Joined Up Care Derbyshire

JANUARY 2024

CONSENSUS ON PRIMARY AND SECONDARY CARE INTERFACE

PREPARED AND PRESENTED BY

ALLIANCE FOR CLINICAL TRANSFORMATION (ACT)

NHS Derby and Derbyshire

CONTENTS

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

Joined up Care Derbyshire
Alliance for Clinical Transformation (ACT)
Clinical and Professional Leadership Group (CPLG)
Derby & Derbyshire GP Provider Board (GPPB) leadership
Derby & Derbyshire Local Medical Committees (LMC) leadership

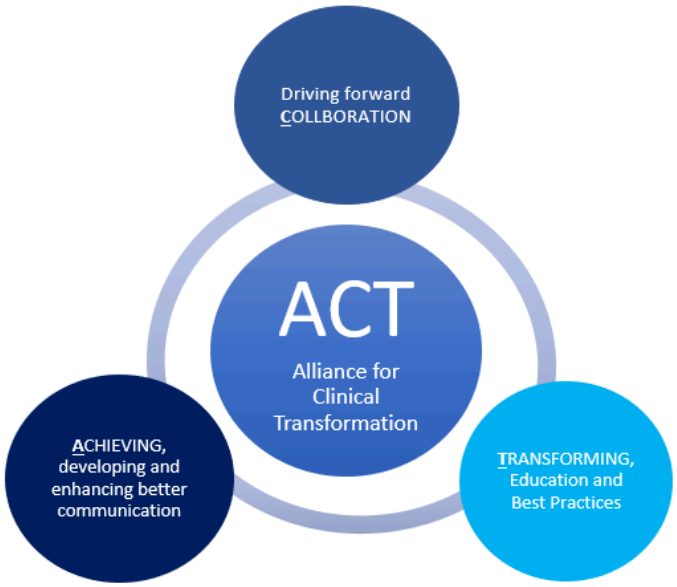
FOREWARD

Joined Up Care Derbyshire Integrated Care System will do all that it can to optimise access to the right care and “pathways” to ensure 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.

We 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 acknowledge and follow 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 we would encourage you to discuss this further in your teams.

We envisage the consensus will provide a platform for individual organisations 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.



We 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 Derbyshire.

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 (including but not limited to Doctors, Nurses, HCA's Phlebotomists, AHP's) 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 Joined Up Care Derbyshire guidance where appropriate.

PRINCIPLES FOR ALL

There are three guiding principles that underpin this document

- **Principle 1 (Opportunity)**

If you or your team can arrange what the patient needs, you should arrange it yourself, rather than passing that request to someone else.

- **Principle 2 (Ownership)**

Never ask another team to follow up a test that you have arranged(for example).

- **Principle 3 (Operational)**

Do not assume that an action can be carried out by another team within a week, unless that is agreed (either by standing arrangement or specific agreement).

- **Treat all colleagues with respect**

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

- 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 ED. 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 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 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 whom. 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 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 a concise, relevant and 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.
- Primary care referrers should ensure that access to community phlebotomy/ diagnostics is available and understood.

- **When referring to secondary care please ensure appropriate Primary Care assessment have been made**

- Check local pathways for pre-referral criteria and potential investigations
- Consider pre-referral 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)**

- 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 ED.
- 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 out standing 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**

- **If discharging a patient for end of life care, ensure anticipatory medicines are prescribed and that DCHS end of life documentation or a Trust medicines administration record (MAR) is supplied, these are required when anticipatory medication is prescribed to ensure patients**

can have medication administered in a timely fashion.

- Ensure all electronic referrals made when a patient is discharged for end of life care contain the nationally agreed dataset.

- The EOLC toolkit includes useful information **Derbyshire Alliance for End of Life Care (eolcare.uk)**

- Note: Where DCHS end of life documentation or MAR has not been supplied at discharge, but there is clear, legible, unambiguous and complete information to enable safe medicines administration, DCHS staff are empowered to administer required medicines. This is in in line with the DCHS Medicines code.

- Non DCHS documentation (e.g. acute hospital discharge letter) should be used and the patient transferred to DCHS documentation at the next change in dose or medication or at the next most convenient opportunity, ideally within 5 days. The administration/stock balance sheet can be used to record when a dose is given

- **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.

- **When an inpatient begins a quit smoking attempt in the hospital, they should be directed to a community pharmacy smoking cessation service to continue their quit smoking journey once they are discharged.**

- **Identify and refer patients who would benefit from a community pharmacy follow up post discharge to the Discharge Medicines Service for support with medicines optimisation and reconciliation**

- **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 Urology.
- If the problem is unrelated to the original reason for referral, e.g. patient in respiratory clinic describes abdominal symptoms this should be passed back to the GP to consider.

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

Joined Up Care Derbyshire

joinedupcarederbyshire.co.uk

@JoinedUpCare

REFERENCE DOCUMENTS

- **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

- **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.qub.ac.uk/sites/qubgp/FileStore/Filetoupload,1011592,en.pdf

- **Royal College of Emergency Medicine guidance for management of investigation results in the Emergency Department**
https://rcem.ac.uk/wp-content/uploads/2021/10/RCEM_BPC_InvestigationResults_200520.pdf