

# Primary Care Networks – what does integrated primary and community care mean for diabetes?

Ed Waller – Director of Primary Care Strategy and NHS Contracts  
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NHS England and NHS Improvement



# NHS Long Term Plan sets the direction and themes for us all for 2019-2029



The NHS Long Term Plan is about integrating services around the patient more effectively, and making inroads into the major 'killer' diseases and causes of ill health. Its three main ambitions:

**1. Making sure everyone gets the best start in life**

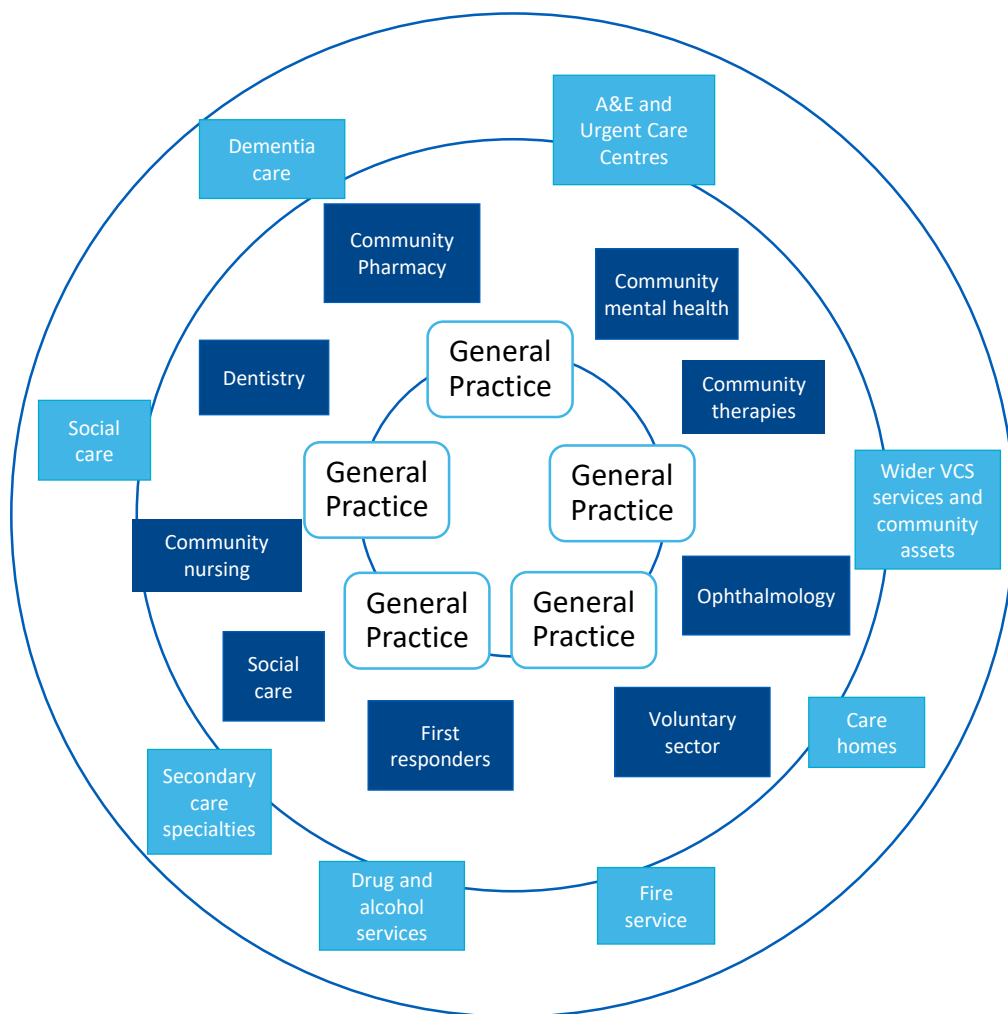
**2. Delivering world class care for major health problems**

**3. Supporting people to age well**

**Ambitions underpinned by action to overcome specific challenges:**

Personalised care, Prevention and health inequalities, Workforce,  
Data and digital technology, Delivering better value

# Primary Care Networks



- Primary Care Networks are small enough to give a sense of **local ownership**, but big enough to have **impact** across a 30 – 50K population.
- They will comprise **groupings of clinicians and wider staff sharing a vision** for how to improve the care of their population and will serve as **units to provide services**, led by a Clinical Director and governed by a Network Agreement.
- Primary Care Networks should enable the provision of **proactive, accessible, co-ordinated and more integrated** primary and community care, improving outcomes for patients.
- They will provide multiple opportunities to consider **what care looks like** for patients, including people with long term conditions, such as diabetes.

# A five year framework for the GP services contract



- Published in January 2019 by [NHS England](#) and the [BMA's General Practitioners Committee in England](#).
- Five year framework: 2019/20 GMS Contract changes and joint proposals for the subsequent four years.
- The Framework [sets direction for primary care](#) and seeks to address the core challenges facing general practice. It introduced [funding and support for Primary Care Networks](#).
- Funding for the core practice contract is fixed for each of the next five years, and [increases by £978 million](#) in 2023/24.
- [Up to £1.799 billion](#) will flow nationally through the Network Contract DES by 2023/24.



# The Network Contract DES



- Primary Care Networks will sign up to the Network Contract DES, which will **outline the contractual requirements** of being in a Network.
- This will include the introduction of **seven new service specifications** which have been identified for 2020/21 and 2021/22.
- Through a new Additional Roles Reimbursement Scheme, Networks will be **guaranteed funding for up to an estimated 20K+ additional staff** by 2023/24.
- New **roles will include**: Clinical Pharmacists, Social Prescribing Link Workers, Physiotherapists, Physician Associates; and Paramedics.
- Networks will also provide **extended hours access** across their patch.

## Investment and evolution:

A five-year framework for GP contract reform to implement *The NHS Long Term Plan*

31 January 2019



# The Network Contract DES: Service Specifications



From April  
2020

Anticipatory  
Care

Personalised  
Care

Structured  
Medications  
Review

Early  
cancer  
diagnosis

Enhanced  
Health in Care  
Homes

From April  
2021

CVD diagnosis  
and prevention

Tackling  
inequalities

- Requirements on five key areas to be added within the Network Contract DES from April 2020 – with a further two introduced from April 2021.
- They will include “standard national methods, processes, metrics and expected quantified benefits for patients.”
- PCNs will benchmark their performance via a Network Dashboard, and be incentivised to improve performance through the Investment and Impact Fund.
- Delivery of new requirements in most areas will be phased in by 2023/24.
- Design and implementation will require cross working between other PCN members such as community services providers and community pharmacy.

# Where are the opportunities?



## New service specifications in April 2020 and April 2021

Increased investment for Primary Care Networks includes the introduction of [seven specific national service specifications](#) under the Network Contract DES, which will come into the contract over the next two years. For the management of long term conditions, such as diabetes, the following services may offer particular opportunities:

### [Personalised Care \(from April 2020\)](#)

- Will deliver national roll out of the *NHS Comprehensive Model for Personalised Care*.
- This includes personalised care and support planning and shared decision making for people with long term conditions.

### [Structured Medications Review and Optimisation \(from April 2020\)](#)

- Will directly tackle instances of inappropriate and unsafe polypharmacy and support medicines optimisation more widely.
- Will focus on priority groups of patients, including those with complex needs who may take a variety of medication.

### [Tackling Local Health Inequalities \(from April 2021\)](#)

- Will identify practical approaches to addressing health inequalities at Primary Care Network level, including those which may lead to conditions such as diabetes.

### [Cardiovascular Disease Prevention and Diagnosis \(from April 2021\)](#)

- Will focus on the identification and prevention of CVD, including the different risk factors which can contribute to the condition.

## Investment and Impact Fund (IIF) from 2020

The Investment and Impact Fund will support Primary Care Networks to [plan for and achieve better performance](#) against Long Term Plan priorities.

It is anticipated that funding will rise from [£75 million](#) in 2020/21 to a [minimum expected £300 million](#) in 2023/24.

# Quality & Outcomes Framework (QOF)



Introduced in 2004, QOF is one of the largest pay for performance schemes in the world. It is made up of indicators covering a range of clinical domains. Diabetes indicators account for 12.5% of the total value of QOF.

A comprehensive review of QOF in 2018 showed that while the framework was valued, there was scope for reform to:

- Deliver better patient care, particularly holistic person centred care.
- Support stability and sustainability in general practice by creating space for professionalism.
- Support practices to impact on the wider system, optimising the use of limited resources.

As a part of this review, the diabetes QOF domain saw a significant overhaul in 2019/20. A range of new, evidence based diabetes indicators were introduced.

The new diabetes indicators represent a move away from a one size fits all approach to diabetes management in favour of segmenting the patient population. In particular, they are intended to reduce the potential for:

- over-treatment of patients with moderate or severe frailty
- under-treatment of patients without moderate or severe frailty.

Quality Improvement modules have also been introduced into QOF from 2019/20, which create space for practices to address aspects of care which do not lend themselves to metric development. New modules will be introduced each year – in 2019/20 they focused on prescribing safety and end of life care.



# Community Pharmacy - a five year settlement



The settlement commits almost £13 billion to community pharmacy through its contractual framework, with a commitment to spend **£2.592 billion in each of the next five financial years**. It is a settlement which:

## Delivers clinical services

- Through the settlement a new national NHS Community Pharmacists Consultation Service will be implemented, connecting patients who have a minor illness with a community pharmacy which should rightly be their first port of call.
- The settlement continues to promote medicines safety and optimisation and the critical role of community pharmacy as an agent of improved public health and prevention.

## Continues to prioritise quality

- The success of the Quality Payments Scheme is recognised as it continues for the next five years under a new name, the Pharmacy Quality Scheme (PQS).
- The PQS will continue at its current value of £75 million and will include important new requirements.

## Retains access

- The settlement underlines the necessity of protecting access to local community pharmacies through a Pharmacy Access Scheme.

## Includes a programme of enabling reforms

- The deal commits all parties to action which will maximise the opportunities of automation and developments in information technology and skill mix, to deliver efficiencies in dispensing and services which release pharmacist time.

Drives the greater use community pharmacy in new, integrated local care models.

All programmes are informed by ongoing stakeholder engagement and patient and public involvement.

Consideration is being given to develop pilots for CVD case finding and smoking cessation. Evidence suggests the following criteria may be used:

**Hypertension screening pilot** - for those not already diagnosed:

- Individuals aged between 40-75;
- People from lower socio-economic groups and/ or from areas of deprivation;
- Those likely to be disengaged with primary care, with a focus towards males; and
- Individuals with high risk factors for hypertension, for example, smokers, overweight or obese, physically inactive, poor diet, African or Caribbean descent.

**Smoking cessation post hospital discharge pilot**

- Smokers engaged in stop smoking services during a hospital stay;
- Post discharge ongoing nicotine replacement therapy and advice.

# Community Pharmacy – a clinical future



There are three key priority areas for the new contractual framework:

## Urgent Care – the NHS Community Pharmacist Consultation Service (CPCS)

- From October 2019 referrals will be made from NHS 111 to community pharmacy for minor illnesses and urgent medicines supply.
- This will replace the current NHS Urgent Medicines Supply Advanced Service (NUMSAS) as well as local pilots of the NHS111 Digital Minor Illness Referral Service (DMIRS).

## Prevention

- By April 2020, being a Level 1 Healthy Living Pharmacy will become an essential requirement for community pharmacy contractors.
- Trained health champions will deliver interventions on key issues, such as smoking and weight management, as well as providing wellbeing and self-care advice, and signposting people to other relevant services.

## Medicines Optimisation

- Medicines use reviews will be replaced by enhanced structured medication reviews delivered by clinical pharmacists in Primary Care Networks.
- A medicines reconciliation service will be introduced to ensure that changes in medicines made in secondary care are implemented appropriately when patients are discharged back into the community.

# Community Pharmacy and diabetes



## Pharmacy Quality Scheme

- Deliver quality criteria in all three quality dimensions: Clinical Effectiveness, Patient Safety and Patient Experience; supporting delivery of The Long Term Plan.
- As of February 2019 there are 9,562 Level 1 Healthy Living Pharmacies proactively promoting wellbeing.
- The prevention domain of the scheme builds on previous schemes.
- For diabetes: confirmation that all patients who present from 1 October 2019 to 31 January 2020 have had foot and eye checks (linked to retinopathy) in the last 12 months and referral as appropriate.
- This seeks to reduce the risk of harm to patients due to complications associated with diabetes.
- Community Pharmacy teams are well placed to identify hard to reach people.

## Wider engagement with Primary Care Networks

- Will engage with the development of service specifications, such as CVD and health inequalities.



## Pharmacy Quality Scheme

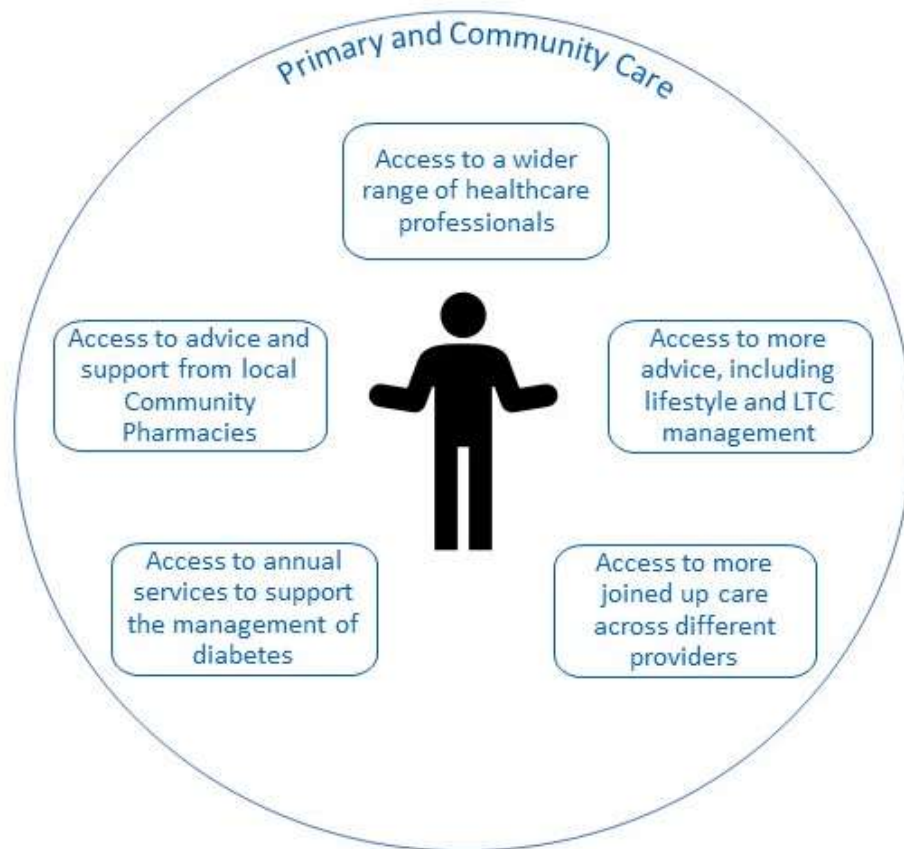
Guidance 2019/20



NHS England and NHS Improvement



# What will patients experience differently in 2023/24 compared to now?



The contractual changes described fit together to form a package of how care will be delivered at Primary Care Network level. We believe these changes will mean that patients can expect to:

- See a [greater range of health professionals](#) for their care, including [Clinical Pharmacists](#) and [Social Prescribing Link Workers](#), within the Primary Care Network setting.
- Be able to [access advice from a multi-disciplinary team](#) such as lifestyle advice and help with managing a long term condition.
- Experience [more joined-up care between different providers](#) including general practice, pharmacy and community services.
- Benefit from [annual services which will help them to manage their diabetes](#), including a Structured Medication Review, and those factors which can lead to or occur as a result of diabetes.
- Receive [support from their local Community Pharmacy](#) with wellbeing advice and monitoring of relevant health checks.