NHS
South Yorkshire
Integrated Care Board

Consensus and Policy on the Primary and Secondary Care Interface in South Yorkshire

Version control	
v.1	Initial consensus document with guidance on onward referral, fit notes, prescribing and communication (Nov 2024)
v.2	Version adopting amendments during the sign-off process (April 2025)

Contents

1. Foreword

The NHS faces unprecedented levels of demand and as a result all parts of the system are under significant strain. At such times it is important that we all remember the overarching principles in which this policy is grounded, that of mutual respect and compassion for each other and for the patients for whom we care. The following document and recommendations within have been a collaborative effort between clinicians and managers working across primary and secondary care and physical and mental health. We hope that they provide a foundation on which to build a more integrated care system. They should serve as a reference and reminder for individual clinicians as to their personal responsibilities when caring for their patients as well as for the leadership of organisations as to the infrastructure and resources needed to facilitate good care. Whilst defining the working arrangements at the interface between primary and secondary care could be a very transactional process, we hope that the collaborative work in developing this policy can serve as a springboard to a more transformative approach.

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2. Principles

The following principles are supported by clinical leaders across Primary Care, Secondary Care, Community and Mental Health Services in South Yorkshire. These principles cover most patient interactions, but it is accepted there will be exceptions.

2.1 General principles

- Treat all colleagues with respect and kindness.
- Ensure the patient is at the centre of everything we do.
- Clinicians should take any required actions themselves without asking other teams or services to do work on their behalf.
- The clinician requesting a test is responsible for the result of that test including ensuring that the patients receive the results of investigations[1].
- The clinician should ensure patients are fully informed regarding their care, understand who is responsible for their care and 'what will happen next'.
- Do not commit other individuals, teams or providers to particular actions or timescales.

2.2 Primary Care principles

- When referring to Secondary Care via eRS, ensure the 'ask' is clear and communicate to the patient who you are referring them to and what to expect (if known).
- Ensure appropriate or additional agreed Primary Care assessments are made and this information is included in the referral.
- Consider optimising Long-Term Conditions prior to referral where appropriate.
- Ensure bypass numbers up-to-date on NHS service finder.

2.3 Secondary Care principles

- Ensure clear and timely communication with the GPs/Primary Care referrers following patient contacts.
- Avoid asking General Practice to organise specialist tests.
- Routinely offer Med3s (fit notes) to all working age patients as medically appropriate and for the full duration likely to be required.
- Follow agreed prescribing principles on discharge and from Outpatients.
- Arrange appropriate onward referral if this is felt to be necessary.
- Ensure contact details/emails are clear on all communications.

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[1] *The clinician requesting a test should share the result with the patient and provide any relevant advice in the first instance. Where abnormal results arise that are unrelated to the presenting complaint or the reason the patient is being seen in a specialist clinic, provided the patient has capacity it is appropriate to ask them to make an appointment with their GP and the result communicated to the GP. Any results requiring urgent action remain the responsibility of the requesting clinician. Secondary Care Clinicians are not responsible for ongoing chronic disease management.*

3. Onward referral in Secondary Care, Community and Mental Health Services

3.1 Onward referral between NHS services

The Academy of Medical Royal Colleges (AoMRC) made a series of recommendations[2] which were incorporated into the NHS England plan to recover access to Primary Care, published in May 2023[3].

One recommendation concerned onward referrals. The guidance states that "If a patient has been referred into Secondary Care and they need another referral, the Secondary Care provider should make this for them, rather than sending them back to General Practice for a further delay before being referred again".

This means that Secondary Care Clinicians (SCC) who identify a clinical problem requiring another referral should make the referral themselves, if they have the knowledge and skills to do so. This differs from previous guidance and the hospital standard contract, which states that SCCs should only refer on to another specialist[4] or service if the clinical problem that they have identified relates to the same symptoms / clinical problem that the patient was referred to them for (or concerns an urgent clinical issue which cannot not wait for reassessment and action by the patients GP). NHS South Yorkshire ICB is proposing to vary the local hospital contracts to adopt the AoMRC recommendation for onward referral.

The AoMRC guidance is better for patients, best utilises our health care system resources and is supported by NHS South Yorkshire ICB. The following should be universally implemented.

- If an urgent referral (e.g. urgent suspected cancer) is needed, the patient must be referred by the SCC to the pathway using the agreed referral route (acknowledging that some non-medical practitioners in non-Consultant led services will need to liaise with primary care to direct these referrals).
- If a patient has been referred and the SCC feels the patient needs to be seen by a different specialist or service relating to the initial symptoms/problem, the specialist should refer on to the appropriate service, i.e. without referral back to the GP, but inform the GP in the usual way.
- If a separate medical problem is suspected based on the specialist's assessment of the patient one of two actions should be taken;
    - i) Where there is no urgent need for the patient to be seen by another specialist or service and there are no patient safety concerns, if the SCC is unsure about required assessment or appropriate management of the separate medical problem, they

[2] GPSC_Working_better_together_0323.pdf

[3] Delivery plan for recovering access to primary care

[4] For clarity 'Specialist' includes all clinicians seeing the patient outside General Practice, including Acute, Community and Mental Health Services.

should ask the patient to see their GP. The patient EPR should be used to document this advice. The advice should also be communicated to the GP in any correspondence, and patient information needs to state when the GP is expected to receive and assimilate the letter (2 weeks). SCCs should avoid telling patients that they will tell the GP to refer, as this may not be necessary after GP assessment and sets unrealistic expectations and may cause confusion. SCCs should also avoid telling patients that the GP will contact them, as this is unrealistic and introduces risks. If you are concerned that a patient might not follow the advice and lacks mental capacity, please contact the GP as soon as possible to inform them of the situation and any concerns.

ii) If SCCs feel that it is clinically appropriate and have the knowledge and skills to direct a new referral to a specialist or service, they should refer the patient directly to the relevant speciality. Please note that the use of eRS is only mandated for GP to specialist referrals and whilst eRS referral would be best practice, not having access to eRS should not prevent referrals being made by hospital and community-based colleagues or other clinicians.

3.2 Onward referral to services procured or outsourced to private providers

The above guidance should apply to all NHS specialist service provision, including:

- Secondary Care contracts outsourced by the Trusts to private providers.
- Directly commissioned NHS services delivered by private providers, and;
- Private to NHS Consultant referrals, particularly where the Consultant is asking the GP to refer to the same NHS Consultant where they do have access to eRS.

These referrals should all be dealt with by the Consultant, either under the local Access Policy or in line with A Code of Conduct for Private Practice[5] published by the Department of Health in 2004 and the Commissioning Policy: Defining the Boundaries Between NHS and Private Healthcare.

NHS South Yorkshire ICB is clear that community-based services and other non-acute Trust services should accept referrals directly from specialists. For example, Rheumatology can refer directly to community based MSK services and community services such as phlebotomy, dieticians or community nurses as clinically appropriate.

[5] A Code of Conduct for Private Practice consultants-code-of-conduct-private-practice-guide.pdf

3.3 Onward Referral - Frequently Asked Questions

What about referring for procedures of limited clinical value?
The ICB details these requirements in the Commissioning for Outcomes Policy[6], which applies to both Primary and Secondary Care covering examples such as hernia, carpal tunnel, hip and knee replacement, tonsillectomy.

All clinicians making/accepting referrals should be aware of this policy. For instance, an Orthopaedic Surgeon should be aware of the guidance on hip and knee surgery and be able to complete the checklist required for onward referral. If the SCC is unsure if a referral is warranted for a condition, the patient should be directed to make an appointment with their GP without raising expectations that a referral will happen. If a SCC feels a patient must be referred, they should refer and complete the Individual Funding Request (IFR).

What if I see a patient with one problem and they raise another?
If a patient raises a separate problem that can be managed at the same time or sequentially, this should happen. For instance, a patient with OA of both knees should not be returned to the GP to be re-referred for the second knee. The specialist should ensure the checklist is completed for the second knee and if the criteria are met, arrange treatment. If criteria are not met the patient should be informed and directed to see the GP if things worsen, or if further help is needed.

If a patient mentions multiple problems and reports that they are finding it difficult to see a GP, the specialist should avoid trying to resolve this themselves and advise the patient to contact their GP practice.

What about patients seen in A&E?
Patients with urgent presentations should be referred directly by A&E clinicians.

For non-urgent problems patients should be directed to see their own GP. Occasionally onward referrals might be made when the A&E clinician feels they have the appropriate knowledge and confidence to refer and/or an Amber shared care or Red TLDL medicine has been initiated (see section 5 – Prescribing).

Will Activity Funding be lost, and how will this be recorded?
NHS South Yorkshire ICB have confirmed there is no penalty for onward referrals, these will be counted in the same way as new GP referrals. When a patient is initially referred, a pathway and associated treatment time target starts. Trusts will need to ensure they record any onward referrals as a coded outcome. This will need to distinguish between onward referral for the existing issue or a new problem.

Is a change in contract required?
Yes, NHS South Yorkshire ICB is proposing to vary the local hospital contracts.

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[6] South Yorkshire – Commissioning for Outcomes Policy
https://syics.co.uk/application/files/5916/8017/2095/FINAL_EBI_CFO_v.24_Final_27_March_2023.pdf

4. Fitness to Work Certificates (Med3) in Secondary Care, Community and Mental Health Services

Also known as ‘fit notes’, ‘sick notes’, ‘med3’s’

Fitness to Work Certificates are required when someone is not able to work for more than 7 days (or might be able to work if certain short-term changes are made to help them) usually due to an acute illness, a procedure or an ongoing physical or mental health issue**.**

4.1 Key principles:

- Patients should not be asked to contact their GP for an initial Med3 if it is likely from the nature of their problem that they will need to be off work for more than 7 days**,** or their employer could make changes to help them to keep working or return to work.
    a. If the patient is physically in a clinic or on a ward they should be given a paper version if no electronic option can be emailed or texted to them.
    b. If the patient has had a telephone consultation or review, they should be posted a paper version if there is no electronic option that can be emailed or texted to them.
- The same applies for any extension to a Med3 already in place, even if the extension is less than 7 days from the discharge, review or consultation.
- The length of any Med3 should be tailored to the expected duration of the problem and/or recovery period. It creates unnecessary disruption to the patient and unnecessary work for the GP if a Med3 is only issued for 2 weeks if the patient is likely to be off for 6 weeks.
- Keep in mind the timing of any further appointments when issuing Med3s and reassure the patient that you will provide further med3s at that appointment if needed.

4.2 What you need to know:

- All patients should self-certify for the first 7 days that they are off, if they are not expected to be off for more than 7 days. Many employers will accept this verbally or by text/email/their own system. If the employer requests a formal record then the patient can be signposted to the SC2 form on the GOV.UK website https://www.gov.uk/guidance/ask-your-employer-for-statutory-sick-pay
- Med3s can be for any period of time. There is no standard duration and clinicians should not default to 2 weeks at a time. During the first six months (26 weeks) of a condition a fit note may only be issued for a maximum of 13 weeks with a very small number of exceptions. After six months the fit note

can be issued for any clinically appropriate period, up to and including indefinite.

- If a patient has not self-certified yet but is likely to be off for more than 7 days, the clinician should issue the patient the Med3 at that contact to cover the likely period they will be unable to work.
- Med3s can be easily 'backdated' if a previous note has run out, or the clinician is only seeing the patient after they have been off work for a period of weeks. The clinician just needs to enter the appropriate start and end dates rather than just the length of time.
- Med3s can overlap if the clinician is issuing a new one for a patient before their previous note has reached its end date.
- If the patient feels ready to return before their Med3 runs out then no additional paperwork is needed, the patient can take the decision themselves or in conjunction with their employer. For example, if a patient is likely to be back at work at 6 to 8 weeks post-op then the clinician can issue the note for 8 weeks but the patient can return at 6 weeks if they feel ready.
- Med3s are also needed for people who do not currently work but would normally be fit to do so. The person will send this to the Jobcentre so that they are not sanctioned for that period.

The clinician responsible for a patient from either a surgical or medical admission is generally in a good position to decide the appropriate length of a Med3. This should be done in discussion with the patient bearing in mind their employment situation as the occupational requirements (desk-based work, home-working, manual work) may need differing periods off work.

The NHS website (www.nhs.uk) provides information on expected recovery from common surgical procedures and other conditions including guidance on driving and the increased length of sick-leave required for manual work (for instance, Cholecystectomy may only require 2 weeks for a home-based worker after a laparoscopic procedure, but 8 weeks for a manual worker after an open procedure).

4.3 Fit Notes - Frequently Asked Questions

Who can issue a Med3?
Med3s can be completed by a Registered Medical Practitioner, Nurse, Pharmacist, Physiotherapist or Occupational Therapist. Some Trusts are developing Fit Note policies and staff may need to complete appropriate training to issue Fit Notes.

Can I tell a patient to see their GP for an extension?
In some circumstances a patient can return to the GP but this should not be the default. A Med3 should be issued for the full expected absence from work but patients can return to work earlier if they feel well enough. It is appropriate to advise a patient that if they do not feel well enough to return at the end of their predicted sick leave, when the note ends, to see their GP for a review. However, it would not

be appropriate to advise them to go see their GP in ‘x’ weeks to get another note. In this circumstance they should be followed up by the original service and a fit note extension given at that point. This guidance is to avoid patients being passed back-and-forth.

Is it easier for the GP as they will know more about the patient’s work circumstances?
GPs rarely have information about a patient’s work circumstance, and like their Secondary Care colleagues would need to discuss this with the patient. This is most easily done with a patient during an admission or Outpatient appointment. A GP would usually have to arrange a separate appointment to obtain the information required.

5. Prescribing and information shared between Secondary Care and Primary Care

To support patients to access timely medication, the following principles have been agreed across South Yorkshire.

5.1 Following an Outpatient appointment

- The specialist assessing the patient should issue a prescription for any new medication being recommended taking into consideration the Traffic Light Drug List (TLDL) status and any other patient factors (see Appendix 1 containing ICB Traffic Light reference lists).

  Green medicines

  - Ideally the clinician who assessed the patient and undertakes any baseline assessment and shared decision making with the patient should also prescribe the medication agreed suitable. Where this is not possible[7] and there is a non-urgent need for the medication, a request for General Practice to prescribe may occur. Patients must be informed this process can take up to 2 weeks.
  - Where there is an immediate need for the medication a minimum of 2 weeks supply of any new medication should be given by the specialist. The GP practice should be informed of the supply.

  Amber shared care medicines

  - Initial prescribing of amber medicines with shared care arrangements should be completed by the specialist, unless an individual agreed shared care protocol specifies otherwise. Specialists should continue to prescribe until a point where the condition or plan is stable, medication / monitoring is suitable for shared care, and a signed acceptance is received from the GP as per individually agreed shared care protocols.

  Amber medicines

  - Initial prescribing of amber medicines should be completed by the specialist. In the process of aligning TLDLs across South Yorkshire, there may be rare occasions where amber medicines agreed at Place are appropriate for the first prescription to be issued in Primary Care, but only where existing arrangements are agreed locally.

[7] May not be possible while South Yorkshire awaits full implementation of e-prescribing (see 5.3 below)

Red medicines

- All prescribing must be completed by the specialist.

Grey medicines

- Prescribing is not suitable in any care setting in South Yorkshire, unless there are exceptions as defined within the TLDLs in Appendix 1.

Vulnerable patients

- To support more vulnerable patients an individual assessment and reasonable adjustments may be needed. Such examples include:
  - A change to a patient's medication where they are receiving medication under a monitored dosage system.
  - Risk of suicide, or
  - Medicines liable to misuse

5.2 Stock shortages

There may be occasions where adjustments to a supply arrangement is needed in response to stock shortages.

5.3 Electronic Prescription Service (EPS)

NHS South Yorkshire ICB is committed to working with all Trusts within South Yorkshire to accelerate the implementation of electronic prescribing to community pharmacy via EPS. This prescribing will provide the functionality for all medications to be routinely issued when first started by Secondary Care colleagues. This will be recorded in the provider's patient clinical record as well as the prescription being sent electronically to the most appropriate pharmacy, supporting patients to access medicines closer to home where appropriate. Current e-prescribing systems do not allow for the automatic updating of the GP clinical record so medications will still need reconciling after discharge or outpatient attendance letters are received.

5.4 Underlying principles

- The clinician requesting that a new medication should be prescribed (in General Practice) for the patient should undertake appropriate pre-treatment assessment, shared decision making and counselling. They are responsible for communicating and clearly documenting the rationale for treatment including benefits, risks and explored alternatives where a first line option has not been recommended.

- When recommending ongoing prescribing in Primary Care all information above should be clear in the communication/request. Without clear information Primary Care will need an additional appointment with the patient. The wording below is provided as a suggestion to enable the medication to be added by the Primary Care team without the need for a repeat appointment or discussion.

  > "I have discussed the treatment options with XXX and through shared decision making we have agreed to try XXX. I have counselled the patient about this medication including the risks, benefits, side effects any ongoing monitoring requirements and the expected duration of treatment".

- The South Yorkshire TLDL and formularies (see Appendix 1) should be referred to prior to asking Primary Care to prescribe. This is particularly important for medications that require monitoring, that are newer, that are for off-license use, or which may be subject to shared care arrangements.
- The four ICB Places across South Yorkshire (Sheffield, Rotherham, Doncaster, Barnsley) have different processes to agree shared care arrangements. The South Yorkshire Integrated Medicines Optimisation Committee (IMOC) is working to harmonise this process. Going forwards, new shared care arrangements require the specialist to retain the prescribing of shared care medication until Primary Care have positively replied to agree to undertake shared care arrangements - note that shared care may be declined by GPs and other Primary Care prescribers. In this interim period please refer to the individual Share Care Protocol agreed either within Place or South Yorkshire and adhere to communication agreed within this. Appendix 2 contains links to all current agreed Shared Care Protocols.
- The specialist must make clear to the patient how they should obtain further supplies of medication and who will undertake any monitoring required.

5.5 Supply At discharge

Discharge from hospital can be associated with increased risk of avoidable medication related harm. NICE guideline NG05[8] included several recommendations as part of the patient discharge process.

Medicines related communication systems should be in place when patients move from one care setting to another. Discharge summaries should be explicit about any change to medications whether started, stopped or a change in dosage.

[8] NICE Guidance NG5 - Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes | Guidance | NICE

Medicines reconciliation processes should be in place for all persons discharged from hospital or another care setting back to Primary Care. Provided discharge summaries are received, this should happen within a week of discharge.

The Discharge Medicines Service (DMS) became a new Essential Service within the Community Pharmacy Contractual Framework (CPCF) in February 2021. Patients are digitally referred to their pharmacy after discharge from hospital using IT systems such as PharmOutcomes, Refer to Pharmacy or NHS mail. Using the information in the referral, pharmacists can compare the patient's medicines at discharge to those taken before admission to hospital. This initial check happens within 72 hours of discharge and as well as reconciling against previous supply, this allows for the interception of any existing medication awaiting collection in the pharmacy. A check is also made when the first new prescription for the patient is issued in Primary Care and a consultation with the patient (and/or their carer) helps ensure they understand which medicines the patient should now be using.

Hospitals should ensure a minimum 14-day supply on discharge, or the entire course if shorter than 14 days. The hospital standard contract states a minimum of 7-day supply, though discharge policies in South Yorkshire already state 14-day supply subject to individual variation. NHS South Yorkshire ICB is varying the local hospital contracts to state 14-day supply subject to individual variation in line with policies.

Prescribing appendix 1

Traffic Light Drug Lists

SY Traffic Light Drug List and criteria

South Yorkshire Integrated Medicines Optimisation Committee
Current South Yorkshire TLDL list
Current South Yorkshire traffic light criteria

Barnsley Place	Barnsley TLDL
Doncaster Place	Doncaster TLDL
Rotherham Place	Rotherham TLDL
Sheffield Place	Sheffield TLDL

Formularies

Place formularies are referenced below. There are no immediate plans to standardise the formularies.

Barnsley Place	Barnsley Formulary
Doncaster Place	Doncaster Formulary
Rotherham Place	No Primary Care formulary, please refer to TLDL.
Sheffield Place	Primary Care formulary Sheffield Formulary
	STH formulary - Sheffield Teaching Hospitals Formulary
	SCNFT formulary - Sheffield Children's Formulary

Prescribing appendix 2

Shared care protocols

South Yorkshire	South Yorkshire Integrated Medicines Optimisation Committee
Barnsley	Barnsley Share Care Protocols
Doncaster	To be confirmed
Rotherham	Rotherham Shared Care Protocols
Sheffield	Sheffield Shared Care Protocols

If there are any queries regarding South Yorkshire or Place commissioning or guidelines please contact syicb-doncaster.imoc@nhs.net

6. Communication guidance between Primary and Secondary Care

High quality, personalised and compassionate healthcare requires effective collaboration between clinicians caring for individual patients. This will enable appropriate, co-ordinated and timely care based on what matters most to the patient and also avoid unnecessary duplication. This will deliver cost effective health care and make the most of the resources available within our health care system.

It is particularly important to integrate effectively across organisational and professional boundaries such as between Primary and Secondary Care. Good communication provides a firm basis for delivery of the right care. This guidance has been developed collaboratively and sets out a set of principles to optimise effective communication.

6.1 Primary Care responsibilities

Referrals from Primary Care

- High quality referrals should include;
  - A clear ask of the service being referred into.
  - A summary of the assessments, investigations and prior management for the symptoms or condition.
- Where a referral is for more than one problem, all relevant problems have been assessment and deemed appropriate for specialist referral.
- Referrals should follow appropriate pre-referral pathways including pre-referral investigations. Note that there is no contractual requirement for GPs to use pre-referral pathways and referral templates, and appropriate referrals should not be rejected purely on this basis if the clinical rational for referral is sound[9]. In the event Trusts are challenged on the basis of locally, regionally or nationally agreed guidance on EBI procedures, they have the right to reject a referral.
- Ensure that when referring for non-urgent reasons, where operative interventions are likely, that chronic diseases have been appropriately optimised e.g. BP and Hba1c.

Bypass numbers for General Practice

- All General Practices should have a functional bypass number accessible to NHS stakeholders. The number should be on NHS Service Finder for other NHS staff to find. Note this is not a publicly accessible website and can only be accessed following NHS email ratification. https://digital.nhs.uk/services/nhs-service-finder. The majority of practice have bypass numbers and these should continue to be updated by local ICB teams in conjunction with GP practices.

[9] South Yorkshire LMCs have made clear that all pathways must be agreed and where this requires additional work rather than auto-filled forms, this must be resourced.

- Bypass numbers should only be used to contact GPs where an urgent/same day response is required.
- GP Practice receptionists can access patient records and are able to arrange for appropriate information to be shared via secure email.
- Most GP practices have a Duty Doctor (on-call GP) system however the Duty GP usually has booked patients between approximately 8am-11am and 2pm-5pm. It may be easier to contact a GP for a clinical conversation during the middle of the day.

Email addresses

- All GP practices have an email address for communication regarding patients. Most emails are seen within one working day (Monday to Friday) and GPs should ensure systems are in place to review emails within 2-3 working days.
- The ICB holds all GP practice email addresses, which are available to all Secondary Care providers.

6.2 Secondary Care Responsibilities

Discharge and Outpatient clinic letters

To help avoid wasted GP appointments and increased GP workload pressures due to missing information:

- Ensure clear and timely communication to the GP following patient contact.
- Ensure clear documentation of;
  - New diagnoses.
  - Interventions.
  - Changes in medication and rationale.
  - Follow up plans including how patients will be informed of investigation results.
- Ensure patients are not told to see their GP for results[10].
- Ensure clear Secondary Care contact details for issues related to Secondary Care inpatient or outpatient attendance, such as a secretary's email and phone number.
- Avoid using abbreviations and acronyms.

[10] The BMA has produced guidance for GPs on duty of care communicating test results and responsibility for communication when Secondary Care doctors recommend drugs for patients (BMA duty of care guidance). In some areas, Secondary Care teams have instructed GPs to find out test results which the hospital had ordered. Both the BMA General Practitioners Committee and Consultants Committee agree this practice is potentially unsafe. The responsibility for ensuring that results are acted upon rests with the person requesting the test. That responsibility can only be passed to someone else if they accept by prior agreement. Handover of responsibility must be a joint consensual decision between the Secondary Care team and GP. If the GP has not accepted this role, the person requesting the test retains responsibility.

Monitoring of medication or responses to treatment initiated in Secondary Care

Monitoring should generally be arranged in Secondary Care so that Secondary Care oversee management and review, except where patients have been discharged back to the care of the GP and standard monitoring is required for common medications such as ACE-I or Diuretics, or the patient is on a stable dose for new medications. In this case, communications need to clearly outline what is needed and when (see prescribing guidance and communication between Primary and Secondary Care).

6.3 General points for awareness

- Patient access to their GP record - Many patients now have full access to their GP records and will be able to see information in their records, sometimes even before this has been seen by the GP.
- Repeat tests should be requested by Secondary Care clinicians on ICE, to allow patients to attend hospital or locally commissioned phlebotomy services such as drive through phlebotomy. GP practices are not routinely funded for phlebotomy services.
- Coding of letters to GP - many letters are viewed and coded by administrative staff and not necessarily seen by a clinician, so it is important to be explicit about any actions for GPs so that administrative colleagues can pass requests and information to the relevant clinician/GP.
- Shared Care arrangements - GPs do not have to accept shared care if they do not feel they have adequate resources, knowledge or expertise as per the GMC guidance. An agreement must have been sent by Secondary Care and a returned agreement from Primary Care to take on shared care, before prescribing and monitoring can move to the GP.

6.4 Primary Care queries or patient queries presenting in Primary Care - tips for contacting Secondary Care and Mental Health Services.

In general, clinical queries should be made through Advice and Guidance on eRS or local Referral Advice System.

- Medication queries post discharge or Outpatient contact should be directed to the Secondary Care clinician who initiated the medication, or the Consultant in charge.
- Patient queries about when they will be seen should be directed to the Consultant secretary or relevant service administration team.
- Non-urgent administrative queries should be made to the appropriate secretary, and Trusts will aim to respond within 48 hours or 2 working days. Email addresses should be clearly indicted on correspondence.
- Patients who contact Secondary Care with worsening or concerning symptoms should be informed their appointment has been/will be triaged,

and appointments allocated on this basis. Patients could be advised, if unhappy, to make an appointment with their GP to review the problem but the majority should be reassured that they are in the system and that their scheduled appointment is as a result of current NHS waiting times. Secondary Care colleagues should avoid directing patients to ask to expediate their appointment as this decision should be left with the GP/referring clinician.