Working Better Together
Consensus & Guidance on the Primary and Secondary Care Interface

January 2024

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Foreward

Significant work has been undertaken to date across the Health and Social Care to develop collaborative working across our primary and secondary care sectors to optimise access to the right care and “pathways” to give our patients the best outcomes. A key priority for the Health and Social Care sector is to continue to embed excellent communication channels between our health and care professionals to improve the services we provide.

This consensus document aims to provide a set of clinically led principles to

guide reviews of pathways which implement good quality and patient centred care. The consensus provides a number of guiding principles which we should all commit to when interacting with colleagues. When fully implemented these principles

will encourage patient centred 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 primary and secondary care to consider their response and I would like to commend the work of colleagues across our primary and secondary care teams in developing this document

1. Introduction

The Covid-19 pandemic has led to significant excess demand across the entire HSCNI system as well as significantly exacerbating the pre-existing patient waiting list in Northern Ireland. It is imperative we work together while tackling increasing presentations and lengthening waiting times for all out-patient appointments and elective care.

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 and communication between colleagues, remove unnecessary administrative burdens and bring about a more efficient system to improve patient flow, care and experience.

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

This document should be used as a starting point to consider our own behaviours and initiate conversations across the system. This will entail further work on what some of these principles mean in reality and how we can implement these locally.

2. 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 emergency departments (EDs). Generally, EDs should refrain from asking GPs to chase investigation results, if an ED clinician requests an investigation, they should be responsible for following up the results.
    - We recognise that transfers of care from ED 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.
- **Consideration needs to be given to the management of incidental findings, whether these need further investigation and if so, by whom?**
    - In general, the default should be that the treating clinician takes responsibility for informing the patient of the findings and dealing with these. If urgent action is required or suspected cancer or another time-sensitive condition is in question this should not be passed onto another clinician. There should be communication between both GP and clinician to ensure that correct care and information will be shared with a patient.
- **Ensure robust systems are in place for patients to receive results of all investigations.**
    - Secondary care colleagues should avoid directing patients to the GP for results and vice versa including to look these up on NIECR/ EPIC and any other systems.
    - It is the responsibility of the clinician requesting a test to review the result and inform the patient of this.

- **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.
    - A contact point should be provided for any queries on test results that are outstanding.

- **Consider picking up the phone to speak to colleagues if in doubt.**
    - Organisations should consider how they might facilitate easy, prompt access for this. Trusts and GPs may wish to consider sharing each other's administrative contact directories.
    - The HSC e-mail system is not considered an appropriate mechanism for clinical contact about patients between primary and secondary care.

- **Consider a process of managing expectations for patients referred to secondary care.**
    - From a regional perspective, communicate 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.
    - It is helpful if both primary and secondary care clinicians do not create unrealistic expectations among patients, such as requests for "expedite" letters in the absence of any clinical justification.

- **The clinician who wishes to prescribe medication for the patient should take the appropriate pre-treatment assessment and counselling.**
    - Clinical responsibility for prescribing should sit with those professionals who are in the best position and appropriately skilled to deliver care which meets the needs of the patient (see HSS(MD) 26/2022).
    - The treating clinician is responsible for communicating the rationale for treatment, including benefits, risks and alternatives, arranging any follow-up requirements that might be necessary and documenting these as necessary.
    - Legal responsibility for prescribing remains with the person who signs the prescription as

directed by HSS (MD) 26/2022[1]. It is the responsibility of individual practitioners to prescribe only within their own level of competence and scope of practice.

- There may be occasions when GP colleagues decline to take this responsibility on and refer patients back to Trust colleagues to supply the medication in question. The most common scenario is where the recommended treatment is 'off-label' or unlicenced or for amber listed medications subject to shared care arrangements. These decisions should be respected, and clinicians may wish to contact GP colleagues to discuss this directly.
- In all cases, it is essential for good patient care that there is prompt and clear communication on the transfer of care between hospital and primary care in both directions, and also at key stages during the outpatient and urgent care pathways.

- **Please avoid committing other individuals or teams to any particular action or timescale.**

[1] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-hss-md-26-2022.pdf

3. Principles for Primary Care

- **When referring to secondary care please ensure you are clear in 'your ask':**
  - Include appropriate clinical information with a sentence stating a clear reason for the referral.
  - Is the reason to seek advice, diagnosis or arrange treatment?
  - What are the patients' expectations?
  - Please describe the reason for referral, rather than 'please see GP summary/consultation'.
  - Include details of investigations to date as well as attaching any relevant documents from GP clinical systems; DOCMAN/ Apollo.
  - Consider before referral to outpatients whether your trust has alternative open access diagnostics.
  - Please avoid using abbreviations and acronyms. These may be commonplace within your team but may not be understood in secondary care or indeed by the patient in the event they wish to access their record.

- **When referring to secondary care please ensure appropriate primary care assessments have been made.**
  - Ensure any appropriate pre-referral assessments have been completed, according to local pathways for pre-referral criteria and potential investigations eg QFit and bloods for lower GI endoscopy
  - Consider consultant advice and guidance where available as well as other sources.
  - Face to face assessment should normally be the default before referral (both elective and emergency) as it may add value.
  - It can be particularly helpful to have a face-to-face conversation with patients requiring a rapid (2 week wait) referral, to ensure they understand fully the plan for their care.
  - It is always useful to highlight frailty or other pertinent disabilities.
  - Highlight the need for interpreters including sign language.
  - Please detail any additional needs, including accessibility requirements, as well as interpreters, to enable the patient to fully access care.
  - This can include, where appropriate, the contact numbers of carers and guardians.

- **When referring to secondary care please clearly communicate to the patient what**

service you are referring them to, the reasons for the referral 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. These are available through the GP clinical systems.
- Check phone contact details as these are particularly important in the event of referral to Urgent Care Settings as well as for Red-Flag pathways.

- **When referring, with the expectation that an operative procedure may ultimately be required, please consider optimising any Long – Term Conditions.**
  - Please consider optimising any Long-Term Conditions Blood Pressure and glycaemic control etc.
  - Please do empower patients to optimise their own health in the waiting period – smoking cessation advice, weight advice etc, explaining the importance of optimisation prior to surgery for any patients on a surgical waiting list.
  - This will reduce the impact of last-minute cancellations in pre-operative clinic.

4. Principles for Secondary Care

- **Ensure clear and timely communication to the primary care colleagues following patient contacts**
  - This applies to both outpatient encounters as well as on discharge from admission and ED.
  - Please highlight any changes in medication and reasons for any changes and use the Electronic Treatment Advice Note to do this where available.
  - Please avoid using abbreviations and acronyms. These may be commonplace within your team and speciality but may not be understood in primary care, or indeed by the patient in the event they wish to access their record.
  - Be clear about what follow up is required, how it will be provided and how any outstanding test results will be reviewed and communicated to the patient.
  - Be explicitly clear about any requests/actions for the GP:
    - If you want the GP to 'monitor' urea and electrolytes 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. This can be done via the phlebotomy hubs or ward/clinic attenders. Direct referral can also be made to trust district nursing services for those patients who are housebound.

- **Avoid asking General Practice to organise specialist tests.**
  - If you want the patient to have their blood test closer to home, then you may wish to check if the GP is signed up to the phlebotomy service so the test can be done at the local surgery.
  - If a clinician wishes the patient to have further tests prior to next review they should look to organise to undertake these investigations in advance.
  - If a patient requires specific preparation/medication prior to an investigation or test, then the treating clinician should organise this.

- **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., a patient is referred to respiratory with breathlessness, but the treating consultant thinks it is a cardiac problem, the respiratory consultant should do the referral to the cardiology team.
- 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 the Renal/Urology team.
- 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 – the patient should be clearly directed to attend the GP for follow up with information shared to the GP.

- **If immediate prescribing is required from Outpatients, please note the following:**
  - HSC Trusts are obliged to have supply arrangements for immediately necessary and high-risk medications. This applies to any treatment that need to be started within 72 hours of the outpatient/ambulatory assessment as per **HSS MD26/2022.**
  - Trusts are asked to supply medication sufficient to last at least until the point at which the clinic's letter can reasonably be expected to have reached the patient's GP, and when the GP or other primary care prescriber can therefore accept responsibility for subsequent prescribing. Consideration should be given to providing a minimum of 7 days' supply where appropriate to allow patients sufficient time to contact staff at their general practice (or shorter if medicines are not required for that length of time).
  - Discharge medications for newly commenced longer-term medications should cover an initial period of at least 28 days, where clinically appropriate (there are some exceptions to this e.g. drugs of potential abuse, original packs of inhalers / creams). Trust pharmacies will also ensure that patients have at least 14 days' supply of regular medicines available on discharge.

- **When recommending ongoing prescribing from the GP please ensure you adhere to the recommendations set out in the Northern Ireland Formulary.[2]**
  - It is important to check that the suggested medication is appropriate for the GP to prescribe.

[2] https//niformulary.hscni.net/formulary/

- **If patients need a fit note (sick line) then please provide one.**
    - Please also ensure this is for an appropriate duration of time (if you know they need 3 months off work don't issue a 2 week note).
    - Fit Notes should be offered where appropriate from outpatients.
    - HSC Trusts should ensure supply of fit notes.

- **Please put follow up plans in place for patients who self-discharge**
    - By definition these patients may 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 as well as discharge letters.

- **Please ensure any patients who 'do not attend' (DNA) are not automatically discharged without clinical review.**
    - Please ensure any discharge-after-DNA letters are promptly communicated to patient and copied to the GP.
    - If patients are transferred to patient initiated, follow up pathways or self-directed aftercare/ follow up pathways please ensure you clearly reference the criteria to access a further appointment as well as a contact point.

5. Selected reference documents used to inform these principles

Royal College of General Practitioners- Primary – Secondary Care Interface Guidance, April 2023 published by the Royal College of General Practitioners

https://www.rcgp.org.uk/getmedia/dbbcac28-b1c9-455a-b2b8-d6f0cd815258/Primary-secondary-care-interface-guidance.pdf

Consensus on the Primary and Secondary Care Interface, 24 June 2022 published by the Cheshire and Merseyside Health and Care Partnership

Consensus on the Primary and Secondary Care Interface - NHS Cheshire and Merseyside

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

AOMRC onward referral

Clinical Guidance: Onward Referral - Academy of Medical Royal Colleges (aomrc.org.uk)

HSS MD 16/2010 - Arrangements for prescribing and monitoring of red list specialist medicines https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-16-2010.pdf

HSS(MD)26/2022 - Responsibility for prescribing between primary, secondary and tertiary care services for the supply of medicines and other pharmaceutical products https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-hss-md-26-2022.pdf