, with GPs averaging 42 patient contacts a day. The 7,500 practices in the UK manage 95% of all urgent care encounters in the NHS.[9]

Workable plans to stabilise primary care are urgently required if we are to realise the triple win of improving population health, increasing the quality of care, and driving down demand and system costs. Just a 1% reduction in urgent care activity in primary care could result in a 20% increase in the demand in secondary care. This is a consequence of the gearing effect of the different urgent care delivery between primary and secondary care.[10] It is therefore our view that the additional healthcare professionals funded through the DES must initially be used to stabilise the current workforce crisis in primary care. The amount of extra, unfunded work

that is being proposed is at odds with the commitments in NHS England and NHS Improvement's *Investment and Evolution* document and could have a massively destabilising effect on primary care.

Workforce recruitment and role mismatch

Whilst the ARRS offers primary care a welcome additional workforce, we believe it does not provide the workforce required to fulfil certain specified roles. For example, advance care planning for those nearing the end of life in the community is resource-intensive and, in most cases, is carried out by an experienced doctor or nurse. Advance care planning will often require travel time (a home visit is usually required), time to delicately conduct a conversation with the patient and family and time to complete the relevant paperwork. This process usually takes at least ninety minutes of clinician time and this pressure will not be relieved with the additional roles being provided through the ARRS.

The recognition that clinical pharmacists, social prescribers and physician associates can play a role in the care of older people is welcome. However, currently many physician associates have relatively little community experience (including in the care of older people with frailty) and therefore would need support from either a GP with an interest in the care of older people or a geriatrician. Similarly, unless a clinical pharmacist has worked specifically with older people, they may not have sufficient expertise. Thus the introduction of new team members is very much to be welcomed, but the need for training for these individuals should not be understated.

We believe it may be naïve to assume that all PCNs will be able to recruit the workforce required for the work set out in this DES. In many areas, PCNs will be recruiting from a small pool for roles such as prescribing pharmacists and advanced nurse practitioners. The reality in many areas is that GP time will be diverted from urgent care duties to do this additional work.

Distribution of workload between providers

The draft specifications dictate which interventions should be done by certain providers. This is overly prescriptive and fails to account for variations between localities in terms of population needs, workforce capacity, skill mix and the capacity of local community services. The prescriptive nature of the DES limits the potential for innovative skill mix or use of technology to blur roles or shift tasks.

Population health and demographic variation

The specifications fail to consider the significant differences in demography in PCNs across the country and the associated implications for population health. Some PCNs have a higher prevalence of socio-economic deprivation associated with multimorbidity and frailty in mid-life while others may have a more affluent older population with higher rates of dementia and institutional care. The DES does not appear to reflect the differing needs, priorities and capabilities of PCNs. This seems at odds with the ethos of a place-based neighbourhood network.

Stability of funding

Many Clinical Commissioning Groups (CCGs) are already offering Locally Enhanced Services (LES) that fund primary care and community providers to deliver some of the services proposed in the DES. The specifications risk destabilising this funding. Although it is suggested that CCG funding should be reinvested to support PCNs, this is at best uncertain and will inevitably disrupt continuity of current services. The Investment and Impact Fund (IIF) is cited as a source of extra funding for practices making good progress towards achieving the specifications. However, this will adversely affect providers in deprived areas, where the workforce shortage is felt most keenly. These areas are less likely to recruit and make good progress and, as such, they will not receive IIF funding. This only compounds their challenges and will further increase health inequalities.

Information sharing

People living with frailty, dementia, or multimorbidity require the expertise of multiple different healthcare professionals and provider organisations, coordinated as a multi-disciplinary team (MDT). Informational continuity is critical for effective coordination of care within MDTs of different providers. Whilst we welcome the importance attached to Information Governance (IG), we feel the timeframes in the specification are unrealistic to allow for the level of information sharing required.

Timing

There is insufficient lead-in time and support identified in the specifications. There are many exemplars of joined-up services between primary care and community providers across the country, some of which have been going for many years. All of these took time to set up; many needed a year of planning and consultation with dedicated project management, Information Governance (IG), IT and contract support and meetings to seek full engagement and cooperation from all local providers of health and social care. Once the services were functioning, more time was required to get the teams running effectively and appropriately trained. As outlined, the specifications will not fund the above support services, and the proposed timescales are unrealistic.

Leadership and organisational development

Delivering all of this at scale and at the ambitious pace proposed will require strong, focused and well-informed leadership with sustained attention to developing the skills and capabilities required for a truly effective multidisciplinary workforce. The Health Foundation in its analysis of the Care Home Vanguards[11], for example, points out that this takes years to achieve, even for services principally delivered by the NHS, let alone building sustainable cross-sector partnerships. A new Kings Fund report[12] reminds us that creating the conditions for primary care teams to function effectively is a complex task. Team members need to be clear about roles and responsibilities and understand how these may shift over time. It is unlikely that 'bolting on' new professionals without re-thinking workflow will be effective. For professionals who work remotely or between practices, co-locating on a regular basis in a shared space can help to improve team working and communication. The DES has implications for the physical infrastructure in primary care. This is all within a context of PCNs having been only relatively recently established, in some cases with considerable structural change.

Accreditation/Training

There is still considerable variation and inconsistency in education and training across the country. This and siloed working between different sectors and professions can be particularly problematic in care of older people. Frailty remains a new area for much of the workforce and work is needed to upskill primary care in the core capabilities for frailty: understanding, identifying and assessing frailty; person-centred collaborative working; managing frailty; and underpinning principles such as ethics and safeguarding. It is important to build on the work already done to 'socialise' the concept of frailty and to train multi-disciplinary teams in the use of the relevant tools.

Metrics

The number of metrics seems overly burdensome with an overemphasis on recording inputs and activities at the expense of an important focus on personal outcomes. We have commented in more detail on the specific metrics for each of the specifications but thought it was important to make this observation as it applies across the whole document.

Key issues with individual specifications

While all of the five specifications are relevant to older people, we have focused our feedback on the three that we consider to be specific to older people rather than to the general population: Structured Medication Review, Enhanced Health in Care Homes and Anticipatory Care.

Structured Medication Review

We welcome this focused specification on reducing problematic polypharmacy. This is a serious problem among older people and introducing structured medication reviews (SMRs) will help to address this. With patient-focused goals and metrics, this specification has the potential to have significant benefit for older people living with frailty.

However, we feel that in parts, this specification is not specific enough and the metrics are not patient-focused. We are concerned that this could become a tick-box exercise over which there is very little scrutiny and therefore will not achieve the intended benefits to patients.

One of the key outcome measures for this specification is counting the number of SMRs completed. We do not feel that this is an appropriately patient-centred goal as it does not focus on the outcome of the SMR. We feel that better metrics for this specification would be a reduction in the number of people with inappropriate polypharmacy or a reduction in the number of drug-related hospital admissions.

There is limited detail about the drugs to be targeted in SMRs and we have concerns about the detail that is included. While we appreciate the environmental impact of switching to low carbon inhalers, we would suggest that this will have minimal impact for individual patients.

The focus on 'medicines that can cause dependency' is unclear. This could be interpreted as functional dependency from drugs such as antipsychotics, sedatives and anticholinergics – in which case this focus is

welcome. Focusing on these medications will have a direct benefit on patients and will reduce risks whilst reducing the overall cost of prescribing. If, however, the focus is on opioids, we are concerned that this may have unintended consequence on pain management in palliative and end of life care situations. This specification must be made more specific to ensure that it provides real benefit to patients and does not cause unintended harm.

The specification could be made much more impactful and patient-focused by targeting specific medications that are associated with harm in older people with frailty and should trigger medication reviews. The benefit and risk from disease prevention medications (for both primary and secondary indications) should be reviewed in people with severe frailty. This includes medications for reducing blood pressure and cholesterol which may have been appropriate when prescribed but are no longer appropriate for some people as they become increasingly frail.

By fine-tuning the metrics and the detail of this specification, there is potential for this to have a significant impact on the healthcare of older people. The enhanced role for pharmacists, funded through the ARRS, supports this.

Enhanced health in care homes

The enhanced health in care homes (EHCH) specification represents an important attempt to address the needs of care home residents who are at risk of inappropriate hospital admission or poorly-managed healthcare. With one in seven people aged 85 and over living permanently in care homes, this issue is of great importance to BGS and to the people that our members support. Research from the Health Foundation found that despite care homes residents comprising 2.8% of the population aged over 65, they account for 7.9% of emergency admissions to hospital in this age group. In addition, many of these admissions may have been avoidable as 41% were for conditions that could be managed or prevented outside of hospital or caused by poor care.[13]

We know that continuity of care is important for people with complex needs and we welcome the commitment to ensuring that patients living in care homes have a named practice and associated MDT, albeit this may take some time to implement.

We believe this specification fails to acknowledge the current crisis in social care – many of the problems currently facing the NHS are exacerbated by lack of capacity in the social care system, including in the availability of appropriate care home places for older people. In addition, the care home sector is far from homogenous with providers including both private and public sector operators and organisations of varying size and structure. While the specification acknowledges that the geographic distribution of care homes mean that this will affect different PCNs in different ways, we do not believe that this has been adequately considered. Some PCNs will serve as many as 400 patients living in care homes and as such, the proposal that PCNs must deliver a weekly 'ward round' for care home residents and that at least fortnightly, this must be led by a GP represents a significant amount of extra work that we do not believe is workable or evidence-based. This effectively means that a GP will need to do a ward round on 200 patients a week which will remove a full-time

GP from primary care. This requirement fails to acknowledge the benefit of digital solutions, such as video consultations. A virtual consultation of this sort could support care home staff to deal with more minor issues, thus releasing some capacity.

Data sharing agreements between private providers (e.g. care homes) and the NHS are a good idea in principle, but are a long way off in most cases. National guidance on data sharing between health and social care is needed before this can be implemented across the board and we would suggest that NHSX should take a lead role in providing this guidance. In addition to guidance, providers should have access to standardised sample data sharing agreements, privacy policies and all information governance documents. This would considerably speed up the shift to effective information-sharing to benefit patients, carers and the workforce.

The specifications outline that PCNs should own and coordinate delivery of a care plan within seven days of a patient arriving in a care home. Most care homes develop their own care plans for patients on arrival. PCNs should value and not duplicate this work. The immediate focus of the practice and PCN should be on medicine reconciliation and review and on establishing a treatment escalation plan or advance care plan in consultation with the patient, family and care home staff.

The document suggests that PCNs and the community should *"provide support and assistance to the care home by…supporting the professional development of care home staff by identifying opportunities for training and shared learning."* We are concerned that this appears to be extra unfunded work. We also acknowledge the unique skills, experience, and expertise of this highly dedicated workforce. While primary and community services should identify opportunities for training and shared learning to assist care home workforce development, training plans in care homes must be led, and coordinated by care home owners and their staff to ensure that the training provided is empowering and tailored to the specific needs of the workforce. Adequate funding must also be provided to ensure that the workforce has the necessary expertise to meet the specific requirements of this specification, such as the urgent community response requirement. This will require a healthcare professional trained and qualified to undertake a clinical evaluation to determine the cause of deterioration in patients living in care homes. Most community providers will not currently have this available and must be funded to provide it.

Anticipatory care

The 2019 NHS Long Term Plan set out key commitments which now form the policy foundations of the newly funded National Ageing Well programme. The Plan specifically committed to building on routine frailty identification which is part of the GMS contractual requirements agreed in 2017. Within the first year, GPs assessed 2.5 million older people for frailty, with almost 1 million older people identified as being at high risk of requiring urgent care, care home admission or of dying. It is disappointing to see that the existing focus on frailty, designed to improve patient and system outcomes for a growing group of vulnerable older people appears at risk of being lost in this specification. The specification as written, shifts towards less well-defined

populations for which validated national segmentation tools and effective interventions are yet to be defined and made available.

We believe that the problems outlined earlier regarding lack of funding, recruitment mismatch, timeframes, IT and information governance challenges and additional unfunded work apply to this specification. The specification does not identify specific population groups to which it applies. This makes it unnecessarily vague, which may result in interventions which are not evidence-based.

This specification would be improved by explicitly targeting people living with complex multiple conditions and those with moderate-severe frailty who are not able to leave their house or are in supported living. However, targeting anticipatory care in this way would require an expansion of PCN services much greater than has so far been envisaged. The engagement of the voluntary sector as part of a team including health and social care staff may be one way of enabling a wider team to be formed, but resource limitations remain a significant barrier.

In terms of identification of this group, BGS would suggest using the Electronic Frailty Index (eFI), supplemented with other methods for identifying complexity. PCNs may choose to customise their IT so that this process also happens opportunistically. This group may then be targeted for assessment and appropriate interventions to improve continuity and coordination in primary care.

In terms of population health management, this approach to anticipatory care is evidence-based. Baker[14] and colleagues studied the impact of anticipatory care planning in primary care. The cohort with an anticipatory care plan had significantly fewer hospital admissions, days in hospital and associated costs than the control group matched for age, sex, multiple morbidity indices, and secondary care outpatient and inpatient activity. Barker[15] reported that patients who saw the same general practitioner a greater proportion of the time experienced 13% fewer admissions to hospital for ambulatory care sensitive conditions than patients who had low continuity of care. The evidence was stronger for older patients and for people with the highest levels of primary care contacts. In Tapsfield's study[16] of all patients who died in 2014 in 9 diverse GP practices, 65% of deaths in patients with anticipatory care were at home or in the community, compared to only 27% of deaths in those without anticipatory care. We would suggest that outcome metrics for this specification could be developed from this research. Potential outcome metrics could include the number of patients with anticipatory care plans who die in their preferred place of care or the number of emergency hospital admissions for people who are in receipt of an anticipatory care approach.

We welcome the non-prescriptive element of this specification, particularly in terms of regularity of MDT meetings and how work is distributed between PCNs and community providers. This empowers local organisations to develop their own solutions, which is to be encouraged.

Suggested improvements

We are pleased to offer constructive suggestions for reframing the DES to address the concerns outlined above. We believe reframing and rephrasing are essential to stabilise primary care and to deliver value from primary

care and community service investments. Without this firm foundation, primary care workload will increase with a high risk of further demotivating staff already working under considerable pressure.

1. The DES could be **simplified as a single service for people with complex needs** – that is, people living with frailty, severe multimorbidity or in complex circumstances associated with health inequalities. The common service model, whether living at home or in a care home, is well-coordinated, person-centred anticipatory care that includes medication reviews and multidisciplinary support for enablement and self-management.
2. PCNs and community services should **be supported to deliver the specifications**. Additional funding could be made available to PCNs and community providers with a shared vision for delivering the specifications to support with design, implementation and evaluation of new models of care.
3. Year 1 should have a **greater focus on building readiness** by addressing the enablers for transformation in the PCN. This would allow flexible use of the additional funding for roles required to stabilise GP workload, releasing capacity for PCNs and community service providers to work together and build strong foundations for further development of services in the community. The expected readiness activities would include
    - Local population needs assessment
    - Risk stratification of the population in each PCN
    - PCN workforce planning to review and optimise skill mix in practices
    - Enhanced triage by practice admin staff, signposting and referral processes
    - Training for new PCN staff and to support current staff to take on new roles.
    - Development of relationships between disciplines and sectors in MDTs
    - Creation of hubs and single point of access routes to urgent care, community services and voluntary sector support
    - Local information sharing protocols
4. Informed by the above and with clarity on their local population needs and workforce planning, PCNs should be able to agree how to **phase the implementation of the complex care service 2020-2024** for their population with different levels of need.
5. **Stability of funding rather than year on year allocation** should be ensured so that long term decisions can be made with regards to recruitment to PCNs.
6. NHSX should provide more **national guidance on data sharing agreements**, privacy policies and IG documents for the purposes of direct care and secondary evaluation of services. This would enable PCNs to use standard templates with their local provider organisations and speed up the shift to effective information-sharing to benefit patients, carers and the workforce.
7. PCNs should be supported to consider what **shared digital and local healthcare solutions** might be employed to support people to lead happier, healthier, independent lives. A toolkit outlining some of these case studies and how they developed shared working could be really useful in supporting

integration across providers. For example, the *Models of Care* website[a] could be a useful platform for case studies.

8. **Adequate time and support for Clinical Directors** of PCNs is needed to come together for peer support and to exchange ideas on emerging interventions.
9. **Simplified metrics** should be developed with a smaller number of high-level system outcomes for which PCNs and their community providers are jointly accountable. These should be supplemented with measures that include information on outcomes for people, for examples using PROMs, PREMs as in the National Audit of Intermediate Care or based on the 'I' Statements[17].

Conclusion

In conclusion, we commend NHS England and NHS Improvement for the opportunity to comment on these draft service specifications. The specifications create a much-needed opportunity to drive clear integration, bringing together partners from health, social care, the community, voluntary and charitable sectors. There is much to be welcomed in these service specifications. However as they stand, they risk not delivering the ambitions of the Long Term Plan nor leading to the health outcomes that we collectively want to see. In particular, the absence of a clear focus on the needs of older people is a missed opportunity to make a step change in primary care provision for them.

We urge you to heed the feedback from frontline professionals working in primary and community care. BGS members and our staff team stand ready to support the next stage of development of these specifications. Our members can provide invaluable expertise from the frontline as well as significant policy experience and expertise. They are keen to provide the insight that NHS England and NHS Improvement need to make these specifications both workable and effective.

We look forward to helping you revise and re-shape these specifications over the coming weeks. Please contact our Chief Executive, Sarah Mistry at s.mistry@bgs.org.uk or our Policy Manager, Sally Greenbrook at s.greenbrook@bgs.org.uk.

British Geriatrics Society

15 January 2020

[a] https://modelsofcare.co.uk

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