Dear LMC colleagues

Last year NHS England accepted taking forward GPC's urgent prescription for general practice. This was followed by them 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 2017/19. 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.

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**.
2. **Hospital Trusts 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, or administrative issues regarding follow up, or delays in appointments etc. The new contract requires that the Provider must 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 if s/he feels 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 7 days** from 1 April 2018. This will reduce significant wasted appointments when patients specifically 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 rebook 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 an increasing phenomenon of patients turning up at a GP surgery sometimes almost immediately after a hospital appointment for an outpatient initiated prescription , and with the GP pressurised to prescribe without relevant clinical information, and with 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 happen themselves overnight, since they need to reverse longstanding ingrained behaviour. This 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 (and responsibility) to act on hospital breaches, including giving notice of remedial action if necessary which could include financial sanctions.*** This is why it vital that adherence to these standards are monitored and that breaches are reported, so that CCGs are held to account both by practices (as members) as well as from LMC pressure.

Action for practices

- Practices will be directly aware when hospitals breach these standards- we have therefore produced template letters for use by practices for each of the hospital standard contract requirements, to both push back on inappropriate demands as well as notify both the provider and CCG of breaches.

- I have highlighted the launch of these new hospital contract changes and these templates in my e-newsletter to the profession today.

- We have also asked practices to send details of the numbers and nature of breaches to LMCs on a monthly basis.

Action for LMCs

- We would appreciate LMCs raising awareness amongst GPs and practice managers in your regular communications of these contract changes and encourage them to use the new templates

- We have produced a template letter for LMCs to send to CCGs (also attached as **Annex A**) to ask them what measures they have put in place to ensure that Trusts implement these new contractual requirements.

- We have also produced a template letter for LMCs to send to hospital providers (also attached as **Annex B**), requesting a summary of what measures they have taken to implement these new contractual requirements.

- LMCs should request that the standard contract is a rolling agenda item at **LMC/CCG liaison meetings**, with feedback of hospital performance on these new contractual requirements.

- Don't forget that the 2016/17 hospital contract changes still apply and that these standards should also be adhered to.

- We would appreciate LMCs feeding back information to GPC on breaches to the hospital standard contract, which will inform our national dialogue with NHS England on adherence to these standards.

I would reiterate that it is only by all of us playing our part to hold trusts and CCGs to account that we will be able to reduce inappropriate workload and bureaucratic shift from secondary care, and realise benefits for practices and patients.

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.

Yours

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GPC England Chair