25th May 2021

**To all practices in Surrey & Sussex LMCs**

Dear Colleagues

**Standard Operating Procedures [SOP]: General Practice: Updated May 2021**

I am writing in relation to NHS England SOP published last Thursday, a week following the ‘memento to incompetence’ (SSLMCs copyright) letter the week before.

Rather than try and repeat this description or find an equally memorable phrase, the LMC is providing updated advice to all practices in relation to this SOP, which as both GPC and LMC have emphasised, is guidance. The contractual position is as below:

***Essential Services***

*4) The services described in this paragraph are services required for the management of a contractor’s registered patients and temporary residents who are, or believe themselves to be—*

*(a) ill, with conditions from which recovery is generally expected;*

*(b) terminally ill; or*

*(c) suffering from chronic disease,*

***which are delivered in the manner determined by the contractor’s practice in discussion with the patient****.*

*(5) For the purposes of paragraph (4)— “disease” means a disease included in the list of three-character categories contained in the tenth revision of the International Statistical Classification of Diseases and Related Health Problems; and “management” includes—*

*(a) offering consultation and,* ***where appropriate, physical examination for the purposes of identifying the need, if any, for treatment or further investigation****; and*

*(b) making available such treatment or further investigation as is necessary and appropriate, including the referral of the patient for other services under the Act and liaison with other health care professionals involved in the patient’s treatment and care.*

The updated NHS SOP (Version 3.3) is available at: [Report template - NHSI website (england.nhs.uk)](https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C1288-COVID-19-SOP-GP-practice-v4.3_May-2021.pdf)

Within this, the changes from the earlier version (April 3.2) are highlighted in yellow.

A summary of the LMC and GPC position is:-

It is for practices to determine how best to manage and deliver their services and the best arrangements for appointments, based on their expert knowledge of their local community, and with regard to the need to maintain good infection, protection and control measures in place. Practices have the contractual freedom to do this in a manner determined by each practice, taking in to account their capacity and workload pressures, and by doing so delivering a safe service to their patients.

**Access to General Practice**

The most significantly amended – in fact rewritten – section is 6.3, Access to General Practice, which reflects the issues clumsily highlighted in the BO497 letter. The LMC’s advice in relation to this section is as follows:-

* Practices should offer both face to face and remote appointments. Face to face appointments should be offered where this is the most appropriate way of safely determining the patient’s diagnosis and deciding a management plan.
* Patients should be involved in a discussion regarding their appointment, but the following, from the SOP: “Patients have a choice of consultation mode” does not follow the Regulations; patients and clinicians do not have a co-equal choice and the final decision is the GP’s. A moments reflection by anyone who understood General Practice would make it clear that, in order to prioritise care in a situation where demand exceeds capacity, this is the only safe, equitable, and best interests operating model.
* The request for consistency of process, in terms of triage face to face at reception mirroring that available online or by phone, whilst “avoiding queues and crowded waiting rooms” (quoted in the SOP) and maintaining the safety of both staff and the public in a situation where perhaps a third of Covid-19 positive patients are asymptomatic, looks impossible. Later the SOP states physical access to practices should be compliant with Infection Prevention and Control guidance. The SOP does state that “all practices must offer online consultation systems”: this is not, as the GPC have confirmed, the contractual position since this is not included within the Regulations, but has been encouraged since 2019, is intended to be included in the Regulations in the future, and many practices believe it is an important aspect of patient care delivery. The LMC is sending a separate letter to practices about this issue.
* The SOP suggests:
* Patients should be able to make requests via an online system at any time.
* Practices are not expected to respond to such online requests outside core hours.
* Practices should inform their CCG before restricting online access.

LMC advice is that the second point is correct, the first is aspirational, not contractual,

and the third is only true if practices cannot restrict online access via their system

themselves. Unfortunately, this is the case for a number of systems. The LMC is

suggesting the following approach to CCGs:-

* requests by practices to switch off online systems outside core hours should be agreed without further enquiry.
* requests to switch off online systems within core hours should be accompanied by a reason from the practice, which is likely to be related to workload and capacity.

If practices can control their own online access, the LMC suggests there is no need to contact the CCG in relation to outside core hours switch off, if online provision was a contractual requirement then depending on the wording there might be in relation to within core hours switch off. This is currently not the case. Thus, practices might find it helpful to present evidence, if asked, for workload numbers capacity, and, if the case, that access to online services has not reduced other demand, such as telephone calls.

* Practices should take into account patient feedback (including engagement with their PPG) when considering services offered to patients, including access.
* Practices should enable online booking of appointments, including planned care, such as immunisation, phlebotomy (if commissioned locally) and LTC management appointments. If the practice is not offering a ‘total triage’ model, then 25% of all appointment types should be offered for booking online.
* The SOP draws colleagues attention to the changing access arrangements to General Practice directed by NHS England (such as the ‘total triage’ model) that has disproportionately affected certain patient groups and, in a rather odd sentence, the SOP states:

“If a patient needs extra support to access remote consultations (e.g. access to phone/IT) raise this with the local commissioner and/or Local Authority.”

The LMC will ask CCGs what they will do if such concerns are raised by GP practices.

* The SOP also notes that patient information about accessing GP services should be kept updated on practice websites.

**Registration**

GP practices are asked to continue to register new patients “where capacity allows”; this is an unusually generous interpretation of the Regulations by NHS England and may be better interpreted as evidence that they do not understand their own applicable Regulations, rather than taken literally.

**Oximetry@Home pathway**

The SOP recommends Oximetry@Home is available for patients who are:

* Covid-19 positive, clinically or by test, and
* Symptomatic, and
* >65 years, or
* >65 years but clinically extremely vulnerable to Covid-19 infection or have other risk factors.

GP practices in SSLMCs have been offered support to identify patients suitable for Oximetry@Home services via the £120 million Covid-19 Expansion of Capacity Funding until September 2021.

**Suspected and Diagnosed Cancers**

This remains a priority for 2021/22 and GP practices should be able to obtain further information from their local Cancer Alliance. The evidence is that referrals for the following cancers remain lower than expected, following the pandemic: lung, urological, upper gastro-intestinal, prostate and skin cancers including melanoma.

Patients with suspected cancer should be referred as normal; secondary care colleagues “will triage and prioritise if capacity is constrained”, General Practice “may be asked to support prioritisation with additional tests alongside referrals, if they have capacity and appropriate access”. Secondary care “will use patient tracking lists where investigations take place at a later date.” Secondary care “continues to require consent from the referring clinician if considering circumstances for the downgrading of any urgent cancer referrals.”

(All quotes from section 10.8 of the SOP.)

**Referrals**

The SOP suggests practices should take into account national guidance on high quality referrals and should “avoid unnecessary outpatient referrals” by using Advice and Guidance (or equivalent) if available, identify appropriate services for patients, and warn patients of likely delays, including restarting routine elective activity, and (ironically) the need for non-face to face consultations.

The LMC recommends patients are referred if their clinical condition makes this appropriate and patients wish to be referred, after explanation, or if the GP needs further support in managing the patient, over and above that available in practice.

I hope this background is helpful; colleagues should regard the NHS SOP as guidance, noting that there are points within it that the LMC believes are fair and reflect the aspirations of General Practitioners to deliver an equitable and professional care to patients. There are also opinions that reflect NHS England’s vision rather than both the contractual position and the reality of delivering that care, and the LMC believes that the latter are more useful reference points for GP colleagues.

With best wishes



**Dr Julius Parker**

Chief Executive