YORLMC LIMITED
Established 2007

Survey of transfer of work from secondary to primary care and its impact

Context

Covid 19 has dominated 2020 and has led to changes in service provision throughout the NHS. Since moving from crisis pandemic management to return of routine care, there has been a marked difference in the transfer of traditionally accepted workload boundaries between primary and secondary care.

Prior to the pandemic, General Practice was suffering from a significant workforce challenge whereby an additional 6000 GPs were required simply to stand still. This was compounded in primary care and in the community by a significant retirement hump in primary care nursing, and marked difficulties in recruitment to community nursing.

One of the intended ways of dealing with this was through the ARRS scheme in the primary care network DES. However, Covid 19 has led to a marked delay in recruitment to the scheme and even now it is only just starting to commence for the 2020/21 financial year. PCN Clinical Directors are also reporting a huge rise in demand for their input and services – whilst supportive of any attempt to improve the resources and impact of primary care, they have only been in post for a year, 6 months of which has been dedicated to crisis management. Their role primarily is in developing and implementing the PCN DES as part of the GMS contract, and currently their framework and administrative support is not mature enough to enable them to diversify into non-PCN related workstreams. Many levels of NHS management including at regional ICS level seem to be unaware of that remit.

General Practice provision has been significantly challenged during the pandemic much as it has been in secondary care due to staff shielding, isolating, or being unavailable due to active infection. Whilst numbers impacted by this have reduced, there remain a number of clinicians unavailable for direct face-to-face contact because of the above issues.

GP Covid funding was only guaranteed to the end of July, unlike secondary care funding, and consequently General Practice has had to commence numerous standard pathways of care to ensure the funding streams no longer guaranteed can be maintained. These multiple small income streams are essential to maintain the business continuity of primary care and the viability of General Practice within the NHS.

For many practices, additional charitable income through the NHS charities scheme, which received multiple millions in donations from the public, is not accessible due to the restrictive and costly regulations attached to those that would wish to bid for this charitable donation funding.

At no point throughout the pandemic have practices closed or stopped seeing patients, and currently almost all practices are reporting that activity levels are in fact higher than at the same time last year.

General Practice now faces several significant challenges as we go into the winter which will increase workload even further within primary care, and significantly impact on the ability of practices to provide good quality care. These include:

- the management of delayed referrals which have been held within primary care at clinical risk over the last six months
- a flu campaign which will be the biggest vaccination programme ever undertaken in the UK
- dealing with delayed demand from patients who have been holding back on presenting with issues during the pandemic
- having to facilitate re-referrals from patients that were discharged by secondary care despite the recommendation that secondary care should be maintaining waiting lists for these patients
- more importantly clinician fatigue which is starting to be clearly identified in General Practitioners, many of who have not taken appropriate leave during the pandemic, and have taken on additional responsibilities and risk as employers that clinicians in secondary care will not have had to deal with. They have also been working above and beyond their expected anticipated usual hours to ensure patient safety and high quality care throughout the pandemic.

The challenge of trying to maintain services is equivalent in both primary and secondary care; both face significantly reduced footfall to try and protect the public, both have to adhere to PPE routines for each contact, however primary care is faced with a significantly smaller capital estate, with smaller rooms, corridors, and access points to facilitate smooth patient flow through their buildings. The total triage model, as it is described nationally, is actually a telephone consultation model with all consultations initially being via telephone (which take as long as a face-to-face consultation) and take place prior to a face-to-face consultation in many cases, thus doubling the workload in relation to a single patient contact.

Once services were restarted, many practices reported that secondary care appeared to be breaching the standard NHS contract, and that many of the advances made in the last two years were seeing significant regression, with inappropriate transfer of care into primary care from secondary care. This featured in a number of areas of patient care, and concerns were raised with regards to the governance and risk attached to the transfer of work in this manner.

The simple fact is that with the combination of:

- the workforce crisis prior to the pandemic
- the new workload which is over and above any previously experienced demand

- the additional requirements of the upcoming winter season and the other challenges mentioned above, General Practice has no capacity or resource to cope with this transfer of work from secondary to primary care.

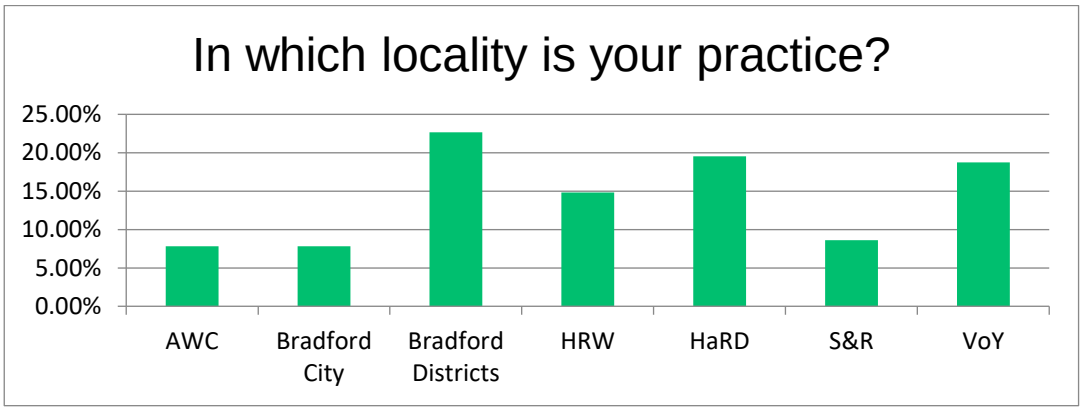
As a system a solution is needed that ensures it does not cause any part of collaboration to be overrun by an inappropriate transfer of demand, from one sector to another, that is unresourced and unachievable.

Due to increasing concerns about the increase in workload shift, YORLMC undertook a survey of practices in North Yorkshire and York and Bradford and Airedale; the results are summarised below.

Survey results

128 responses were received, made up of responses from each locality as follows:

Question 1



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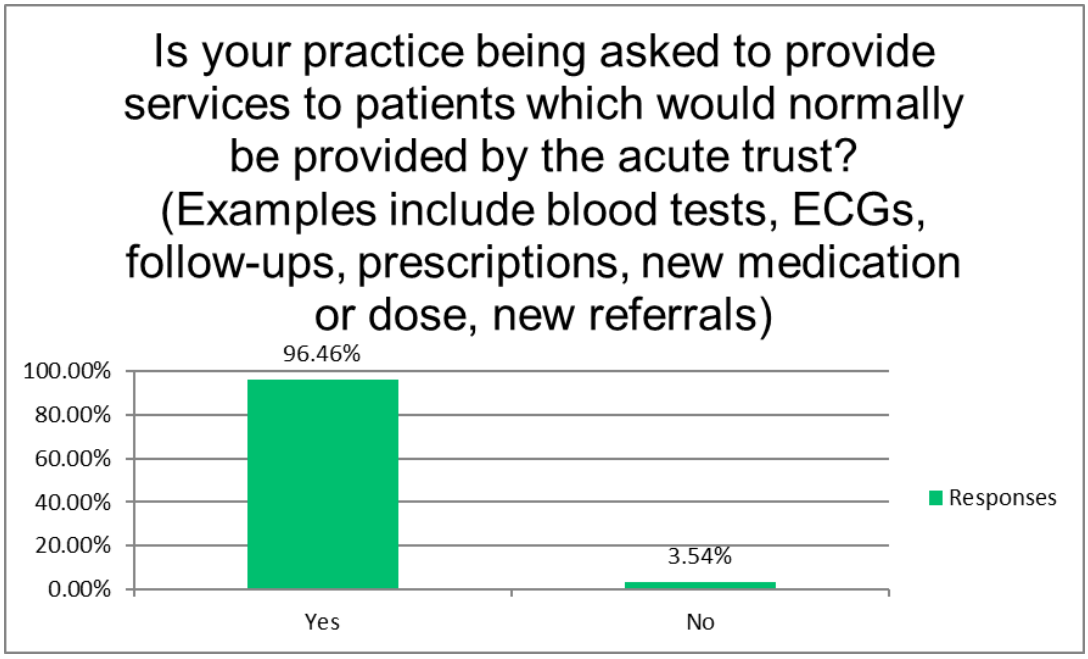

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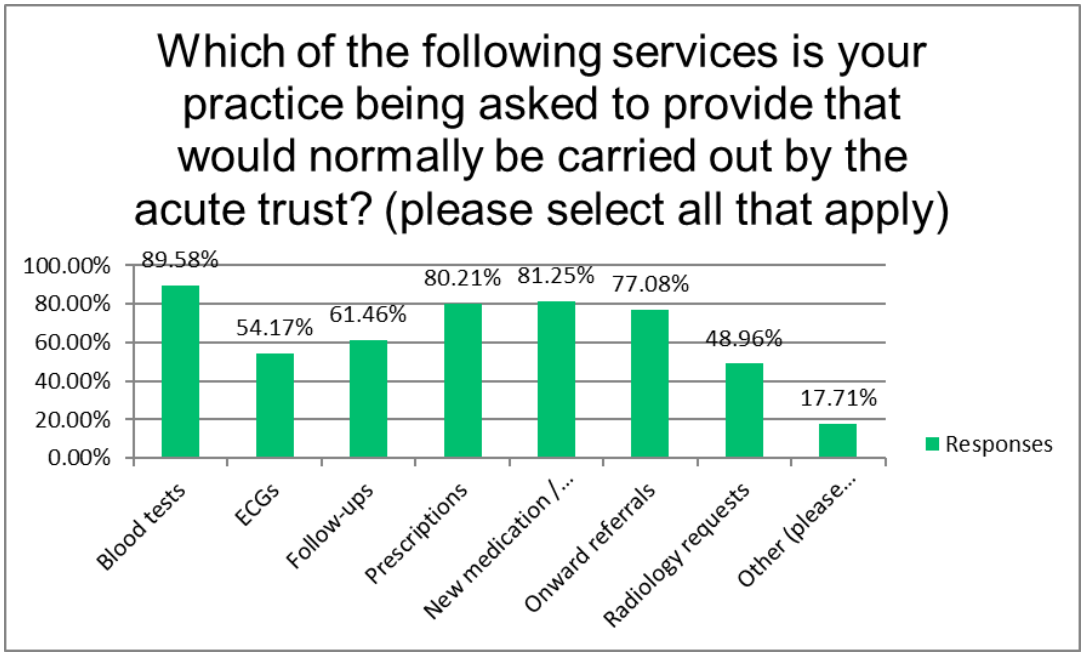

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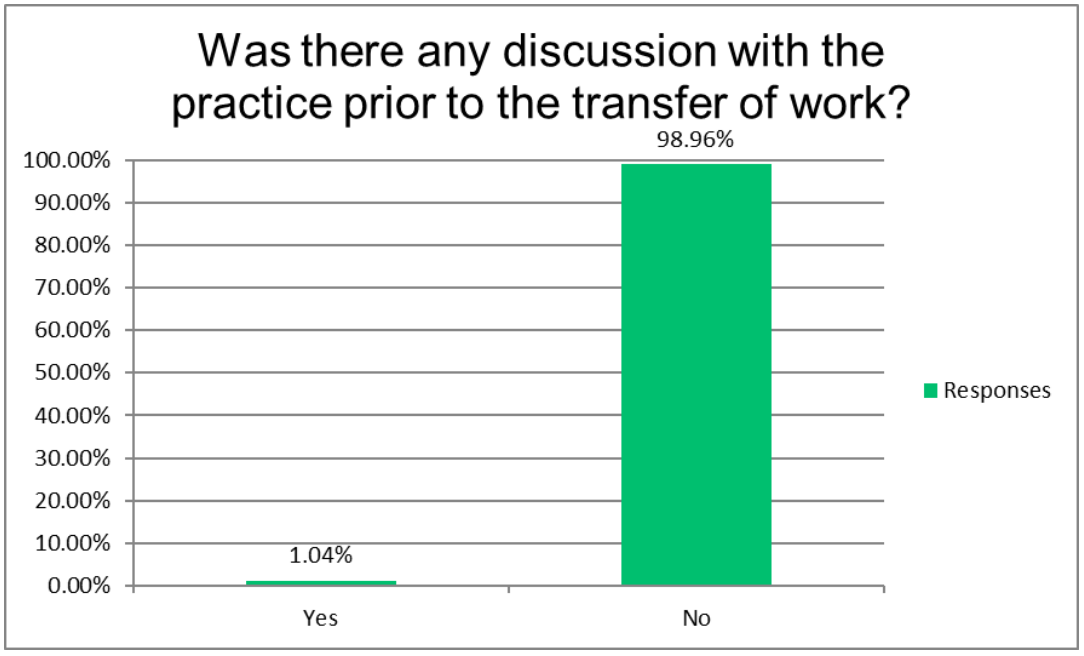

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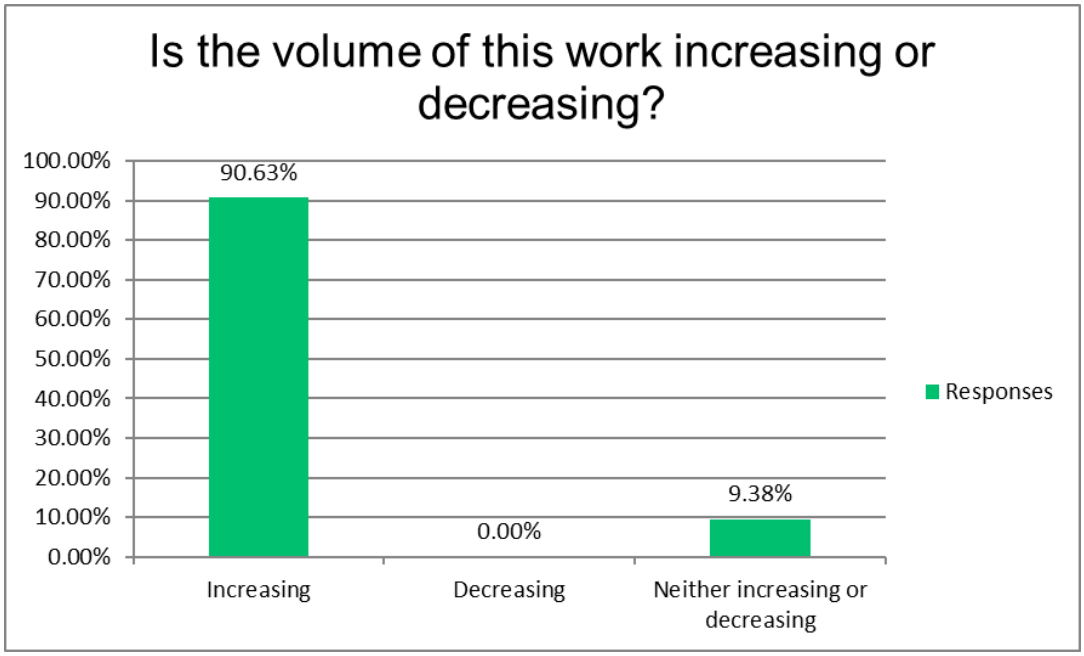

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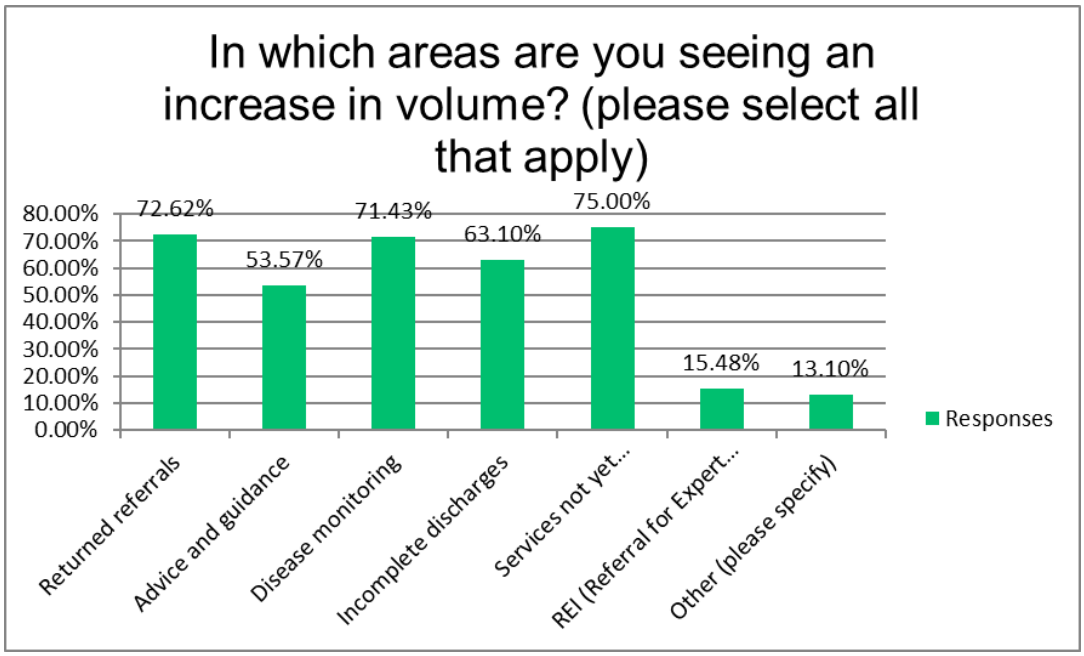

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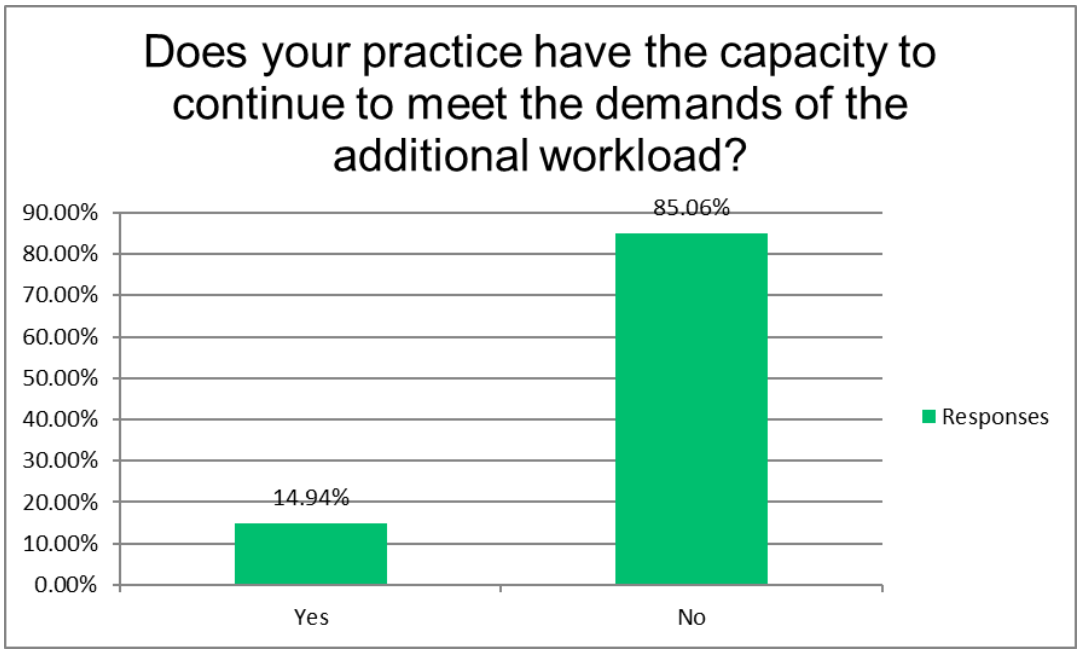

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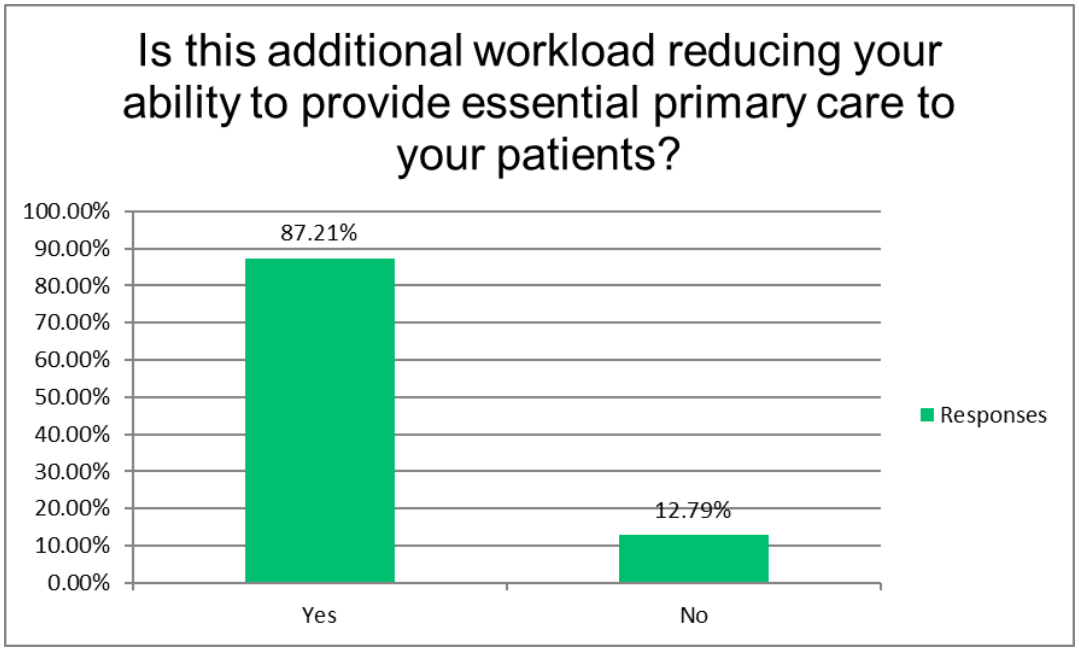

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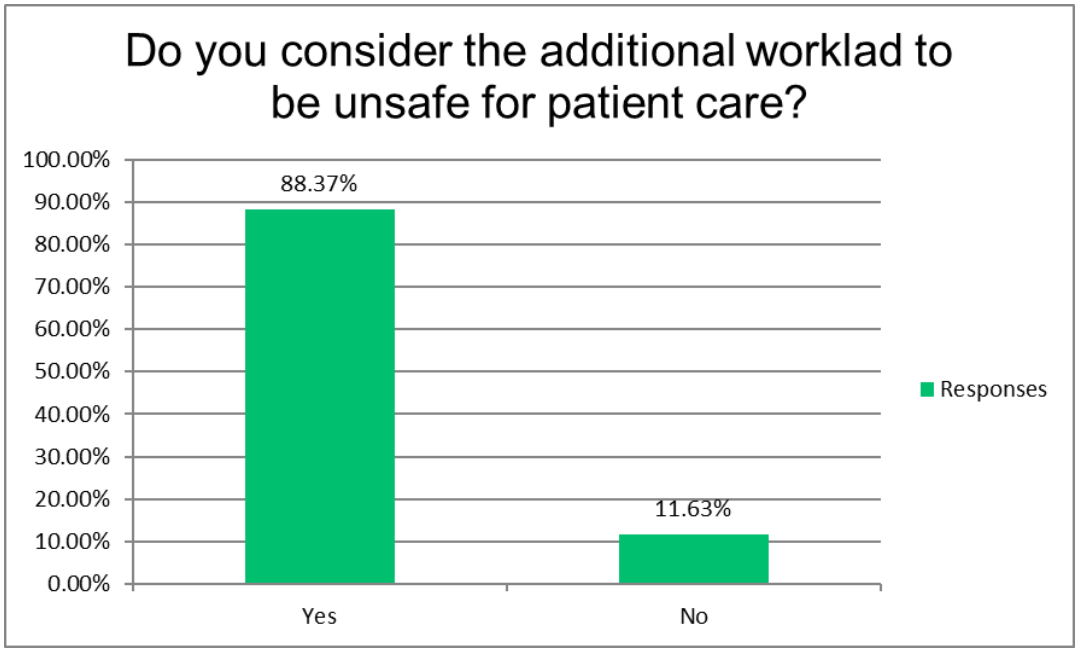

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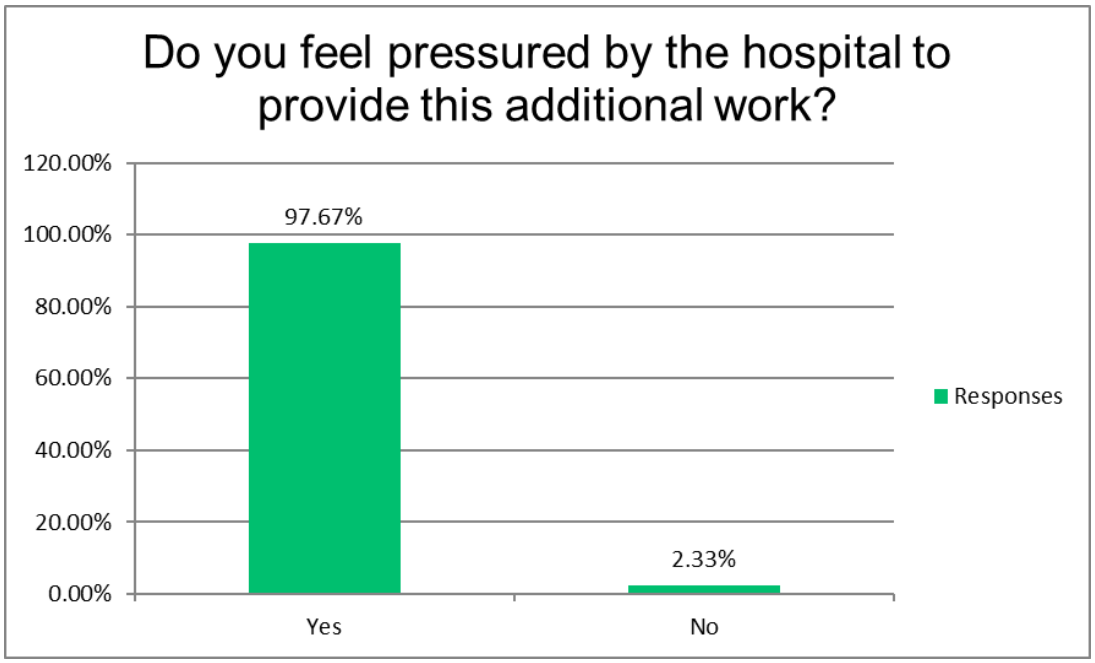

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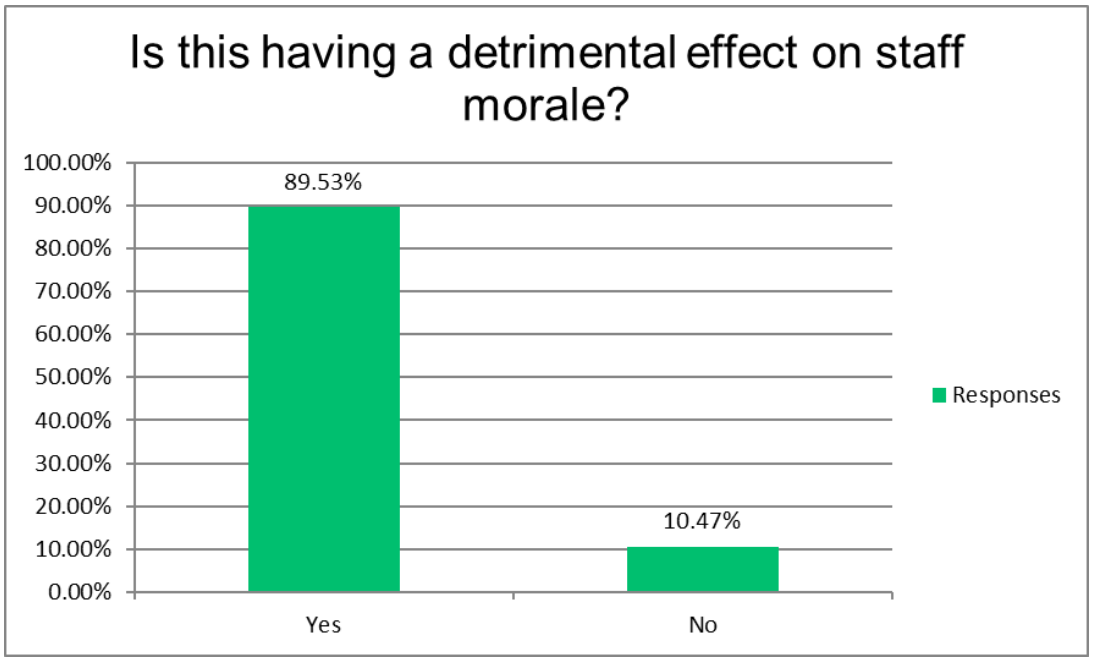

<u>Verbatim responses from the survey can be found in appendix 1</u>

Review of survey findings

Over many years robust agreements have been drawn up between primary and secondary care to ensure both safe and high quality care is provided for patients. These include:

- shared care agreements, which require the agreement of both secondary and primary care
- amber drugs agreements
- contractual agreements which currently include:
    - the ability of consultants to make onward referrals without referring back to a GP
    - that under Good Medical Practice the doctor requesting a test is responsible for acting on the result of that test, and should make that request personally
    - that medical certificates, if required, should be issued at the time of requirement without asking a patient to attend their GP for that certificate.

From the comments in appendix 1 it is clear that there are multiple other areas of transfer of work particularly with regards to:

- requests for phlebotomy – which is not an essential service under the GMS or PMS contract
- ECG requests - which is not an essential service under the GMS or PMS contract
- radiology requests - which specifically put workload onto a GP as it has to be a qualified medical practitioner making the request
- administrative requests - such as onward referrals and re-referrals
- follow-up requests – which are incredibly difficult in primary care as there is no access to recognised call and recall systems
- implementation of care plans without discussion
- patients calling secondary care who are diverted to General Practice to request expedite letters for their referrals
- prescription requests
- the introduction of new medication - which carries significant clinical risk particularly if the GP is not familiar with the medication being requested.

In all of these areas the governance and clinical risk has passed from secondary to primary care with no consideration of the workload or the implications or the resources required to carry out this work.

In Q4 [Was there any discussion with the practice prior to the transfer of work?] the absence of good communication and discussion prior to transfer of work taking place is evident. This demonstrates a lack of collaboration and agreement; General Practice colleagues and highly skilled General Practitioners are left feeling they have become the community junior doctors of the consultants.

Several requests to facilitate radiology and re-referrals, have been clearly demonstrated to be requests that are inaccessible to GPs due to local restrictions within secondary care trusts or a failure to restart the services. This makes the request impossible to achieve and leads to confrontation with patients that the GPs have to manage, despite it being no fault of their own.

Q7 [Does your practice have the capacity to continue to meet the demands of the additional workload?] demonstrates that practices feel they do not have the capacity to continue working in

this way. Continuing to exceed capacity will result in workload overload, workforce issues, burnout and fatigue within the General Practice workforce, and more broadly a lack of resource available within the community in the longer term.

Q8 [Is this additional workload reducing your ability to provide essential primary care to your patients?] shows the impact the transfer of work is having on standard provision of General Medical Services within the community, decreasing the access for patients as GPs have to withdraw their availability to facilitate the secondary care work. There is concern around increased risk within primary care, potential impact on quality and a significant potential for increased patient dissatisfaction.

Q9 [Do you consider the additional workload to be unsafe for patient care?] should be seriously considered and reviewed by everyone within local health systems. Patient safety should be a system priority, resilience in General Practice was already at risk and has been for many years, and the survey demonstrates the vast majority of practices feel the additional workload is making provision of health care in the community unsafe.

Q10 [Do you feel pressured by the hospital to provide this additional work?] is an indicator of the culture in relation to this transfer of work. The absence of communication and collaboration, and consideration for whether transfer of work is appropriate, resourced, or achievable within current capacity, is risking the development of less robust relationships. This will have significant implications for the ICSs moving forwards. General Practice currently carries out 90% of all patient contacts for less than 9% of the available NHS resource. Put simply, there is no room to facilitate the current requests being passed to General Practice.

Q11 [Is this having a detrimental effect on staff morale?] demonstrates the impact this is having, not just on General Practitioners, but also on the whole team within General Practice. The drop in morale, sadly enhanced by recent media headlines, and comments from some colleagues in secondary care, which failed to be robustly responded to by NHS management, have led to a feeling amongst the General Practice workforce that they are unsupported, and not valued. This is significantly impacting on resilience in General Practice whilst adding to the Covid19 fatigue, and the drop in morale and self-esteem felt by many in the primary care team.

Next steps

Many of the issues here could be resolved quickly - simply by requesting that when outpatient clinics are restarted, albeit by telephone or video link from secondary care, that those conducting outpatient clinics do not send requests to General Practice but instead ensure that any blood forms, radiology requests and care plans are implemented within the secondary care system.

Access to a community prescribing pad, or more ideally access to an electronic prescribing system that links into the national EPS system, would mean that consultants could complete any prescribing they wished to initiate and post a prescription to a patient, or send electronically to a pharmacy. Medical certificates can be dealt with in a similar way.

Patients should be provided with a clear indication of exactly what timescale they should expect, and under what conditions they should consider applying for their anticipated wait to be expedited, and that request could be carried out by the secretaries within secondary care rather than via General Practice.

To be truly collaborative as a system, it is important that the voice of primary care is heard equally to that of all other providers, and there is a need to ensure that the impact of any new system and transfer of workload is considered at a system level, particularly with regards to ensuring resources are directed to where the work is undertaken.

Many of the comments within the survey demonstrate the emotion, frustration, and anger related to the current circumstances; ultimately if primary care fails the NHS will fail as the floodgates will open as patients will need to seek direct care from secondary care on a daily basis.

There is the reality that within several of the areas represented by YORLMC practices are on a precipice; significant recruitment issues, demand outstripping the supply of clinical availability, low income in many practices, significant risks in relation to a second spike of Covid19 due to the demographics within many practices.

How this is dealt with now is vitally important for the future. It is overtly driving a wedge between primary and secondary care, when what is needed is a closer relationship and a better understanding of the impact each of us has on the other – at an ICS level we have simply not reached this shared understanding yet. It is beholden on those at the very highest level seeking to develop a true system approach, to consider the impact of what is currently happening and try and put in place mitigations and processes to repair the damage that has already been done, and to secure the system and pathways of care going forwards.

YORLMC is keen to discuss the implications of this paper, and possible solutions going forwards, and welcomes the input from all system partners to make these solutions work.

A plea – who is going to step forward to work with us on this?

Appendix 1 – verbatim survey responses

Q3 Which of the following services is your practice being asked to provide that would normally be carried out by the acute trust?

- We are also being asked to refer for scans and echos etc, then the referral is rejected saying GPs can't refer. Despite saying that the consultant has recommended it. You then have to chase around phoning people trying to explain. It takes ages.
- explain the outcome of outpatient consultations to patients
- Lots of letters saying if e.g. a result comes back with a particular result do this, is not do something else. Means we need to contact and take on the patient
- Patients advised to contact us to expedite appointments when offered new or follow up appts that are unacceptably far in the future
- Follow up of abnormal results found by secondary care, or anaemia
- Telephone assessment of MSK referrals, then discharged with advice GP to re-refer if no better
- Patients discharged from MSK after tel consultations with advice to re-refer if no better after covid
- Patient wanting to rebook appointment and told needs re-referring. Been told to re-refer so have and then referral bounced. Secondary care are bouncing everything back to general practice
- taking over prescribing earlier than agreed by the shared care agreement
- recalls, following up investigations requested while as an inpatient
- Re-referrals for the referrals which were cancelled/rejected due to Covid.
- booking radiology appointments, sick notes,
- Telling pts to ask for letters to allow them to be seen sooner in 2ndry care. Rejecting appropriate referrals and advising primary care monitor
- Spending a lot of time chasing up secondary appts / operation dates for patients who have been lost in system.
- Breaking bad news - informing a patient they have lung cancer and brain mets on a CT scan (we refused to do this)
- Being asked to take photos of lesions for maxfax rather than maxfax seeing patients face to face
- blood test which on discharge particularly irksome as the hospital employs the DNs

Q6 In which areas are you seeing an increase in volume?

- Requests for us to re-refer the patient back onto the waiting list they were already on but suspended
- Expedite requests
- Refusal of referrals to memory clinic as not seeing any patients F2F
- routine tests following a remote consultant consultation
- Asked to request MRI or CT follow up scans in the future so available to hospital MDT meetings in the future...
- Returned referrals due to Covid. Patients calling us to ask when they will get an appointment after Covid.
- TIA service- consultant retired yet no plan for f/u for those already under his services to hand over
- Prescriptions for specialist medication

- Radiology referrals returned as not emailed by clinician which is apparently new agreement, not sure this has gone through LMC
- actions from telephone consultations are passed back to us
- Primary care are currently being treated as secondary care's PA. We have been asked by gynae to do pipelle biopsies for example. Secondary care not responding to patients who contact their secretaries re waiting lists - they are all being signposted to primary care

Q12 Please share any other comments you have regarding transfer of work

- I understand why a transfer of work is sometimes better for patients, especially when as a surgery we are remote, however it's becoming unmanageable. Especially when we can't offer our usual number of appointments to patients due to having telephone triage first and then f2f later in the day. Donning and doffing takes time so consults are extended, meaning that number of appointments are reduced. Yet more patients are presenting as they "have saved things up".
- It all falls under similar headings to the standard "contract breach" letters we've been using for several years now. I'm fairly good at saying no and batting it back, usually with a BMA letter with a copy to the CCG. But nothing changes. I was completing perhaps half the breach notifications in 2018/19 and this generated about 20 per quarter from myself. If all GPs did this you would have (conservatively) about 5000 contract breach notifications per quarter. But the CCG has no leverage with the trust as far as I can see on this issue as every bit of work that secondary care can successfully transfer to primary care is £££ saved for the trust finance director. I'm going to start sending copies of my contract breach letters to CQC as well I think. See if that has more of an impact on the trust.
- We have had a lot of requests for monitoring bloods that would usually be done by secondary care. Also initiating medication that would usually be started in secondary care.
- Creating lots of inappropriate activity in practices, with lots of chaotic contacts between patients, staff & GPs. Patients taking their frustrations out on our staff & often insisting on urgent attention. A lot of this activity is low value administration. Patients also given unrealistic expectations & opinions by secondary care workers, also suggesting GP is not doing any work at present.
- Huge amount of work being carried out in primary care whilst patients are waiting for secondary care appointments , e.g ongoing pain relief, joint injections,
- The hospital don't seem to understand what their responsibilities are re onward referrals, reviewing own investigations etc
- We have had comments in letters to patients such as 'when your GP surgery re-opens please ask them to do a full set of bloods' and 'difficult to have a telephone conversation with this patient as confused - please touch base and let me know if he wishes to proceed with urological investigations'.
- certainly increased due to COVID. Lack of communication within the trust e.g secs telling us they are only accepting urgent referrals and nothing else when we know this is not the case. Patients being returned to referrer for no good reason. also I refer you to the tone of the email from the CCG - reminding practices of their duty to do blood tests and not refer to secondary care. Subsequent emails from a number of GPs have gone unanswered raising the concern about the trust sending so many blood tests are way. Such an Email from the CCG is in poor tone, and a reflection of the fact that they are out of touch with regard to the transfer of work from secondary to primary care.
- After a period of sustained improvement in the last 18months even prior to the pandemic a small but sustained reversal of some shift in work had start started to appear. It is not a huge problem currently but we are concerned that it is increasing

- COVID has frankly been used as an excuse I fear and I expect it to get worse. One consultant told me a patient was more my patient than theirs after asking me to chase bloods for them - I fear this is probably the reality of how secondary care colleagues think. some are very good however.
- Staff are feeling the pressure, morale is low, we feel stressed at work and worry that patient care and safety is being compromised
- we are sending the work back but the amount of time required to do so is having an impact on our own workload.
- Increasing problem. Already making steps to prevent this. Had numerous discussions with consultants and their secretaries around this transfer of care. This is not a new problem and certainly in South Tees has not been sorted over a number of years. This is an opportunity to produce a service fit for purpose for the future that allows patients to have a service provided closer to home but that is funded appropriately. If this is not possible we as a practice will stop doing unfunded work and return requests back to secondary care where the procedures are funded
- We can still Almost cope with this extra work at the moment but are not sure how sustainable it is.
- This transfer of work was happening way before covid but has increased since covid. It feels petty to refuse to do it now, in the spirit of all helping out. I worry though that they will expect us to keep doing these things post covid. They have not reopened the phlebotomy service for gp pts at hospital or at Asda so we have been doing a lot of them. I worry they will just not reopen it. Our nursing staff need to be prioritising other things like taking smears.
- Patients even on admission aren't being properly investigated/sorted out. Left to us to refer back if we feel " it is clinically appropriate" and they have seen the patient, not us! Poor quality discharge summaries.
- This is not a new issue and has been occurring long since prior to Covid-19. Simple changes could be made by the hospital (eg consultants/CNS adding their blood test requests on ICE, properly informed discharge summaries) could have a huge impact in reducing primary care workload.
- Some of this workload shift is understandable and in the patients' best interest in terms of reducing their exposure risk. It is frustrating to see though that some areas of secondary care have not been using lockdown to prepare their services to meet the demand post lockdown with the new SOPs.
- Slow and insidious increase in work as hospitals work remotely and ask us to check bloods, BP and ECG as they do not have the patient in front of them. One persistent offender is TEVW both pre and post pandemic asking us to prescribe monitor and discharging before even seeing if effective. I have done multiple surveys of this type and nothing has changed. worse since COVID which i understand. The problem with most of these surveys is fewer were fill out unless action results from it. Invariably it doesn't.
- The mass rejection of outpatient / elective work in March with no care taken at hospital level to maintain lists of affected patients and recall them appropriately is the most unsafe work dump I have ever experienced. The CCG have offered pennies to us to fix it rather than ensuring that the problem was firmly lodged back in secondary care where it belonged. The ongoing risks and pressures of this are difficult to assess, but I judge them to be enormous. The derogation of contractual responsibility and assumption that primary care would pick up the pieces with no prior discussion was surely illegal?
- It is as if they think we have nothing to do
- Patients having appointments cancelled then asking us what's happening, how long are waiting times, what services are working and how
- Seems unsustainable when combined with ever increasing primary care generated workload. No funding for any of this to enable employment of additional staff to manage this.

- seem to be passing normal secondary care work to primary care since covid crisis
- The additional work, although not increasing and was fine in the beginning is starting to have a large effect on us not being able to seeing patients for other things due to being used for those that could have been done at the hospital. It also means we are having to follow up on these
- Referrals bouncing back are probably the worst. Patients are ring secondary care about their referral and secondary care are just bouncing them back to us. When they ring us we then have to ring secondary care to find the answer.
- The perceived attitude of secondary care is that the pandemic is difficult for them but not for us, so that primary care seeing a patient or arranging a blood test etc is easier than it is for them. We have had 100% capacity throughout they are still not up to 100% in some areas and are getting additional funding to achieve this
- We are now at the point where to keep on top of phlebotomy and similar work we will need to pay for additional unfunded staff hours which seems very wrong. However we would not wish to see our patients fail to receive the proper level of care so we feel we have no choice but to carry out the tests if the acute sector can't or won't.
- in most cases we are not accepting it - only when it will clearly be detrimental to the patient are we doing it - but the workload in bouncing these requests back is also significant and frustrating
- We continue to do the "extra work" as we have high standards and do not wish our patients to be let down but this cannot continue without either formalisation & evidently funding to be able to recruit additional staff OR with the trusts taking back control of the work that they want to be carried out
- happy to take burden away from secondary care, usually better for patients too. quite department- or individual-specific variation however
- unless challenged it becomes the new norm. and yet challenging it is often harder than just getting on with it!
- HDFT cancelled/rejected all routine referrals due to Covid. This was done without prior discussion (that I'm aware of). We only became aware of this when we began to receive letters notifying us. Often the letters were unclear as to if the patient needed to be re-referred after Covid or if they would simply be put onto a waiting list at HDFT. Once we were able to re-refer HDFT passed the re-referral process back to the GP's which causes mountains of extra work for the secretarial staff. The letters from HDFT which have been sent to patients asking them to contact their GPs to be re-referred don't state the Specialities which they need to be re-referred on to. The letters have also been sent to patients asking them to contact their GP when the GPs have not done the initial referral eg Optician may have done the referral, or may have been referred from one HDFT Consultant to another within HDFT. All of these mistakes from HDFT combined are causing stress and a lot of extra work for secretaries as they are having to do detective work into who did the referrals and where to re-refer to.
- Bloods tests and urgent prescriptions pre op in particular with less than a 1 days notice means that patients are cross with us and it is leading to more complaints. Phlebotomy services are not back up and running- there does not seem to be any acknowledgement from the hospital that we are not contracted to provide and blood tests for those apart from amber drugs/monitoring. We have been told they do not have a system in place that allows them to screen for covid- we do this ourselves and manage this. They should certainly be able to. It would be nice if the funding for this could be transferred to primary care as we are doing the work!!
- I have kept a detailed list of examples sent to me by colleagues in the past 2-3 weeks which I can share if useful for examples of specific issues. There is a HUGE pressure for primary care to perform investigations recommended in remote outpatient clinics, with no systems in

place to monitor/control this. Patients are being told to call up and book appointments for bloods urgently themselves with no correspondence from the hospital detailing any clinical details or which tests are required. Specialists are asking for us to do bloods and then refusing to follow up any abnormal results. Haematology are specifically guilty of this. Both ENT and Urology have refused a 2ww referral due to covid. If anyone would like to contact me about this my e-mail is XX

- retiring april!
- Workload increasing stress for primary care practitioners, workload feels unmanageable on most days.
- I understand strains on secondary care but not sure the feeling is reciprocated especially with some of workforce affected by shielding etc
- I am feeling that my workload is becoming unsafe. The volume of blood tests being done in primary care for secondary care is especially burdensome, as the results now come to us, so although we have not directly requested them, feel that we need to take clinical responsibility for them, increasing pressure on our working day
- It needs to stop
- Seen within our practice as essentially "dumping" clinical work load and risk to primary care. With LMC support we are taking a hard line against any such practice.
- Rheumatology (for bloods for hospital monitored drugs) and Urology (PSA's) biggest referrers. This was ok in the midst of the pandemic but now we're trying to provide all of our normal chronic disease monitoring with reduced capacity due to PPE changes we cannot take this from the hospital (without additional resource) and they need to be told this ASAP.
- It is causing huge pressure. Patients are increasingly contacting primary care wanting to know when they will be seen by secondary care which is taking up huge amounts of our time. Secondary care not seeing patients is causing huge problems and is dangerous as takes our time away from direct patient care. Secondary care need to manage their waiting lists and be honest with patients about current waits etc. Secondary care are expecting primary care to manage their workload which is unacceptable.
- This predates COVID. The CCG seem to encourage it, and yet whenever possible they chose to pass on the relevant funding to the acute trust instead of practices. It would really help if the CCG could understand the role and value of general practice.