Dear Colleagues,

Apologies for the length of this e mail. Please do read it through to the end.

I am fully aware of how stretched things are for clinical teams. By raising these issues there is no implied criticism of the hard work that you are doing and complete acknowledgement of the changes in practice that you have undertaken to keep services running through these tricky times.

COVID 19 has not only stretched our services, and is also causing a great deal of strain to our GP colleagues. It seems that new pathways which seek to minimise face to face patient visits to STH have inadvertently worsened the strain on general practice. GPs have picked up a significant amount of extra work from us. They have sent the MD office multiple examples from a wide range of GP practices of inappropriate activities being transferred to primary care. Many of these transfers have been made in good faith and in the spirit of trying to minimise patients' risk of coming into contact with COVID 19. However they are breaches of the contractual obligations around what we should be doing and what we may ask GPs to do.

1) **Consultant to Consultant referrals.**

   Historically there was a policy to restrict and reduce these, but in an effort to avoid wasting GP time by needlessly referring
   back to them, it was agreed with the CCG that:

   a) Anything that is clinically urgent may and should be referred directly to another consultant.
   b) Non-urgent problems may and should be referred direct to another the consultant if:

      a. There is some connection to the original referral problem (eg to explore another explanation for the presenting symptoms or for necessary consultant assessment of a co-morbidity needed before surgery and anaesthesia), or there is an established pathway eg gastroenterology to GI surgery.
      b. The referral letter does not suggest, and we have no other reason to think, that the GP would have reason to object to the onward referral
      c. Greater holistic knowledge of the patient that the GP may have is not needed to decide on the referral

2) **Implications of Virtual Clinics**

   2 main issues have been raised.

   a) Prescriptions: If we have seen a patient in clinic, even virtually, contractually we should still provide the prescription. This is done by writing the prescription as normal on a standard STH/Boots OPD prescription form ensuring that the patient's current address and a contact telephone number is clearly visible. The level of clinical urgency should be displayed on the main body of the prescription form so that pharmacy can select the most appropriate method of delivery. You should write URGENT for prescriptions needed within 24 hours *(for delivery via Boots local PDC network or commercial courier)* and ROUTINE for all others *(for delivery via Royal Mail Track and Trace postal service)*. If you are prescribing a controlled drug, you should also write CONTROLLED clearly on the prescription above the medicine you prescribe. Scan the prescription and

email directly to the Boots dispensaries situated on the site the clinic takes place (NOT STH pharmacies). The email addresses to use are: Northern General site: sth.BootsNGHPharmacy@nhs.net; Royal Hallamshire site: sth.BootsRHHPharmacy@nhs.net.

b) Blood tests: If a blood test is required as a result of a clinic appointment it is our responsibility to arrange this test and follow up the results. The scenario of us asking the GPs to arrange the test not only leads to delays, but may also cause difficulty for the GPs in trying to interpret the results. Blood tests can be arranged by ordering the test on ICE and advising patients to attend the Sheffield Arena. There is a very limited phlebotomy service in primary care. The link to details of the arena service on the intranet is http://nww.sth.nhs.uk/nhs/coronavirus/DriveThruBloodTests.html

c) Investigations : we should be arranging investigations for patients that we consider necessary, and not asking the GPs to do this for us.

3) **Investigations on discharge/explanations of results**

At times we discharge patients with the plan of an investigation a week or two later eg. U&E after a change in diuretics or an interval chest X-Ray. This may make sense to free up beds but the primary care view is that this should form part of the hospital episode of care. Therefore we should keep such requests to an absolute minimum, and if the test is related solely to an inpatient episode, we should request this ourselves. If it is related to an on-going chronic or pre-existing condition then it is reasonable to ask the GP to arrange it. A blood test within a week of discharge would be very difficult for GPs to arrange and this should be avoided.

I have attached a letter describing the contractual obligations regarding key issues in our interface with primary care for your reference.

The key requirements of the contract that we are obliged to observe are:

issues are:

- Hospitals should issue ‘fit notes’ (previously sick notes) to patients under their care for the anticipated length of time they are required for.
- Timely production and transmission of clinic letters (where clinically required) following clinic attendance, to GP practices, no later than 10 days (from 1 April 2017) and 7 days (from 1 April 2018). Please advise patients that there will be a delay between a virtual clinic and the GP receiving the clinic letter
- A requirement for hospitals to put in place efficient arrangements for handling patient and GP queries promptly and publicise these arrangements to patients and GPs, on websites and appointment / admission letters, and ensure that they respond properly to patient queries themselves, rather than passing them to practices to deal with.
- Providers to supply patients with medication following attendance at OPD for the period established in local practice or protocols, but at least sufficient to meet the patient’s immediate needs up to the point at which the clinic letter reaches the GP.
- Hospitals must only initiate shared care arrangements where the patient’s GP is content to accept the transfer of responsibility.

I am conscious that some of the changes that we have made to our services during the pandemic may have made it more difficult to undertake certain tasks. Please highlight any that remain unresolved..

Many thanks
Jennifer

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