Cheshire and Merseyside
Health and Care Partnership

NHS
Cheshire and Merseyside

Primary Secondary Care Interface Communications Toolkit

This toolkit is intended to provide sample communications that can be used by colleagues to disseminate information relating to the Primary Secondary Care Interface. This toolkit is intended for use in both Primary and Secondary Care.

Contents

1. How to use this toolkit

The Consensus on the Primary Secondary Care Interface has been published and supported by the whole system across Cheshire and Merseyside. The consensus can be found here and should continue to be disseminated and promoted at every opportunity.

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

The toolkit provides narratives that can be used to support the need for the consensus as well as clear guidelines and principles taken from the document.

It is envisaged that organisations can disseminate the information to provide easily understood messages and information. Each topic is found on a single page with key messages highlighted in bold type. Organisations may wish to share the contents a page at a time to avoid information overload.

What to do

Clinicians should seek to follow the principles with the Consensus, keeping the patient at the centre of all they do and treating colleagues with respect. Clinicians should seek to undertake any required actions themselves without passing to other teams, and endeavour to make every contact count, reducing hand-offs and avoiding unnecessary delays in the patient pathway.

What to expect

We should all expect to be treated with respect by our colleagues. We should expect clear, timely communications relating to patient care and for agreed pathways to be followed.

2. Why we need a Consensus on the Primary Secondary Care Interface (PSCI)

The whole system is working hard to manage the demand being faced. We are all struggling to develop the capacity required. Two years ago we asked front line clinicians for their views around what could be done to improve system pressures. Many of the responses related to the Primary Secondary Care Interface. We therefore developed this consensus document:

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

We believe that following the principles found within the consensus will improve pathways for patients, and free up much needed capacity.

From recent audits in Accident & Emergency, it is estimated that approximately 230 patients who attend A&E within Cheshire and Merseyside each day, would be better seen in Primary Care[1]. Anecdotally, many of these patients report attending the Emergency Department because they could not obtain an appointment with their GP. Conversely GPs report approximately one appointment per surgery is taken up with PSCI related issues. As such there may be up to 1500 GP contacts across Cheshire and Merseyside every day dealing with issues that could have been managed in the secondary care environment (sick notes, prescriptions, referrals etc)[2]. Freeing up this time could enable more patients to be seen in the Primary Care setting, reducing pressure on A&E services. In addition, it is important to be aware of the impact of the volume of correspondence GPs receive each day which can include being routinely copied into correspondence and results/reports being sent to consultant colleagues or even to the patient themselves (including letters offering appointments in some cases).

[1] Estimates based on an multi-disciplinary case note audit demonstrating around 10% of ED attendances may have been better dealt with by General Practice. There are approximately 2300 ED attendances each day within C&M.

[2] Estimates based on perceived daily patient contacts for PSCI issues within a GP practice. Further work is being undertaken to validate these estimated numbers.

Hospitals are also dealing with referrals that could have been better communicated, or where pathways have not been followed.

This needs to be seen as a system problem, tackled together by improving relationships and understanding between disciplines.

Fundamentally, improving the Primary Secondary Care Interface will improve pathways for patients.

Please also see:

General practice and secondary care - Working better together - Academy of Medical Royal Colleges (aomrc.org.uk)

https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/

3. Strengthening Relationships between Primary and Secondary Care

Our recent survey of Consultant and GP Colleagues demonstrated that we all have the same priorities with regard to the Primary Secondary Care Interface. The issue that was ‘voted’ the most important priority was that of improving the relationship between Primary and Secondary Care colleagues.

While we would suggest that improving relationships should be a key part of all Primary Secondary Interface Groups, we would propose some actions that could be considered to bring colleagues together:

A. Consultant-GP educational meetings

- While joint educational meetings used to be commonplace, they are much less frequent nowadays.
- With increased workload during the working day, lunchtime meetings are harder to attend, PSCI groups could consider evening meetings, or remote meetings to avoid travel time.

B. GPs delivering education within the hospital setting

- GPs would seem to be well placed to deliver education around discharge summaries, and perhaps being involved in FY doctor education would be helpful.

C. Job shadowing

- GPs spending a day shadowing a consultant, and vice-versa can dramatically improve mutual understanding and respect.
- Colleagues can be encouraged to arrange this themselves, or PSCI Groups could look to facilitate

D. Social Events

- PSCI groups may wish to consider either formally or informally arranged social engagements – this could be as simple as arranging to meet for a walk or a drink at a local pub or café. It could be as elaborate as a local clinician's ball!

4. Specific Topic Guidance

A) Referrals

1. Primary Care to Secondary Care

a) Quality referral information is crucial to triage and pre-assessment investigations
b) General Practice clinicians need to include the specific reason for the referral and an explanation of the clinical rationale for the referral, suggested query or objectives
c) While including the consultation is helpful, it is often insufficient to merely request the secondary care team read the consultation.
d) Patients should not be referred without adequate physical examination if this is crucial to decision making
e) Patients should only be referred following discussion, and consent, with the Primary Care Clinician
f) 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
    - Please do empower patients to optimise their own health in the waiting period – smoking cessation advice, weight advice etc

2. Secondary Care to Secondary Care

Clinicians should arrange onward referral without referring back to the GP where appropriate

a. A hospital clinician should be expected to arrange an onward referral if:
    i. 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.

ii. 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

b. 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.

c. We would suggest a common-sense approach is taken. If a clinician has decided that an onward referral is indicated, they should undertake this without passing the work to another clinician or team.

3. **The ICB has committed to honour payment for hospital consults even if there is no GP referral UBRN code**
4. **The above also applies to all private providers where a patient seen by a GP or consultant privately deems they are in need of ongoing NHS treatment.**

B) Prescribing

1. **The clinician who wishes to prescribe** medication for the patient **should undertake appropriate pre-treatment assessment and counselling** –
    a. 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.

2. **If immediate prescribing within the next 14 days is required from Outpatients, please prescribe**
    a. We would suggest work on ePrescribing for hospitals is accelerated

3. **When recommending ongoing prescribing from the GP please check locally agreed Prescribing Formulary first** to ensure that the intended prescription is appropriate to prescribe, and potentially appropriate for continuation in Primary Care. This is particularly important for any medications that require monitoring, for medications that are being used off-license and for any newer medications that may be unfamiliar to other clinicians.

4. **Local Formularies can be found here:**
    a. Formulary - Pan Mersey APC
    b. Cheshire Formulary (cheshireformulary.nhs.uk)

C) Fit notes (sick notes)

1. It is important that the healthcare professional responsible for the episode of care is the one who issues the fit note e.g., surgeons should issue the fit note to their patients' post operatively. In particular it is imperative that patients are not signposted to other healthcare professionals when discharged from a hospital setting purely for the purpose of certifying a fit note.

2. Fit notes can, and should, be issued for as long as thought to be required up to a maximum of 3 months for the first note (clinicians are allowed to provide a fit note for longer than 2 weeks where appropriate)

3. Fit notes can now be provided by a variety of health care professionals, not just doctors. The following can provide them:
    a. Doctors
    b. Nurses
    c. Occupational Therapists
    d. Pharmacists
    e. Physiotherapists

4. Patients can self-certify for the first week of illness

5. Patients being seen for review in any setting can be provided with a fit note if required

6. Managers should ensure that fit note pads are available in clinic, ward, A&E and GP consulting room settings (electronic fit notes are widely available for completion in Primary Care and work being undertaken for this to be available in Secondary Care)

7. Managers should ensure that clinicians able to provide fit notes are clear on their roles and responsibilities relating to this
8. If fit note is issued in Secondary Care, please include detail of this including dates added to the fit note in any GP communication

9. For clinicians new to issuing Fit Notes, there is an eLFH module which can be accessed here: The Fit Note - elearning for healthcare (e-lfh.org.uk).

D) Arranging Investigations

1. **Avoid asking other teams/services to arrange investigations that you have decided are required**

2. Arrange investigations yourself to ensure that you receive the results thus facilitating continuity of care

3. If you want the patient to have their blood test closer to home, then provide the blood form and enable community phlebotomy.

4. If a clinician wishes the patient to have further tests prior to next review they should look to undertake these investigations themselves. Consider posting the ICE form if required.

5. It is essential that we work with local Primary Secondary Care Interface Groups to work through any challenges this may pose

E) Investigation Follow Up

1) **Whoever requests a test is responsible for reviewing the results, interpretation and any action required resulting from the investigation**

    - 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 Emergency Departments (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.

    - Where the ED is unable to complete the full pathway of care (once emergency management has been completed), consideration should be made to either onward referral to an appropriate speciality or discharge back to the GP to investigate.

    - 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.

2) Ensure robust systems are in place for patients to receive results of investigations, and that they understand what is going to happen.

3) Clinicians should avoid directing patients to other services for results

F) Communications

a) Primary Care

1. **Clinicians should ensure referral communications are of high quality**
    a. This should include details of assessment, investigation and management that has already taken place
    b. GPs should be clear in what they are asking secondary care colleagues to do
    c. GPs should ensure any appropriate pre-referral pathways are followed including any appropriate pre-referral investigations.
    d. GPs should ensure that when referring for non-emergency reasons where operative intervention is likely, that appropriate ongoing chronic disease management occurs (ensuring BP checked for those with hypertension and HbA1c for those with diabetes for example). Where patients have treatment resistant conditions that may cause issues at pre-operative assessment, this should be highlighted at the point of referral.

2. **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. Of note this is not a publicly accessible website and can only be accessed following nhs email ratification
    a. **https://digital.nhs.uk/services/nhs-service-finder**

b) Secondary Care

1. **Ensure clear and timely communication** to the GP following patient contacts.
2. **Highlight any changes in medication and reasons for any changes**
3. **Avoid using abbreviations and acronyms**

4. **Be clear about what follow up is required**, how it will be provided and how any outstanding test results will be reviewed
5. **Be explicitly clear about any requests/actions for the GP**
6. **If you want the GP arrange monitoring** e.g. Urea & Electrolyte, please say why, how often, for how long and what your expectations are if results are/remain abnormal
7. **If you need a repeat test within 2 weeks**, **please arrange this to avoid potential delays.**
8. Please be aware that patients now have access to their full records including documents sent between General Practice and Secondary Care and visa versa.
9. Trusts should provide clear points of contact for GPs to access with any queries

G) DNAs and Self Discharge

1. Ensure any DNAs, including children not brought to appointments, are not automatically discharged without clinical review

2. Ensure any self-discharge is communicated to patient and GP with reason why.

3. 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 where possible.

5. Additional Resources

The following reference documents may be helpful. Many have been used in the creation of 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-careworking-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-devolvednations/Northern-Ireland/2019/RCGP-principle-leaflet-2019.ashx?la=en

Academy of Medical Royal Colleges ‘Working Better Together’ - https://www.aomrc.org.uk/wp-content/uploads/2023/05/GPSC_Working_better_together_0323.pdf

NHS Service Finder - https://digital.nhs.uk/services/nhs-service-finder