2017-19 NHS Standard Contract provisions across primary and secondary care

Implementation toolkit for local systems

In partnership with:

Academy of Medical Royal Colleges

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NHS Clinical Commissioners
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Royal College of General Practitioners

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Introduction

The General Practice Forward View (GPFV) made a commitment to improve collaboration and working practices across the interface between primary and secondary care, with a further commitment to introduce new provisions into the NHS Standard Contract https://www.england.nhs.uk/nhs-standard-contract/ in order to improve the organisation of care across the interface between primary and secondary care.

These commitments were driven in part by a recognition that good professional practice requires care for patients to be seamless, however patients sometimes find themselves caught in a 'no man's land' in their journey between primary and secondary care. Examples of this include patients being unsure of who to ask if they have questions about their care following discharge from a secondary care provider, or running out of medication and being unable to access more in a timely manner.

What do the contract provisions cover?

The Contract provisions cover seven main areas:

1. Managing DNAs and re-referrals
2. Managing onward referrals
3. Managing patient care and investigations
4. Communicating with patients and responding to their queries
5. Discharge summaries and clinic letters
6. Medication and shared care protocols
7. Issuing fit notes.

The provisions are set out in full in the NHS Standard Contract itself: https://www.england.nhs.uk/nhs-standard-contract/

For queries email nhscb.contractshelp@nhs.net

Background

A Primary Care Foundation and NHS Alliance report indicated that 27% of GP appointments could potentially be avoided with changes to how the system works, attributing 4.5% of these to how primary care and secondary care work together, equating to an estimated 15 million appointments nationwide.

According to research from The King's Fund[1], the total number of GP appointments and telephone consultations increased by 7.5% between 2015 and 2017. With 27,773 full-time equivalent GPs (NHS Digital March 2018) and an estimated 5m GP appointments per week (NHS England 2015/16), full-time GPs are each having contact with on average almost 180 patients per week.

King's Fund research into hospital activity shows a similar pattern of increased demand[2], with an overall increase in elective admissions between 2003/4 and 2016/17 of 82%.

Over the same period, the total number of referrals to outpatient services increased by 62%.

An ageing population with increasingly complex multiple health conditions, along with rising public expectation and the steady expansion of new treatments and cures, means that the demand on primary and secondary care services is set to increase.

Against this background, good organisation of care between general practice and secondary care providers is crucial in making the best use of clinical time and NHS resources in both settings and, most importantly, in ensuring that patients receive high-quality care.

[1] The King's Fund Quarterly Monitoring Report June 2017 http://qmr.kingsfund.org.uk/2017/23/
[2] The King's Fund How hospital activity in the NHS in England has changed over time https://www.kingsfund.org.uk/publications/hospital-activity-funding-changes

Purpose of the toolkit

The purpose of this toolkit is to set out some **practical ways in which organisations can collaborate locally to implement the NHS Standard Contract provisions** relating to primary and secondary care. The toolkit includes:

- **Practical steps for enabling implementation**
- **Case studies** demonstrating how some local areas have approached this work
- **Example local primary/secondary care agreement** (see Case Study 1) involving LMC, CCG and secondary care provider
- **Detailed guidance** (Appendix A) to facilitate conversations between CCGs and providers to **better understand how each of the measures is being implemented** and to help identify and unblock any issues in any particular area.

It is estimated that full implementation of these contract provisions would be equivalent to a potential saving of 225,000 GP appointments per year, equivalent to adding approximately 1,500 GPs to the national workforce.

What resources are available to support implementation of the contract provisions?

The resources listed below to support this work are available at: https://www.england.nhs.uk/gp/gpfv/workload/interface/resources/

- Key messages for clinicians and managers to explain the contract changes
- Patient leaflet, so that patients know what they can expect to happen if they are referred by their general practice to see a specialist or consultant at a hospital or a community health centre.
- Clinical Guidelines on Onward Referral
- The Contract provisions were launched via a joint NHS England/NHS Improvement letter to CCG Accountable Officers and Chief Executives of NHS trusts and NHS foundation trusts.

Practical steps for enabling implementation

This toolkit has been developed in collaboration with stakeholders across the health system and engagement has taken place with provider trusts, LMCs, CCGs and GPs to understand what is already proving to be helpful in implementing the contract provisions. Practical suggestions include for all local organisations to do the following:

1. **Sponsor and promote the contract provisions collectively as best practice** in order to achieve a seamless patient journey and make best use of time and resource for clinicians and all other staff.

2. Create a **forum for regular meetings** between CCG, local providers and local general practices (through the governing body, the LMC and other routes e.g. local primary care networks) in order to:
   - Ensure **safe and seamless care for the patient** remains at the heart of discussions and agreement on responsibilities for patient care
   - Understand different organisations' views of current uptake of the contract provisions. Use **Appendix A** to support conversations around implementation of specific contract provisions
   - **Agree local priorities and implementation plans** where appropriate, including timeframes
   - Develop a **local primary/secondary care agreement (example provided in Case Study 1)** covering implementation of the contract provisions
   - **Meet regularly, provide feedback on implementation and hold each other to account.**

3. Explore how providers are:
   - **Raising awareness of the contract provisions** amongst senior clinicians
   - **Including the contract provisions in junior staff training and in induction**
   - Making **practical arrangements** to allow staff to operate according to the contract provisions and what oversight is provided for junior staff to enable and assure compliance.

4. **Engage with patient groups, diverse population groups and the voluntary, community and faith sectors** to understand their perspective and allow any learning to influence local plans.

5. Ensure that local general practices are kept up-to-date with progress and that there is a clear local system, such as a dedicated email address through which the general practice can notify the CCG if they become aware of issues with fulfilment of specific contract provisions.

6. Ensure all work is underpinned by **a commitment to collaborative working and mutual respect**.

The overwhelming feedback has been that effective relationships, collaborative working, honesty and trust are vital enablers of this work. Those areas where there are positive working relationships between commissioners and providers are finding it easier to agree a way forward for implementation of the contract provisions.

Collaborative working and local agreement

Humberside LMCs, Hull and East Riding of Yorkshire CCGs, Hull and East Yorkshire Hospitals NHS Trust

Work on building relationships between primary and secondary care has gone on for many years in Humberside. A combination of robust national policy , with the introduction of changes to the NHS Standard Contract and supporting national resources, together with strong local clinical leadership, has meant that the team has been able to make significant progress in the last few months. CCG clinical chairs and provider trust Medical Director were determined to address the need to better control clinician workload by streamlining patient journeys, resulting in a local agreement between primary and secondary care, developed and signed by LMCs, CCGs and provider trust.

The agreement covers local access policies (DNAs and onward referral of patients); clinic appointments (expediting letters); managing patient care and investigations; clinic letters and discharge summaries; medication requests; shared care protocols; MED3 (Fit Notes); follow up; communications with patients.

The journey has not been without its challenges and the agreement was not expected to change practice overnight. It is, nevertheless, proving to be a useful locally owned resource that has influence locally and which clinicians and the wider practice team can refer to in order to improve patient journeys and to decrease workload across the system. The next round of local discussions to build on the existing agreement is due to commence shortly and the expression of interest to engage with this work has now moved up from two organisations locally to all the NHS Standard Contract service providers in the Humber region and all four CCGs.

Full case study:
Local primary/secondary care agreement: https://www.england.nhs.uk/gp/case-studies/humberside-primary-secondary-care-interface-agreement

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Clinical interface committees

Frimley Health NHS Foundation Trust

The Clinical Interface Committee was established with an explicit objective to 'improve and maintain open communications and strong working relationships between hospital consultants and local GPs'. The emphasis is on having a clinically-led, managerially-delivered approach and the aim is to continually address problems between primary and secondary clinicians that may hamper day to day clinical interaction across the system and affect patient care.

The group meets for two hours every other month and addresses two key issues, with the agenda being shaped by the GPs and Consultants through a 'priorities-first' approach. A constant theme is how the workload that falls between primary and secondary care is managed by clinical colleagues and the NHS Standard Contract changes form the backbone of what the CICs are currently focusing on.

CIC members are working to resolve these issues and ensure that there is a mutual understanding as to where the responsibility lies in the primary – secondary care spectrum.

The vast majority of issues have been resolved through a mixture of professional guidelines and common sense, however others are more contentious and require a significant change in culture. We envisage that, through constant dialogue with colleagues in primary and secondary care, these can and will be resolved and the new working practices will become the custom and practice of the future. A lot has been achieved so far, from the development of a community glaucoma service and the interpretation of cardiology diagnostics, to joint education events for GPs and consultants defining what makes a good referral and key contact telephone lists to allow better communication. There is much to do but the maintenance of good relationships will ensure that future developments will be easier to implement.

Full case study: https://www.england.nhs.uk/gp/case-studies/clinical-interface-committees-cics-at-frimley-health-nhs-foundation-trust

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Consultant-GP liaison schemes

Wessex

The consultant-GP liaison scheme is a simple, cost neutral concept with key themes of clinical leadership and partnership, driven by passion, determination and meticulous planning.

Secondary care consultants and local GPs volunteered to host and visit each other's workplaces for half a day to appreciate the challenges they face within the NHS.

All clinicians completed an anonymous reflection template of their experiences, submitting voluntarily to the project lead. The reflection templates were categorized and analysed for common themes to determine if practical and pragmatic changes could be implemented to improve the local delivery of care.

Participants reported that the scheme was useful, that morale and insight were improved and that they were willing to consider new ways of working as a consequence of building better relationships. The success of the scheme has led to it being rolled out in several local areas.

Full case study: https://www.england.nhs.uk/gp/case-studies/gp-consultant-liaison-southampton-2017-southampton-city-clinical-commissioning-group

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Junior doctor and trainee GP shared learning video

Nottinghamshire

Investigation by the local hospital and CCG of specific cases of causes for concern flagged by GPs/CCG identified a recurrent theme of lack of awareness amongst junior doctors of the implications of work generated in secondary care and the direct impact on primary care workload and patient care. Current medical training allows all GP trainees to attend hospital as part of their training rotation, but not all hospital speciality trainees spend time in general practice. Induction for junior doctors on joining a new setting was found to cover common procedures, but, as an extremely busy programme, did not cover working as one system across different care providers, for the benefit of the patient.

A video was produced of dialogue between two junior doctors (hospital and GP trainee), using the structural framework of the NHS Standard Contract 2017-19, exploring solutions for common clinical scenarios based on their own experience to enhance the patient journey and improve the primary and secondary care interface. The aim was to build a culture of collaborative working as a team of professionals across different organisations, breaking down barriers and delivering joined-up care for maximum benefit of the patient.

Vlog: https://m.youtube.com/watch?v=1XZwdcPBsdc
Some of the information discussed in the video has been superseded by revisions to the NHS Standard Contract 2018-19, but the video remains a useful tool to stimulate thinking about how to manage situations and issues in a collaborative way.

Full case study: https://www.england.nhs.uk/gp/case-studies/junior-doctor-vlogs

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Appendix A: Detailed guidance for CCGs and providers

Managing DNAs and re-referrals (Service Condition 6.5)

The Contract requires that a provider's local access policy must not involve blanket administrative policies under which all DNAs are automatically discharged; rather, any decisions to discharge are to be made by providers on the basis of clinical advice about the individual patient's circumstances.

1. Review the provider's local access policy and check that it meets the Contract requirement that "any decisions to discharge patients after non-attendance are made by clinicians in the light of the circumstances of individual Service Users and avoiding blanket policies which require automatic discharge to the general practice following a non-attendance".
2. Review a sample of patient appointment letters to check that these do not suggest that a blanket policy is being applied.
3. Review, with the provider, activity data showing DNA rates and post-DNA outcomes by specialty, split between first and follow-up attendances.
4. Where a specialty shows a very high proportion of DNAs being discharged, this may suggest that a blanket discharge policy is being pursued – which can then be examined further with the provider and the affected specialty.
5. Discuss with the provider how the policy is applied in practice and what training is offered to consultants and administrative staff in relation to the policy and confirm that, in practice, decisions to discharge following DNA are made by consultants.
6. Where % DNA rates for first attendances are high, consider further examination to determine whether this relates to referrals to particular specialities or referrals from specific practices.
7. Where DNA rates for follow-ups are high, consider undertaking research with patients and equality and engagement policy leads to understand this further.

Managing onward referrals (Service Condition 8.2 - 8.5)

The Contract allows the provider clinician to make an onward outpatient referral to any other service, without the need for referral back to the general practice, where:

- **either the onward referral is directly related to the condition for which the original referral was made or which caused the emergency presentation (unless there is a specific local CCG policy in place requiring a specific approach for a particular care pathway);**
- **or the patient has an immediate need for investigation or treatment (suspected cancer, for instance).**

1. Analyse, with the provider, the pattern of onward referrals – which specialties are making and receiving onward referrals and in what volume?

2. Review the findings to identify learning opportunities in primary care (appropriateness of first referral) or within provider specialities (appropriateness of onward referral).

3. Where the data indicates concerns about onward referral levels, meet with specialty clinicians and agree appropriate action.

4. Where appropriate, refer clinicians to the Clinical Guidelines on Onward Referral developed by the Academy of Medical Royal Colleges, in collaboration with partner organisations, available at: http://www.aomrc.org.uk/reports-guidance/clinical-guidance-onward-referral/

Managing patient care and investigations (Service Condition 12.1)

The Contract makes clear that, within the context of the elements of the service which it has been commissioned to provide, a secondary care provider must arrange and carry out all of the necessary steps in a patient's care and treatment rather than, for instance, requesting the patient's GP to undertake particular tests within the practice. Examples of this could be asking the GP to follow up urine test results, blood test results, organise further investigations or provide prescriptions in the community for abnormal test results.

1. Ensure the provider has appropriate mechanisms in place to both request tests and follow up results.

2. Ask the provider to provide evidence of follow up processes in place.

3. Ask the provider for evidence of how it complies with Standards for the communication of patient diagnostic test results on discharge from hospital (https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2016/03/discharge-standards-march-16.pdf)

4. Consider undertaking research within general practice to understand whether they are aware of any issues and whether these relate to specific services. Further steps could be for CCG and provider to review the care pathway for that service and agree any appropriate changes.

Communicating with patients and responding to their queries (Service Condition 12.2)

It is important that providers take responsibility for managing and responding to queries received from patients. The Contract requires providers to put in place efficient arrangements for handling patient queries promptly and communicate the results of investigations and tests carried out by the provider to patients directly.

1. Ask the provider to provide evidence about how it publicises arrangements for responding to patient queries in patient letters and on its website.

2. Consider undertaking research with practices to understand if they are aware of any issues and whether these relate to particular specialties. Discuss with the provider and agree any appropriate changes and or equality and access issues.

Discharge summaries and clinic letters (Service Condition 11.3 - 11.7)

The contract sets out clear requirements on providers in terms of the provision of discharge summaries and clinic letters to general practice.

1. Ask the provider to confirm whether it has implemented an electronic system for communicating discharge summaries and clinic letters to the general practice. If no system has yet been implemented, agree with the provider a commitment to a timescale for implementation as part of the initial action plan; if a system exists but has only been partially rolled-out, get commitment to full implementation to a specific timescale.

2. Where electronic transfer systems are in place, ask the provider for ongoing monitoring information, by specialty, on the timeliness of discharge summaries and clinic letters, relative to the Contract requirements.

3. Where no electronic system has yet been implemented, accessing comprehensive monitoring information is likely to be difficult - so agree with the provider, as part of the initial action plan, to carry out a rolling programme of audits, potentially at both the hospital end and the general practice end, to understand the relative performance of different specialties - and then agree targeted improvement plans.

Medication and shared care protocols (Service Condition 11.9 - 11.10)

The Contract allows the period for which the provider must supply medication to be determined in a local policy, but this must at least cover a period of no less than 7 days (unless a shorter prescription is required clinically).

1. Ask the provider what has been done to make sure that
   a) clinical staff are aware of the requirements and that a supply of FP10s (prescription notes) are available in clinics and on wards; and
   b) consideration of a patient's need for a prescription is built into discharge planning processes.

Fit Notes (Service Condition 11.11)

Where there is an appropriate opportunity (on discharge from hospital or at clinic), the Contract requires that provider clinicians must issue fit notes to appropriate patients. It is acknowledged that current legislation does not allow non-medical clinicians to write a fit note.

1. 1. Ask the provider what it has done to make sure that
   a) clinical staff are aware of the requirements;
   b) consideration of a patient's need for a fit note is built into discharge planning processes; and
   c) a supply of fit notes is available on wards and in clinics.

NHS England

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www.england.nhs.uk/gp/gpfv/workload/interface/resources/

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