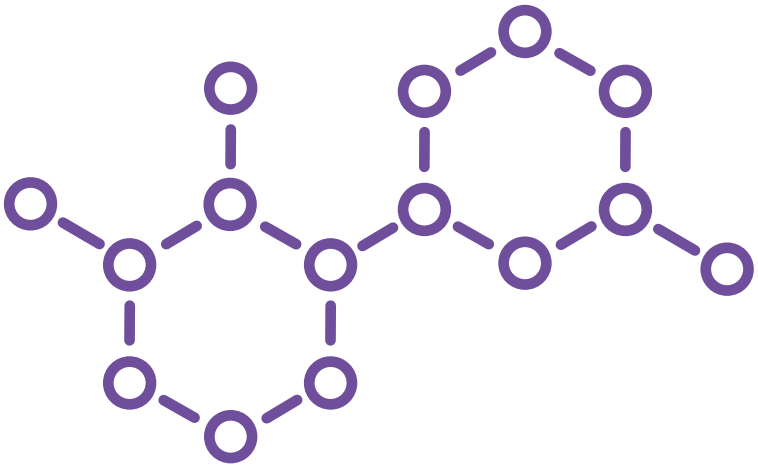
BMA

Supporting effective collaboration between primary, secondary and community care in England in the wake of Covid-19

Since the start of the pandemic earlier this year, there has been a significant reduction in non-Covid care and activity within the NHS and private sector, with elective procedures cancelled, outpatient attendances down and fewer urgent cancer referrals[12]. The NHS whilst pre Covid, was already struggling to deal with increased activity, capacity constraints and financial pressures, is now facing a huge uphill struggle to deal with the inevitable backlog of care that has developed since March. These challenges, unless appropriately tackled, will inevitably present with short, medium and long-term consequences for patients.

Tackling these challenges over the coming months will require effective collaboration between systems and clinicians across primary, secondary and community care. However, there are a number of pre-existing barriers to making this happen, including high workload, the need to adapt physical spaces to prevent the spread of infection, lack of joined up IT, historic workforce shortages and a lack of consistent communication and trust between different parts of the health system. 73% of BMA members, for example, say that traditional barriers between organisations, teams and funding streams result in increased bureaucracy and administrative costs and 60% say these barriers result in compromised quality and safety of patient care.

Prior to the outbreak of the pandemic, in response to our members' concerns, the BMA had been looking at solutions to tackle these longstanding problems between different clinical teams through its *Caring, supportive, collaborative* campaign. This work has been made more urgent by the additional pressures placed on the system by Covid-19 and we have continued to work with doctors from across branch of practice to identify the solutions set out in this paper. Some of these can be implemented now to help better support clinicians to restart services and deal with the backlog caused by Covid-19. Others will require more sustained longer-term action, so that as health systems recover, we also support them to create the conditions for increased collaboration that will improve patient care and the working lives of doctors for the future.



1 Health systems must bring together clinicians at a local level to review the backlog of referrals

The immediate challenge health systems now face is to review and chase up on patient referrals which could not be completed over the last few months due to the disruption to services caused by Covid-19.

Given the current reduced capacity to deal with the high number of accumulated referrals, there is a need to ensure referrals are prioritised and patients who need access to specialist care most urgently can be seen first. With clinicians across primary, community and secondary care all reporting high workloads as NHS services restart, capacity to be able to achieve this will be a challenge.

NHSE/I have recently confirmed that secondary care clinicians will be expected to review elective care referrals and make decisions about which patients should be prioritised but have not issued specific instructions for how other pre-existing and new referrals should be reviewed and prioritised.

CCGs (Clinical Commissioning Groups) now need to bring together clinicians from across primary, community and secondary care to agree a local approach to reviewing and processing the backlog of referrals which is acceptable to all parts of the system. This could, for example, include establishing and funding dedicated clinical teams to support the process of reviewing referrals. Retired doctors and doctors who are shielding, could also potentially contribute to reviewing the backlog of referrals. Those who decided to register again and help the NHS at the outset of the pandemic, for example, could be invited to help provide clinical expertise. With the appropriate funding and support from Government and regulators, these doctors could play a role within these dedicated clinical teams.

For elective referrals, capacity constraints in secondary care need to be taken into account, as well as some of the practical challenges. For example, in some cases it may be necessary for secondary care doctors to seek a view from GP colleagues, who as expert generalists are likely to know more about patients' background and circumstances, to support decisions about which patients should be prioritised for treatment.

In the long run, redesign of pathways of care for some common conditions will provide alternatives to referrals in secondary care and will make the delivery of care in primary and community care settings possible. Any such redesign must take into account the resources necessary to deliver a safe and effective service, without simply shifting and creating cost or workforce pressures.

2 CCGs must increase routine diagnostics capacity in the community

Access to adequate diagnostics capacity in different settings (supported by IT infrastructure to enable this) will be crucial in underpinning effective management of the referral backlog.

As reforms to outpatient activity continue to progress in the wake of Covid-19 and in preparation for a potential second wave, learning from the experiences during the pandemic, it is likely that remote consultations will be used far more commonly by all clinicians.

In such circumstances, it will become increasingly important that primary, community and secondary care clinicians as well as patients have rapid, and ideally same-day access to properly commissioned community-based monitoring and diagnostic services. These services, previously delivered in hospitals, should now be considered part of hospital outreach programmes in the community.

If a patient could attend a locally-based service for a blood test, ECG, spirometry, ultrasound or other diagnostic service that could be reasonably provided in a community setting, this would reduce the need for patients to travel to hospital and enable all clinicians to continue to care for their patients – both in terms of diagnosis and longer-term monitoring. Crucially, these results should be available for viewing across primary and secondary care, regardless of where the request originated.

Clearly defined lines of clinical responsibility should also be agreed at a local level. The BMA has previously published guidance[3] confirming that unless any agreement has been reached locally between clinicians, as a principle, the requesting doctor is responsible for handling the results.

As part of its decision to accelerate the return of non-Covid health services, in the letter[4] on the third phase of the NHS's response to Covid-19, NHSE/I have asked health systems to ensure that sufficient diagnostic capacity is in place in Covid-19-secure environments, through the development of Community Diagnostic Hubs. This is an encouraging step towards the establishment of increased routine testing capacity in the community and will improve the services patients receive. NHS England and NHS Improvement now need to ensure there is appropriate funding for these hospitals outreach programmes and for CCGs to increase diagnostics capacity in the community.

3 NHS Digital and NHSX must increase investment in IT infrastructure to better support information sharing

Lack of adequate IT infrastructure is one of the biggest barriers to creating a more collaborative and coordinated NHS. Both patients and doctors report frustrations with not being able to quickly and securely share vital information between primary and secondary care, as well as with other parts of the health service.

Over the past four months, enhanced sharing of data via the Summary Care Record (SCR) has been implemented as a way to ensure a greater range of patient information from the GP record is made available to clinical staff in secondary care. The functionality of the SCR does not allow secondary care clinicians to amend the GP record directly, but it still negates the need to request specific information from GPs which helps to reduce duplication of work across the interface.

While this is an important step towards ensuring information governance processes are in place to allow greater information-sharing between primary and secondary care, the infrastructure to do this is still largely absent. For collaboration to work more effectively, clinicians in different settings should ideally be able to see and contribute to relevant shared patient records, observations, results and background notes from any location, in real-time. Action is needed to develop systems with commonality in the coding structures that allow input from clinicians on all sides.

Many secondary care clinicians across various specialities are still struggling with inadequate IT provision. IT provision within secondary care lags behind for a variety of reasons including significant recent under investment, but also a lack of user input into system design. Investing in infrastructure that supports patient journeys from end to end and working across the interface will not just allow better joint working between primary and secondary care, it will also allow the continuation of more remote working, which will be important in case of a second wave but also has wider work-life balance benefits for both patients and staff.

If the NHS is to capitalise on the changes mandated by the recent pandemic, it is important to address these IT issues urgently.

4 CCGs should set up joint prescribing budgets and restrictions on hospital doctors' ability to prescribe lifted

The current norm of holding separate budgets for prescribing in primary and secondary care creates perverse financial incentives and acts as an additional barrier to closer joint working.

Financial and organisational priorities discourage many secondary care clinicians from issuing prescriptions for more than a limited period to patients as costs are not being budgeted for within their trust. This creates unnecessary duplication, with patients sometimes being sent back to their GP for an NHS prescription that they could have received in hospital.

This is proving increasingly problematic in these exceptional circumstances where health services are facing unprecedented levels of pressure and increased workload.

Establishing joint prescribing budgets – overseen by a committee with representatives and genuine input from primary, community and secondary care – and enabling secondary care clinicians to prescribe to their patients in the community would help overcome this barrier and provide safer care for patients who need specialist experience for their medication. This would reinforce continuity of care and allow specialist clinicians who prescribe specialist medications to retain responsibility for their patient's care.

In addition to joint prescribing budgets, joint working could be facilitated by opening access to EPS (Electronic Prescription Service) to secondary care clinicians. With access to EPS they would be able to prescribe following a remote consultation, without the need to request the GP to prescribe or for the patient to have to visit the hospital pharmacy to collect their prescription. NHSE/I have indicated that a number of secondary care outpatient pilots had been initiated using the same models and solutions that allowed for progress in digital prescribing in primary care. Unfortunately, these pilots have now been suspended due to technical issues related to the functioning of ePrescribing systems in hospitals. Trusts and system suppliers are working together to ensure hospitals will be able to use EPS over the next few months.

This change would allow hospital doctors and specialists working in the community and in tertiary centres to provide end-to-end services, avoiding duplication of work, freeing up GP time and improving the quality of services that patients receive across the system. Patients would benefit in multiple ways including having to make fewer journeys and spend less time traveling to and from appointments.

5 NHSE/I should resource NHS bodies in a way that encourages collaboration rather than competition

The payment mechanisms which were in place prior to the pandemic resulted in perverse incentives for providers and encouraged workload shift between health settings. Instead of providing financial incentives for NHS providers to increase activity, the NHS should be moving to mechanisms that encourage health systems to work together to focus on preventing ill health and reducing the need for patients to be admitted to hospital wherever possible. Previously, hospitals were effectively penalised for helping to keep patients out of hospital, because much of their funding was linked directly to levels of activity. In addition, clinicians' time was being wasted completing outcome forms and other administrative tasks related to this funding complexity.

At the start of the pandemic, NHSE/I decided to suspend the usual PBR national tariff payment architecture and move to block contract payments for all NHS trusts and foundation trusts from April 1 to 31 July 2020[5].

Government and NHSE/I should now build on this and scrap activity-based payment models such as the PBR national tariff payment permanently. This would empower NHS bodies and GP practices (through PCNs and Local Medical Committees) to work together to plan how they will make best use of resources to meet the expected needs of patients in their local areas, as highlighted by the example below. There needs to be a locally accepted approach on how health economies deal with the resources left when the level of activity in secondary care is reduced. This approach needs to balance the need to adequately fund hospital services for their work whilst investing in services in the community that will prevent more patients from requiring acute care. Ultimately it is likely that this will require an overall increase in investment (at least initially) to support this transformation.

Box 1: Block contracts: Northern, Eastern and Western Devon CCG[6]
Northern, Eastern and Western Devon CCG has stopped using the Payment by Results (national tariff) system, moving to block contracts instead. This move has enabled commissioners and providers to focus on how they proactively manage expected demand, rather than reactively responding to higher-than-expected demand and the financial pressures these cause among providers or commissioners. This has meant the CCG was able to go from having the largest cumulative deficit in the NHS in England to breaking even in 2019.

Since this shift in contracting arrangements, the CCG has also been able to keep £4 million together in operating costs. The organisational focus of the CCG has also been narrowed to focusing on "delivering best value while servicing demand" since moving away from payment by results. In addition, the move away from activity focused contracts has reduced the bureaucratic burden for both commissioners and providers.

6 Health systems should bring together clinicians and patients to agree a radical new shared approach to designing and funding care pathways

Longer term, health systems should develop forums which bring together clinicians working across traditional organisational divides to agree and design shared approaches to how patient care is delivered according to patient need rather than organisational barriers. These forums must involve key representative bodies from community and secondary care, as well as primary care such as LMCs (local medical committees).They should also involve patient groups and be informed by direct input from patients themselves.

A starting point for such discussions should be a shared recognition that there are workload, workforce and funding pressures on all sides and that the challenges posed by Covid-19 make it more important than ever that clinicians work together across traditional divides.

There should also be a shared agreement that as a matter of principle one part of the system will not make significant changes that affect the others without discussion and agreement first. These agreements must translate into action, with consultation and involvement of all groups. Time must be made available for GPs, secondary and community care doctors to engage with this process and attend meetings.

Establishing a shared approach to care pathways including the hand-over of care – taking into account the 'new normal' the NHS is now adapting to – means working together to agree how patients with certain conditions should typically be cared for. This will involve ensuring their journey through the system can be made as seamless as possible to improve the quality of care they receive and reduce inappropriate delegation of care or unnecessary duplication for both patients and clinicians.

It also means agreeing how resources and capacity can be best directed to match this. To achieve this, local health systems and the NHS could change the ways services are commissioned, developing shared budgets for specific care pathways that cut across traditional divides between primary and secondary care. Under such new commissioning arrangements, clinicians in primary, community and secondary settings would be encouraged and enabled to work together as co-providers of care, with shared goals rather than the competing interests that often dominate the current system. In the past some CCGs have appointed interface leads to drive forward this engagement work.

NHSE/I have indicated that they are planning to work with clinicians and other key stakeholders together to review and redesign outpatient pathways across primary, secondary and community care. The BMA will take part in that work to enable local systems to transform their services, enabling seamless integration, truly patient-centred pathways and more convenient access to necessary treatment and care for patients.

Commissioning structures are now changing, and it is vital that clinicians from across primary, community and secondary care are able to have a voice in new planning structures. The BMA has heard reports from members of positive work to improve interface working at CCG level being lost due to STPs (sustainability and transformation partnerships) and ICSs (integrated care systems) not seeing them as a priority. It is vital that as the NHS moves to larger scale system-level commissioning and planning, local relationships and initiatives are given the backing they need to succeed. The response to Covid-19 showed the value of harnessing clinical input into system change.

7 Establish quality improvement programmes that bring together clinicians from across primary, community and secondary care

While responding to the first wave of the pandemic presented incredible challenges for health systems, the lifting of bureaucratic and regulatory barriers allowed clinicians to adapt to unprecedented circumstances very rapidly and develop innovative ways of delivering care.

Local health economies should now build on this and develop clinically led quality improvement programmes focused on supporting clinicians and other healthcare professionals to come together to input into service redesign, backed up with investment to provide doctors with protected time to achieve this.

There are opportunities to develop these programmes digitally and online to allow clinicians to engage at a time convenient for them, at low cost, in large numbers and possibly on a regular basis if successful.

These programmes should take inspiration from the experience of involving clinicians in system redesign in Canterbury, New Zealand (Box 2 below).

Box 2: Clinical Engagement – Canterbury, New Zealand[7]
Both doctors and non-clinical staff were heavily involved in the creation and implementation of a shared vision for integration in Canterbury, New Zealand. Senior leaders were given specific training to empower staff to lead change and a large-scale 'Showcase' programme, which ran for six weeks, brought over 2,000 staff together to discuss and devise solutions to the problems facing their health and care economy. Both approaches were considered successful in ensuring clinicians and frontline staff saw themselves as active participants in system transformation.

8 NHSE/I must support hospitals to implement changes to the standard contract designed to improve primary-secondary care coordination

The 2015 Making time in general practice report found that an estimated 4.5%, 15 million GP appointments could be freed up if GPs were not having to spend time rearranging hospital appointments and chasing test results.

In 2015-16, the BMA negotiated changes to the NHS standard contact with NHS England to clarify expectations of which part of the system is required to do what across the primary and secondary care 'interface'[8]. The new key requirements in the contract, which came into effect in 2016-17, cover a number of areas in relation to the 'interface' between primary and secondary care[1], aimed at improving the convenience of services for patients, and releasing capacity in general practice.

A summary document[9] was produced by NHS England's Interface Working Group to describe the new requirements and ensure effective implementation.

With the introduction of these changes, doctors in hospitals are now required to issue fit notes to patients under their care where required or, for instance, agree with the patient's GP the transfer of responsibility when initiating shared care arrangements.

Extreme levels of pressure on secondary care, financial, infrastructure challenges and workforce shortages as well as bureaucratic barriers are preventing doctors in their trust from following these requirements. There are reported instances where secondary care medical staff would not have access to fit notes, even in a non-digital format. This must change. The BMA wants to see secondary care doctors to have access to electronic fit notes and there should also be greater use of consultant-to-consultant referral within hospitals.

Unfortunately, the inconsistent adherence to these requirements among trusts continues to cause workload repercussions in primary care which then present as capacity challenges and impedes consultants' and other hospital doctors' ability to deliver an end-to-end service.

It is important that local health economies, including commissioners, ICS, STP and Trust leadership teams, work jointly to remove bureaucratic and administrative barriers to improve adherence to the contract requirements, and that Government, NHSE/I address the historic financial and workforce shortages, including A&C support staff, in secondary care.

Some health economies have already established local fora to decide on how best to resource each part of the system to ensure adherence to the key requirements of the standard contract. Commissioners, secondary care providers and PCN leaders could set up local arrangements to ensure safe and effective delivery of care for patients across the interface. This is particularly important as hospital doctors' and GPs' workload continues to increase as NHS services are re-starting and when rapid solutions to reduce the backlog need to be found.

1 These include: referrals into secondary care; discharge summaries and clinic letters; management of DNAs and re-referrals; management of onward referrals; communication with patients and response to their queries; prescription of medication and the implementation of shared care protocols; management of patient care and investigations; the issue of fit notes.

In the longer term, the NHS should move beyond the current approach of holding separate contracts for secondary care activity and towards more integrated contractual arrangements based around shared care pathways – as outlined in section 6 above. The current contractual framework ultimately rewards trusts for focusing on their own activity and efficiency – we need to move to new arrangements that incentivise trusts to take the whole system into account, working alongside primary and community care to reduce duplication and improve care pathways in ways that benefit both patients and those involved in their care.

Next steps

As NHS core services are re-starting, there is an opportunity for the health system to implement changes towards more effective collaboration between primary, secondary and community care, which will contribute to addressing the backlog in the short term and improve patient care and the working live of doctors in the long run.

The BMA is keen to draw upon the recommendations made by frontline clinicians and work with Government, NHSE/I and stakeholders within the health system to develop and implement these solutions. They include:

Priorities	Organisations responsible for delivery	Timescale for delivery
Bring together local clinicians to establish a local approach for how to review and process the backlog of referrals which helps to achieve effective priorisation is acceptable to all parts of the system.	LNCs (local negotiating committees), LMCs, local systems	Immediate action required
Empower CCGs, including financially, to establish and increase the commissioning of locally based services for blood tests, ECG, spirometry, ultrasound or other diagnostic services in the community, and to allow clinicians regardless of the care setting they work in to book these tests and monitor results.	NHSE/I and local commissioners	Immediate action required
Invest in IT systems, especially in secondary care, which respond to the need of clinicians, including information sharing and an ability to continue remote consultation.	NHS employing bodies	Immediate action required
Develop locally agreed joint prescribing budgets and open access to EPS to secondary care clinicians to enable them to issue prescriptions more easily and reduce GPs' workload.	NHSE/I	Immediate action required
End the PBR national tariff payment mechanism and replace it permanently with less complex funding arrangements– such as block contracts – designed to empower NHS bodies to work together to plan how they will make best use of resources to meet the expected needs of patients in their local areas.	NHSE/I	Immediate action required
Bring together local clinicians, health leaders and patients to agree a radical new shared approach to designing and funding care pathways.	Local health systems	Medium-term objective
Develop clinically led quality improvement programmes focused on supporting clinicians and other healthcare professionals to come together to input into service redesign.	Local health systems, NHSE/I	Medium-term objective
Engage with local health economies, including commissioners, ICS, STP and Trust leadership teams to improve adherence to the NHS standard contract requirements.	NHSE/I and Trust leadership teams	Immediate action required

References

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9 NHS Standard Contract 2017-19 provisions, *NHSE's Interface Working Group* (2017): https://www.england.nhs.uk/publication/the-interface-between-primary-and-secondary-care-key-messages-for-nhs-clinicians-and-managers/

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