Londonwide LMCs
The professional voice of London general practice

4 February 2020

Londonwide LMC's response to "NHS Standard Contract 2021/22: A consultation"

CONSULTATION QUESTIONS:

6. Interface with primary care: We propose to include a new requirement for each provider:

- **to publish a self-assessment of its performance against the existing Contract requirements; and**
- **to agree and implement an action plan to address any deficiencies.**

Yes No Not applicable
Please explain your response:

It is clear that there are currently interface issues between primary and secondary care, but London GPs firmly believe that these issues are best resolved by effective partnership working and collaboration.

We agree with the assessment that implementation of interface requirements remains patchy, resulting in sub-optimal services for patients and wasted resource in practices, and welcome the proposal to introduce a new requirement of agreeing and implementing an action plan to address deficiencies in the primary care interface (Service Condition 3.17) **with the caveat** that it is critical that the process of identifying which deficiencies are to be addressed, and how these are understood to impact, is informed by both sides of the interface. The assessment of performance and potential impacts of any mitigation on providers and patients must be considered collaboratively before moving to action planning.

There should be regular opportunities for local clinical engagement between GPs and consultants to highlight and address issues at the interface and work towards a new way of working collaboratively that is clinically more appropriate for today's NHS. These comments are being made in the context of current commissioning arrangements. Were they to change in light of recent and future consultations, we feel it would be important to further consult on the interface.

Poor decision making is recognised as having a significant impact on services, quality, performance and financial viability of providers, and we would welcome inclusion of an independent body to assist in resolving/ arbitrating interface issues believed to have safety implications.

7. Collaborative work in integrated care systems: The Contract already contains a requirement on commissioners and providers to work together to deliver their local system plan and in support of the NHS's "triple aim" of better health, better care and financial sustainability. We propose to strengthen this by including a specific reference to active participation in, and constructive mutual support and challenge to, and from, members of the local integrated care system.

Yes **No** **Not applicable**

Please explain your response:

Outwith the recently concluded engagement exercise there has not, to date, been a meaningful consultation on ICS footprints, authority or governance at either a national or regional level. As such, practitioners have expressed concerns that proposed developments regarding integrated care systems lack robust clinical representation and clinical engagement across all spheres of the local system. Only with such representation and engagement in place can the environment exist for constructive mutual support and challenge to be meaningful and effective.

Whilst it is clear that the relationship between the different strata of the health system needs attention, concerns expressed by London practices regarding the new entities, and the omission of local general practice representation in the form of LMCs as mandatory members of ICS governance arrangements, include that "…Acutes will get away with whatever they want …" this being in the context of GPs as patient advocates.

Fears have been expressed that the incredible skill, adaptability and resilience shown by general practice teams during this pandemic will be lost. Furthermore, that there may be loss of local leadership and expertise with the centralisation of decision making and funding. General practice in London calls for a more respectful inclusion of primary care representation to account for the large amount of care that is overseen and dealt with in primary care. As such we seek reassurance that the implementation of revisions to Service Condition 4.6 would not be at the expense of existing and future relationships with independent general practitioners and their teams beyond any staged developments of ICS, and are not at the expense of the valuable clinical collaboration which has been developed and has paid dividends over the past 12m of the pandemic.

8. Remote consultations: We propose to add a requirement for providers to offer patients, wherever clinically appropriate, a choice between a remote consultation and a face-to-face one.

Yes **No** **Not applicable**

Please explain your response:

The use of alternatives (video / telephone) to traditional face-to-face appointments is now a key tool, in terms of safely and conveniently maximising general practice capacity. Through the last year of the Covid-19 pandemic, GPs and their practice teams have continued to deliver care remotely, supplemented by face-to-face investigations where necessary. A key tenet of general practice is its ability to work as part of a multi-disciplinary team to ensure that patients remain as comfortable as possible; supporting patients, their careers and families to meet their psychological, social and spiritual needs.

Practices have also supported colleagues in other settings in delivering care and treatment plans by arranging follow-up blood tests, prescriptions, wound dressing, FIT tests and many other investigations whilst colleagues in other settings have worked in different ways by necessity. Whilst we recognise the value for patients and clinicians in all settings of the option to consult remotely, this must go hand in hand with the ability to prescribe remotely, and the necessary supports for required investigations. Through the pandemic this additional activity has placed significant pressure on GPs and their teams. If Trusts are planning increased remote working, they need to be able to

undertake all of their role in a remote model of care, particularly with respect to electronic prescribing. This must be enabled as a priority to enable safe prescribing and patient care.

Any further or systematic adoption of remote consultation which would add to the demands community based primary care provision, as covered by Service Condition 10.5, must be considered holistically, and adequately resourced to ensure that community services are available to support any required physical follow-up resulting from a shift to remote consultation. We would also welcome further detail on the consideration and mitigation of clinical safety issues identified as resulting from any such shift.

9. Tackling health inequalities: We propose to amend the Contract to require each provider to identify a board-level executive responsible for overseeing the Provider's actions to address and reduce health inequalities. We also propose to add a new Health Inequalities Action Plan Schedule to the Particulars.

Yes No Not applicable
Please explain your response:

Designating a board-level executive as the lead member on primary care interface and health inequalities issues would be a welcome indicator that there is senior buy-in and support for the earlier measures outlined regarding the improvement of interface between primary and secondary care. London GPs firmly believe that these issues are best resolved by effective partnership working and collaboration, however the ability to address safety or other concerns beyond individual departments, where appropriate, would be of value.

Addressing and reducing health inequalities will require the bodies involved in providing joined-up care to work together differently through a new model of care in which all providers have responsibility for reducing inequalities in and between our local communities.

We would do well to learn from our learning during the recent Covid-19 pandemic regarding:

- The need for clinical prioritisation and clinical problem-solving.
- The need for united clinical leadership –managing relationships and poor decisions at interfaces.
- The impact on health inequalities and the increased importance of GPs within the community and of health and social care provision at the local level; and
- The need for informed, practical and current clinical leadership to inform decisions, with the power and autonomy to act in an agile way and adapt to circumstances as required.

10. Green NHS: We intend to continue to strengthen the requirements in the Contract on green issues by adding requirements on providers to:

- **identify a board-level officer accountable for actions to deliver on 'Net Zero' commitments;**
- **ensure all electricity purchased is from certified renewable sources; and**
- **implement further measures focused on the reduction of harmful greenhouse gases and air pollution.**

Yes No Not applicable
Please explain your response:

11. Infection Control and Prevention: We propose to add a specific requirement that all providers must designate an infection control and prevention lead at Board level.

Yes **No** **Not applicable**

Please explain your response:

12. Evidence-based interventions: National guidance on a second set of 31 additional interventions has now been endorsed by NHSE/I and published on the Academy of Medical Royal Colleges website. We propose to adapt the Contract wording and definitions to include appropriate reference to this second set of guidance.

Yes **No** **Not applicable**

Please explain your response:

13. Safeguarding: We propose to broaden the existing requirement in relation to supporting implementation of the Child Protection Information Sharing Project, with this in future applying to all providers (including specifically outpatient and mental health services), rather than just to urgent and emergency acute services as previously.

Yes **No** **Not applicable**

We welcome any change that helps to safeguard children.

14. Freedom to Speak Up: We propose to strengthen the Contract wording on "freedom to speak up" by requiring providers to inform the National Guardian's Office of the identity of its nominated Freedom To Speak Up Guardian(s); and to co-operate with the National Guardian's Office in any case reviews. ***

Yes **No** **Not applicable**

15. Enhanced Health in Care Homes: Contract requirements for Enhanced Health in Care Homes came into effect gradually during 2020/21 – so we now propose to update Schedule 2Ai to remove references to actions which were to have taken place in 2020/21 and to make clear that these are now ongoing requirements for 2021/22. ***

Yes **No** **Not applicable**

We support measures which will encourage and support closer working with clinical colleagues from other providers, building strong professional relationships. Having the autonomy to deliver services collaboratively and in the best ways to meet the needs of individuals and our diverse communities without the constraints that come from delivery models that push us apart and stop personal communication, is essential.

It is critical to adopt the right form and scale for the service, and to consider how trusts support staff who are split across multiple sites to engage fully with general practitioners and fellow professionals from other disciplines.

Further comments on the above points are outlined in response to question 16, below.

16. Anticipatory Care: We propose to include detailed requirements for relevant providers of community physical and mental health services to work with PCNs to implement the Anticipatory Care model. ***

Yes **No** **Not applicable**

The focus on Primary Care Networks, without recognition that PCNs are formed out of a voluntary sign-up to an Enhanced Service to which some practices have not signed up and from which some practices may withdraw over time, is concerning and suggests a lack of awareness that within each place, services are delivered by general practices, either individually, or where appropriate, in collaboration with other practices or local partners, which may be, but not exclusively through a PCN. As such, proposals based exclusively and explicitly on the basis of working with PCNs should, we believe, be revised to reflect the role and responsibility of general practice GMS, PMS and APMS contractors.

We support working more closely with clinical colleagues from other providers, building strong professional relationships. Having the autonomy to deliver services collaboratively and in the best ways to meet the needs of individuals and our diverse communities without the constraints that come from delivery models that push us apart and stop personal communication, is essential. General practitioners and their fellow professionals are expert generalists. Reducing interactions to messages and task rather than having collaborative discussions between peers from different disciplines, without sharing risk and decision making, is to devalue the work done in community health nationally and throughout London, and to deny patients their best care. We are, therefore, hopeful that embedding mental health professionals within general practice settings will be to the benefit of practitioners and patients.

Furthermore, the NHS is increasingly focused on large scale organisations. NHS publications have ceased to refer to practices as entities and only refer to PCNs. Staff who would be able to add greater value to individual practices are having to be shared across PCNs and contracts that would be best delivered at practice level are offered to PCNs despite PCNs not being organisational entities in most cases, resulting in complex lead practice models with the option of subcontracting back to practices. Local practices are very good value for money and having autonomy to deliver care in the way that they best see fit enables local need to be meet in the most appropriate way for that community. Local practices also offer greater opportunity for continuity of care and anticipatory care which should not be overlooked. It is critical to adopt the right form and scale for the service, and to consider how trusts support staff who are split across multiple sites to engage fully with peers from other disciplines.

17. Black, Asian and minority ethnic representation: We propose to require each provider to publish a five-year action plan setting out how it will ensure that the level of black, Asian and minority ethnic representation in its board and senior workforce will reflect that in its overall workforce, or in its local community, whichever is higher.

Yes **No** **Not applicable**

18. NHS People Plan: We propose to amend the Contract wording to make it clear that providers must implement the actions expected of employers as set out in the NHS People Plan.

Yes **No** **Not applicable**

19. Core Skills Training Framework: We propose to add a requirement to the Contract that a provider must provide its staff with training in accordance with the requirements of the Core Skills Training Framework. ***

(•) Yes ( ) No ( ) Not applicable

20. Hosting of doctors in training: Health Education England will shortly publish new guidance setting out the role of non-NHS providers to work with Trusts in hosting doctors in training. We propose to include a requirement for providers to have regard to this guidance.

(•) Yes ( ) No ( ) Not applicable

21. Violence prevention and reduction standard: We propose to add a requirement on providers to have regard to the new NHS Violence Prevention and Reduction Standard. ***

(•) Yes ( ) No ( ) Not applicable

22. Workforce sharing: NHSE/I have published an Enabling Staff Movement Toolkit, which provides suitable documentation to support workforce sharing between organisations. We propose to add a requirement that, where providers intend to agree workforce-sharing arrangements, they should do using the Toolkit documentation.

(•) Yes ( ) No ( ) Not applicable

23. Removal of financial sanctions: We propose to remove from the Contract nationally set sanctions on providers for failing to achieve national quality and performance standards. This will be more consistent with today's emphasis on collaborative working at Integrated Care System level. ***

( ) Yes ( ) No ( ) Not applicable

Please explain your response:

There are many positive implications in removing financial sanctions. Especially where a failure to achieve national quality and performance standards is related to the inability to allocate sufficient resources. However, removal of financial sanctions could result in unforeseen consequences / perverse outcomes. We would therefore welcome the opportunity to further discuss and understand how the system intends to ensure that appropriate national quality and assurance standards are agreed, managed and met.

24. Reduced frequency of financial reconciliation: NHS payment rules under the National Tariff Payment System now place greater emphasis on fixed payments for many providers/services, with much less variation in relation to actual levels of activity in-year. We propose to reduce the frequency of financial reconciliation required under the Contract from monthly to quarterly, thus reducing the administrative burden. ***

( ) Yes ( ) No (•) Not applicable

Please explain your response:

25. Counter-fraud arrangements: The NHS Counter-Fraud Authority (NHSCFA) will be publishing revised counter-fraud requirements in line with the new Government Functional Counter-Fraud Standard. We propose to amend the Contract provisions accordingly. ***

Yes No Not applicable
Please explain your response:

26. Smaller changes to the Contract: We also propose to make a number of smaller changes to the Contract, set out under section 3.3 of the consultation paper. If you have any comments on these, please add them here:

27. SCFMA. An updated model System Collaboration and Financial Management Agreement (SCFMA), for local adaptation, is published on the NHS Standard Contract 2021/22 webpage [https://www.england.nhs.uk/nhs-standard-contract/21-22/nhs-standard-contract-2021-22-consultation-documents/]. We welcome feedback on the model SCFMA.

28. NHS England would welcome further suggestions for improving the Contract. Please add any further comments you may have here.