BMA

From your BMA GPs committee chair

Important changes to the hospital contract to stop inappropriate workload shift onto GPs

Dear ,

Last year NHS England accepted taking forward GPC's **urgent prescription for general practice**. This was followed by setting up a dedicated primary/secondary care interface group, to develop our proposals to reduce bureaucracy and the continued shift of inappropriate workload onto GP practices.

I am pleased to announce that as a result, we have secured important changes to the hospital contract in England for 2017/18. These build on last year's changes to the 2016/17 hospital contract following pressure from GPC, which include:

- That the results of investigations requested by hospital clinicians should be communicated by the hospital directly to patients.
- That hospitals should directly liaise with patients should they miss an outpatient appointment rather than ask GPs to re-refer.
- That hospitals should make direct internal referrals to another department or clinician for a related medical problem rather than send the patient back to the GP for a new referral.

Don't forget to continue to use our **practice templates for the hospital 2016/17 contract changes** to push back on instances where these standards are not being met.

Further changes to the hospital contract 2017-19

The new changes to the 2017-19 hospital contract are designed to further reduce inappropriate workload on GP practices, and also improve patient care across the primary/secondary care interface as follows:

1. **Hospitals to issue fit notes, covering the full period until the date by which it is anticipated that the patient will have recovered.** It is a waste of GP time, and appointments, for patients to be given (for instance) an interim fit note from a hospital discharge for two weeks and to be told to see a GP for a continuation, when it was clear from the outset that they needed two months off work after major surgery – this contract change requires that the patient receives a fit note covering the full period.

2. **Hospitals to respond to patient queries for matters relating to their care rather than asking the patient to contact their GP.** This would put an end to a culture spanning decades, of patients being told to 'see your GP' for a host of issues that should clearly be the responsibility of secondary care – such as queries regarding hospital test results, treatment and investigations, administrative issues regarding follow up, or delays in

appointments. The new contract requires that the provider respond to patients (as well as GP queries) 'promptly and effectively to such questions and that these are publicised using all appropriate means, including in appointment and admission letters and on the provider's website; and deal with such questions themselves, not by advising the patient to speak to their referrer'.

3. **Hospitals must not transfer management under shared care unless with prior agreement with the GP.** GPs should not therefore be asked to prescribe specialist medications by virtue of a hospital letter or instruction alone. Any such shared care arrangement must be explicitly agreed first by the GP based on whether they feel competent to do so, and which may include being resourced to do this as a locally commissioned service.

4. **Hospital clinic letters to be received by the GP within 10 days** from 1 April 2017, and **within seven days** from 1 April 2018. This will significantly reduce wasted appointments when patients specifically arrange to see a GP following an outpatient clinic appointment, but without us having the relevant clinical information to manage the patient, often requiring the patient to book another appointment.

5. **Issuing medication following outpatient attendance** at least sufficient to meet the patient's immediate clinical needs until their GP receives the relevant clinic letter and can prescribe accordingly. This addresses the growing phenomenon of patients turning up at a GP surgery sometimes almost immediately after a hospital appointment for an outpatient initiated prescription, with the GP pressurised to prescribe without relevant clinical information, and with accompanying clinical governance risks.

Remember, these changes are not recommendations but contractual requirements, and therefore if hospitals do not abide by these standards they are in breach of their contract.

Making these changes take effect

These changes won't simply happen by themselves overnight, as they represent changes to ingrained longstanding behaviour. Change requires hospitals to become aware of and implement these contractual changes, and for CCGs as commissioners to hold providers to account. CCGs also have the ability to act on hospital breaches, including giving notice of remedial action which could include financial sanctions. Remember that practices are members of CCGs – I urge you to hold your CCG board itself to account to deliver on its responsibility to ensure hospitals adhere to their obligations.

I have today written to LMCs with template letters which they can send to their local CCG and hospitals, requiring them to detail how they will ensure these contract requirements are implemented.

Playing your part – use our new templates

Practices will be key to enabling this change, since it is GPs and our staff who will be directly aware when these standards are not met. It is vital that we push back on inappropriate demands rather than allow them to continue unchallenged, and report breaches to both the provider and CCG. To make this easier, we have devised **practice templates** for each of these five contractual requirements. Please use them – they have been adapted to be uploaded onto clinical systems – so that you can produce a pre-populated template letter at a keystroke.

Let us please ensure that this is a case of 'deeds not words' through each of us playing our part to hold trusts and CCGs to account for abiding by these requirements. It is so important that we must not waste the opportunity to deliver on our negotiated changes to end much of the bureaucratic burden which we all work under.

Practice checklist for hospital contract changes

1. Make all staff in the practice aware of these contractual requirements.
2. Develop a practice policy for how to act on breaches to these contract changes.
3. Use our practice templates for both the **2016/17** and **2017-19** hospital contract changes to report breaches to both the provider and CCG (the latter should not include patient identifiable details without patient consent).
4. Hold your CCG to account to deliver on its responsibility to ensure hospitals abide by these standards.
5. Notify your LMC of the type and numbers of breaches each month.

Finally, I would like to take this opportunity to thank Farah Jameel, GPC lead and her team of GPC members Mark Corcoran, Peter Horvath-Howard, David Wrigley, Robert Morley, and Andrew Green, who have helped to drive through this programme of work.

With best wishes,

Chaand Nagpaul
BMA GPs committee chair
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Helping us to manage our workload – meet GPC lead Farah Jameel

Dr Farah Jameel is GPC's lead on workload management, and has played a vital part in our work to achieve the hospital contract changes. She also oversaw the development of our practice templates.

Read Farah's blog on these changes here

Farah has over the past year led the development of our successful **Quality First** web resources, which provide information, materials and tools to help practices manage workload. The Quality First website launched in May 2016 and has had over 44,000 unique hits since.

If you have not already done so, please see the Quality First resources here

Farah was born and brought up in the UAE. She completed her undergraduate medical training there, prior to relocating to the UK in 2007 for postgraduate training. She is chair of Camden LMC, a GP appraiser in north west London and an OSCE examiner for UCL medical students. She has been a member of GPC since 2014 and works as a sessional GP in London.

Commenting on her role, Farah said: ‘With ever increasing workload burden within a resource limited environment, we find ourselves in a position that requires innovative ideas and solutions. This includes addressing long-standing issues such as reducing the effect of “failure demand” workload being dumped from one part of the system to the next, ensuring that work undertaken in general practice is adequately resourced, utilising the strengths of a diverse workforce, and embracing concepts such as patient empowerment, self-care strategies and different ways of working, including exploring the role that technology can play.

‘I am delighted to be the GPC lead on Quality First, which is aimed at LMCs, practices and individual GPs, and is a single portal bringing together practical ways to manage workload and deliver safe care. There are “how tos” and real examples of good practice. It is my hope that we have created useful tools to support and empower GPs to effectively negotiate, influence and ultimately manage workload.

‘It’s a dynamic site and we keep adding to our resources. Since May we have added two new **template packs**, new guidance on **managing dental problems**, and additional **case studies**. We hope to keep adding examples of good practice from around the country. You can contribute to case studies by **emailing us**, or **sign up for notifications** to stay abreast of new content.’

Medical charities web portal

I would also like to take this opportunity to let you know that the main independent medical charities have come together to produce a **new website portal** which will help doctors in difficulties find the most suitable charity to apply to.

The portal brings together five independent charities that support doctors when they need confidential financial assistance. These benevolent funds provide vital support to help doctors in genuine financial need get their lives and careers back on track.

The charities involved are the **Cameron Fund** (the charity for GPs), the **Royal Medical Benevolent Fund**, the **Royal Medical Foundation**, **BMA Charities** and the **Society for the Assistance of Medical Families**.

By following the **link**, doctors (or their dependants) and medical students can answer a very short questionnaire to find the best charity to help them. They can then use the portal to link to that charity for more information about eligibility and application.

The portal also links to information about other organisations that can offer help.

Important note on QOF calculations

Some GPs have reported concerns with the recent QOF calculations and aspiration payments, which NHS England and NHS Digital are investigating as a matter of priority.

So far, this has identified discrepancies with some prevalence calculations which could impact on some practices’ achievement and as a result on final payment and aspiration. NHS England and NHS Digital have informed us that they are working to resolve this as soon as possible to minimise any impact on practices. NHS England has assured us that practices will all receive aspiration payments on time.

In the meantime, if practices and local commissioners could temporarily stop any QOF

approval processes; further information will be communicated in more detail as soon as we can.

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