Cheshire and Merseyside
Health and Care Partnership

NHS
Cheshire and Merseyside

Consensus on the Primary and Secondary Care Interface

Contents

This document was created in collaboration with the following groups and organisations:

- Cheshire and Merseyside System Pressures Task and Finish Group
- Cheshire and Merseyside Trust Medical Directors Group
- Cheshire and Merseyside Primary Care Providers Forum
- Local Medical Committees
- Endorsed by RCGP Mersey Faculty

Foreword

Cheshire and Merseyside Integrated Care System will do all that it can to optimise their access to the right care and “pathways” to give our patients have the very best outcomes. It is essential that we embed excellent communication channels between our health and care professionals and eliminate gaps in the services we provide. Siloed working is sadly a reality, and we must grasp the opportunities within our System to address this.

I believe this consensus document represents a strong set of clinically led principles to guide reviews of pathways which have a common architecture of good quality, patient-centred communication. The consensus provides a number of guiding principles which we should all commit to when interacting with colleagues. Abiding by these principles will encourage us to keep the patient at the centre of our decision making and ensure that actions taken are completed in a timely way, by the most appropriate individual or team and understood by all.

The document covers a wide range of situations including prescribing, fit notes, diagnostics and more. It is important these are read and understood by all clinicians, and I would encourage you to discuss this further in your teams.

I envisage the consensus will provide a platform for local Places to consider their response. More detailed work will need to be done to bring the consensus to life locally and articulate what this means for specific pathways. As an ICS we will support this and promote discussion about the principles at future events for clinicians.

I commend this Consensus about the Primary and Secondary Care Interface document to you and hope and expect we can use this to break down any barriers which exist between colleagues for the benefit of the people of Cheshire and Merseyside.

Rowan Pritchard-Jones

Medical Director Designate

Cheshire and Merseyside Integrated Care Board

The Covid-19 pandemic has led to significant excess demand across the entire NHS system. It is imperative we work together while tackling increasing presentations and lengthening waiting lists.

The following principles are supported by clinical leaders in both Primary and Secondary Care. They are not rules to follow and there will be exceptions. Clinicians are trusted to make appropriate decisions based on the individual circumstances they face. The underlying intent of this document is to improve relationships between colleagues, remove unnecessary administrative burdens and bring about a more efficient system for the benefit of all of the patients we serve.

Please note: any examples given are not intended to be exhaustive.

This document should be used as a starting point for us to consider our own behaviours and initiate conversations across the system. We are aware that further work will now need to be undertaken particularly in local Places to define what some of these principles mean in reality, and we will also pull together Cheshire and Merseyside guidance where appropriate.

Principles for all

- **Treat all colleagues with respect**

- **Remember to keep the patient at the centre of all we do**

- **There is an underlying principle that clinicians should seek to undertake any required actions themselves without asking other teams or services to do this**
  - Clinicians will, of course, need to operate within the limits of their professional competency and are only able to undertake actions if they have access to the relevant investigations or treatments.

- **Whoever requests a test is responsible for the results of that test**
  - This includes ‘chasing’ the results, receiving the results, actioning the results/determining management plan, and informing the patient of the results.
  - There may be some exceptions around shared care and potentially A&E. Generally, EDs should refrain from asking GPs to chase investigation results, if the ED requests an investigation, it should be responsible for chasing the results.
  - We recognise that transfers of care from A&E attendances are a particular area of potential difficulty and would suggest that local solutions are put in place and clearly communicated to Primary and Secondary Care clinicians in line with RCEM guidance.
  - Consideration needs to be given to the management of incidental findings, whether these need further investigation and if so, by who. We urge local systems to clarify such pathways to avoid duplication, inappropriate investigation, or failure to further investigate where appropriate. As a general

rule we would expect the requesting clinician to take responsibility for informing the patient of the findings and dealing with these, if within their competency. If urgent action is required, we would not expect this to be passed onto another clinician.

- **Ensure robust systems are in place for patients to receive results of investigations, and that they understand what is going to happen**
  - Secondary Care colleagues should avoid directing patients to the GP for results and vice versa.
  - It is the responsibility of the clinician requesting a test to review the result.

- **Ensure patients are kept fully informed regarding their care and 'what is going to happen next'**
  - This includes how they should raise concerns about clinical deterioration that should avoid directing them to other services (unless appropriate such as directive to attend ED when clinically required)
  - Ideally this should be in a written format and referenced within the discharge summary.
- **Consider picking up the phone to speak to colleagues if in doubt**
  - Organisations should consider how they might facilitate easy, prompt access for this.

- **Consider a process of 'Waiting Well' for patients referred to secondary care**
  - Consider communicating with patients on waiting lists to ensure they know their referral has been received, how long the wait may be and what to do in the event of deterioration in their condition.
  - This will likely require work at Place level across Primary and Secondary Care so that this process can start at the point of referral with the Primary Care clinician empowered with up-to-date knowledge around what the patient should expect.

- **The clinician who wishes to prescribe medication for the patient should undertake appropriate pre-treatment assessment and counselling**
  - They are responsible for communicating the rationale for treatment, including benefits, risks & alternatives, arranging any follow-up requirements that might be necessary, and documenting all of this in any related correspondence.

- **Try not to commit other individuals or teams to any particular action or timescale.**

Principles for Primary Care

- **When referring to secondary care please ensure you are clear in your 'ask'**
  - Why are you referring this patient? Are you looking for advice, diagnosis, treatment?
  - Please describe the reason for referral, and don't just put 'please see GP summary/consultation'
  - Ensure an up-to-date medication list is available along with investigations to date
  - What are the patient expectations?
  - If referring looking for a diagnostic procedure, please check local pathways for open access opportunities (this could include endoscopy, cardiology investigations or paediatric blood tests)
  - Please avoid using abbreviations and acronyms. These may be commonplace within your team but may not be understood in Secondary Care.
  - Place based systems should ensure that access to community phlebotomy/diagnostics is available and understood by clinicians

- **When referring to secondary care please ensure appropriate Primary Care assessments have been made**
  - Check local pathways for pre-referral criteria and potential investigations
  - Consider consultant advice and guidance
  - Consider other sources of help and guidance
  - Consider when face to face assessment may add value before referral (both elective and emergency)
  - Remember, it can be helpful to have a face-to-face conversation with a patient who requires Rapid (2 week wait) Referral to ensure understanding of the pathway being used and to record physical/frailty status of the patient

- **When referring to secondary care please clearly communicate to the patient who you are referring them to, for what and what to expect (if known)**
  - At this current time as we recover from the impact of the Covid-19 Pandemic please advise patient that waiting lists may be long and that first contact may be a remote consultation.
  - Consider the use of Easy Read patient leaflets (where available) to inform about their condition

- **When referring with the expectation that an operative procedure may ultimately be required, please consider optimising any Long-Term Conditions**
  - BP control for hypertensives, glycaemic control for those with diabetes etc.
  - Please do empower patients to optimise their own health in the waiting period – smoking cessation advice, weight advice etc
  - This will reduce the impact of last-minute cancellations in pre-op clinic

Principles for Secondary Care

- **Ensure clear and timely communication to the GP following patient contacts**
  - This applies to both Outpatient encounters as well as on discharge from admission and A&E.
  - Please highlight any changes in medication and reasons for any changes
  - Please avoid using abbreviations and acronyms. These may be commonplace within your team but may not be understood in Primary Care.
  - Be clear about what follow up is required, how it will be provided and how any outstanding test results will be reviewed
  - Be explicitly clear about any requests/actions for the GP
    - If you want the GP to 'monitor' U&E for example, please say why, how often, for how long and what your expectations are if results are/remain abnormal
    - If you need a repeat test within a short period of time e.g., 2 weeks, please arrange this to avoid potential delays.

- **Avoid asking General Practice to organise specialist tests**
  - If you want the patient to have their blood test closer to home, then provide the blood form and enable community phlebotomy.
  - Place based systems should ensure that access to community phlebotomy/diagnostics is available and understood by hospital colleagues.
  - If a clinician wishes the patient to have further tests prior to next review they should look to undertake these investigations themselves

- **If patients need a fit note (sick note) then please provide one**
  - Please also ensure this is for an appropriate period (if you know they need 3 months off work don't issue a 2 week note)
  - Please issue fit notes from Out-Patients if these are required rather than sending back to the GP
    - Trusts should ensure fit notes are available for colleagues in Out-Patients

- **If immediate prescribing is required from Outpatients, please prescribe**
  - We would suggest work on ePrescribing for hospitals is accelerated
  - For longer term medications please prescribe an initial course of at least 14 days

- **Discharge medications for longer term medications should cover an initial period of at least 14 days, or longer as locally agreed**

- **Make use of the Discharge Medicines Service, nationally commissioned from community pharmacy**
  - This should be used for all appropriate patients to ensure they benefit from this essential service and that safety improvements are realised upon transfer of care.
  - Ensure all electronic referrals made under this system contain the nationally agreed dataset and use the electronic platform commonplace across Cheshire & Merseyside.

  - The toolkit references both high risk medicines and high risk patients appropriate to send information on – this should be the minimum.

- **When recommending ongoing prescribing from the GP please check locally agreed Prescribing Formulary first**
  - Important to check that the suggested medication is appropriate for the GP to prescribe
  - Each local system will have a clinically agreed Prescribing Formulary which will detail appropriateness of prescribing and by whom.

- **Refer all patients discharged on a smoking cessation pathway from secondary care to the community pharmacy Smoking Cessation Advanced Service once it is available (expected 2022/23)**

- **Please put follow up plans in place for patients who self-discharge**
  - By definition these patients are thought to be unwell and vulnerable. They may have chosen to decline in-patient treatment, but they are still in need of our care; which may mean appropriate follow up in clinic is arranged.
  - This also includes providing appropriate discharge care and medication.

- **Please ensure any DNAs are not automatically discharged without clinical review**
  - Also please ensure any discharge is communicated to patient and GP with reason why.
  - If patients are transferred to patient initiated follow up (PIFU) or seen on symptoms pathways, please ensure you clearly reference the criteria to access a further appointment (SOS)

- **Please arrange onward referral without referring back to the GP where appropriate**
  - A hospital clinician should be expected to arrange an onward referral if:
    - The problem relates to the original reason for referral. E.g., patient referred to respiratory with breathlessness and respiratory consultant thinks it is a cardiac problem, the respiratory consultant should do the referral to cardiology.
    - A serious and very urgent problem comes to light. E.g., CT chest shows a renal tumour. Respiratory consultant should arrange the urgent referral to renal
  - If the problem is unrelated to the original reason for referral, this can be passed back to the GP. e.g., patient in respiratory clinic describes abdominal symptoms – this should be passed back to the GP to consider.

Reference documents used to inform these principles

- GMC Good Medical Practice
  - https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

- GMC Good Practice in Prescribing and Managing Medicines and Devices
  - https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices

- GMC Good Practice in Delegation and referral
  - https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/delegation-and-referral/delegation-and-referral

- BMA guidance on Primary and Secondary Care working together
  - https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/primary-and-secondary-care/primary-and-secondary-care-working-together

- NHS England guidance on Improving how Secondary Care and General Practice work together
  - https://www.england.nhs.uk/publication/improving-how-secondary-care-and-general-practice-work-together/

- Professional Behaviours & Communication Principles for working across Primary and Secondary Care Interfaces in Northern Ireland
  - https://www.rcgp.org.uk/-/media/Files/RCGP-faculties-and-devolved-nations/Northern-Ireland/2019/RCGP-principle-leaflet-2019.ashx?la=en

- Royal College of Emergency medicine Guidance when discharging patients to General Practice
  - Discharge_to_General_Practice_011221.pdf (rcem.ac.uk)

- Royal College of Emergency Medicine guidance for management of investigation results in the Emergency Department
  - RCEM_BPC_InvestigationResults_200520.pdf

Following your local health and care organisations on social media is an easy and effective way to get accurate and timely information.

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