Humber and North Yorkshire
Health and Care Partnership

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Consensus on the Primary and Secondary Care Interface – Northern Lincolnshire

Contents

Cover image by Freepik

Overview

This consensus statement was produced by the Northern Lincolnshire Primary and Secondary Care Interface Group with input from representatives of the following:

- Humber and North Yorkshire ICB Place Leadership for North Lincolnshire
- Humber and North Yorkshire ICB Place Leadership for North East Lincolnshire
- Northern Lincolnshire and Goole Foundation Trust
- North Lincolnshire PCNs
- North East Lincolnshire PCNs
- Humberside LMC

The statement was produced to summarise the consensus of key stakeholders on the responsibilities of clinicians in both secondary and primary care in relation to various interface issues that have sometimes resulted in misunderstandings and tensions between clinicians across the interface and/or between clinicians and patients. Those issues have at times also resulted in delays in care and poorer outcomes. The statement is one contribution to improving interface working and there will also be a document for patients explaining what to expect following referral that will contain matching information about responsibilities across the interface. The Interface Group will continue to work on other ways of improving interface working.

The principles contained in the statement are informed by various national publications listed as reference sources. Many of the responsibilities are defined by the NHS Standard Contract and some are the result of local agreements made in the Northern Lincolnshire Primary and Secondary Care Interface Group.

Principles for all

- **Treat all colleagues with respect.**

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

- **Clinicians should undertake any required actions themselves without asking other teams or services to do this (whilst operating within the limits of their professional competency and only undertaking actions if they have access to the relevant investigations or treatments).**

- **Whoever requests a test is responsible for responding to the results of that test.**
- This includes following up results, receiving the results, actioning the results/determining management plan, including potentially onward referral, and informing the patient of the results.
- There are some exceptions:

  1) where another practitioner has accepted that responsibility for a patient under a formal shared care arrangement that defines a different approach

  2) occasionally, arising from ED attendance.
  - EDs should never ask GPs to look for investigation results.
  - If an ED clinician requests an investigation, they are responsible for ensuring the results are reviewed and for undertaking immediate management or any urgent onward referral that is identified as clinically necessary.
  - However, occasionally findings unrelated to the original presentation may be apparent in ED results. Where these are non-urgent, communication between ED clinicians and primary care should take place to ensure appropriate sharing of information and handover.
  - ED clinicians remain responsible for follow up of any delayed findings of trauma that were not identified at the original attendance, including informing the patient.

- **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 not direct patients to their GP for results and vice versa.
- It is the responsibility of the clinician requesting a test to review the result and inform the patient.

Principles for all (contd.)

- **The clinician who recommends a medication to a 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.

- **Responsibilities under a shared care arrangement for prescribing or monitoring only apply AFTER a general practitioner has accepted responsibility for a specific patient.**
- Acceptance must not be assumed simply because a shared care agreement framework exists.

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

- **Communicate directly with other services, not via patients.**

- **Be aware that NHS Standard Contract responsibilities apply to NHS Providers, but not independent sector organisations.**

Principles for Primary Care

- **Before referring to secondary care, first make essential checks with the patient.**
- Confirm their choice of provider in line with their legal rights. (NHS Choice Framework - what choices are available to you in your NHS care (www.gov.uk)
- Confirm that they will be available in the next two weeks, if making a referral for suspected cancer as a 'two week wait' referral and only send the referral when they can be.

- **When referring to secondary care, ensure you are clear in your 'ask'.**
- Why are you referring this patient? Are you looking for advice, diagnosis, treatment?
- Describe fully 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.
- Include patient expectations.
- When appropriate, use local pathways for open access opportunities (this could include endoscopy, cardiology investigations or paediatric blood tests).
- Avoid using abbreviations and acronyms. These may be commonplace within your team but may not be universally used or understood.

- **When referring to secondary care, ensure appropriate Primary Care assessments have been made.**
- Check local pathways for pre-referral criteria, including investigations.
- Consider using advice and guidance requests as an alternative to outpatient referral.
- Non-medical clinicians and clinicians in training grades should particularly consider seeking clinical advice from more experienced clinicians within their primary care team before deciding to make onward referrals.
- Consider when face to face assessment may add value before referral (both elective and emergency).
- A face-to-face conversation is encouraged with any patient who requires urgent referral (2 week wait), to ensure their understanding of the pathway being used and to record the physical/frailty status of the patient for inclusion in the referral.

- **When referring to secondary care, ensure referrals are sent in a timely manner.**
- Urgent or suspected cancer (2 week wait) referrals should be sent no later than the next working day from the decision to refer.
- Routine referrals should be sent no later than 3 working days from the decision to refer.

Principles for Primary Care (contd.)

- **When referring to secondary care, clearly communicate to the patient who you are referring them to, for what and what to expect.**
- Advise patients of the latest known waiting times. (provide link)
- Link the patient to the locally agreed patient information about what happens following referral (and provide in print form if the patient is unable to access/use the digital version). (What happens when you are referred by your GP to see a specialist? (england.nhs.uk))

- **When referring with the expectation that an operative procedure may ultimately be required, attempt to optimise any Long-Term Conditions.**
- BP control for hypertensives, glycaemic control for those with diabetes etc.
- Support patients to optimise their own health in the waiting period – smoking cessation advice, weight advice etc.

- **Following referral, update secondary care on any significant change in a patient's condition that might affect prioritisation of their initial or review appointment if you become aware of that during their ongoing management of the patient.**

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.
- It is always preferable for communication to be completed by a clinician who has been involved in a patient's care.
- Highlight all changes in medication **and** reasons for any changes.
- Avoid using abbreviations and acronyms. These may be commonplace within your team but may not be universally used or understood.
- 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 ask the GP to 'monitor' U&E, say why, how often, for how long and what your expectations are if results are/remain abnormal.
- If you decide a repeat test is required within a short period of time e.g., 2 weeks, arrange this directly rather than ask the GP practice to, to avoid potential delays.
- If communications are known to be taking longer than 2 weeks to reach GP practices, for whatever reason, adjust accordingly the time within which repeat tests are directly arranged.

- **Don't ask General Practice to organise specialist tests.**
- If a clinician wishes the patient to have further tests or tests repeated prior to their next review, they should request these investigations themselves.

- **If patients need a fit note (sick note), provide one.**
- Ensure this is for an appropriate period (if you know they need 3 months off work don't issue a 2 week note).
- Issue fit notes from Out-Patients or Wards, if these are required, rather than directing the patient to their GP.

- **If new or altered medication is considered necessary to commence within two weeks, prescribe it at the time of an Outpatient attendance.**
- For short course medications, prescribe the full course.
- For longer term medications, prescribe an initial course of at least a 28/30-day pack (according to the default size for the specific medication).
- If communications are known to be taking longer than 2 weeks to reach GP practices, for whatever reason, adjust accordingly the quantity of medication.

- **Make use of the Discharge Medicines Service, nationally commissioned as a core service from all community pharmacies.**
- 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.
- The toolkit references both high risk medicines and high-risk patients appropriate to send information on – this should be the minimum.

Principles for Secondary Care (contd.)

- **Discharge medications for longer term medications should cover an initial period of at least 14 days.**

- **When recommending ongoing prescribing from the GP, ensure the recommendation is consistent with the Humber Area Prescribing Formulary.**
  - Important to check whether the suggested medication is for specialist prescribing only or is subject to shared care being agreed **before** the GP would be expected to take prescribing responsibility.

- **Put follow up plans in place for patients who self-discharge.**
  - These patients are likely to be unwell and vulnerable. They may have chosen to decline in-patient treatment, but they may still be in need of care, which may mean appropriate follow up in clinic should be arranged.
  - This also includes providing appropriate discharge care and medication.

- **Do not automatically discharged people who DNA without clinical review.**
  - 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 state the criteria to access a further appointment (SOS)

- **Ensure patients are kept fully informed regarding their care and 'what is going to happen next'.**
  - On discharge following inpatient care, advise how a patient should raise concerns about clinical deterioration.
    - This should not routinely direct them to other providers.
    - This advice should be provided in a written format and referenced within the discharge summary.
  - Following referral to secondary care outpatients:
    - alert patients to local arrangements for 'Waiting Well'.
    - communicate with patients on waiting lists to ensure they know their referral has been received, how long the wait may be and how to inform Secondary Care if the patient thinks they need contact earlier than planned, due to a deterioration in their condition.
    - prior to an initial appointment, if a patient or their representative contacts the Trust with concerns about their condition and/or requesting an earlier appointment, advise them to contact their GP practice for further assessment and advice on their condition. Do not advise them to request an expedite letter from their GP.
    - once under review after an initial appointment, if a patient or their representative contacts the Trust with concerns about their condition and/or requesting an earlier appointment, review the information they can provide and take relevant action (expedite or not/give further advice), as clinically indicated. Do not advise them to request an expedite letter from their GP.

Principles for Secondary Care (contd.)

- **Arrange onward referral instead of asking the GP to, where appropriate**

– Hospital clinicians should undertake onward referral, if they decide it is clinically indicated, to other services whether within their own organisation or with any other provider when:
  - The condition/complaint is *directly related** to the original reason for referral (including self-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. OR
  - Urgent referral is indicated e.g., CT chest shows a renal tumour. Arrange the urgent referral to Renal.

– Hospital clinicians need not arrange an onward referral if:
  - The condition/complaint is not *directly related** to the original reason for referral and is not urgent, this can be passed back to the GP to consider referral e.g., patient in respiratory clinic also mentions skin symptoms – this should be passed back to the GP to consider.
  - The problem directly relates to the original reason for referral, but the hospital consultant thinks it might be managed in primary care without onward referral e.g., the suspected condition(s) that the patient's symptoms suggested have been excluded (e.g., a cancer) but the patient might benefit from further management of a condition now identified as the cause which is usually managed in primary care (e.g., pain due to osteoarthritis).
  - *In determining what is *directly related,* consider*:*
    - If the answer to any of the following is yes, it would be appropriate for the secondary care clinician to refer.
      - Is the cause of the original referred condition/complaint related to a different speciality or system? (e.g. abdominal pain due to unrecognised pregnancy; mental health conditions presenting with physical symptoms)
      - Is the indication for onward referral due to a complication (including a treatment side effect) of the referred condition/complaint?
      - Is the indication for onward referral related to the referred condition/complaint as a manifestation in a different system? (e.g. sarcoidosis in respiratory/joint/neurological)
    - If the answer to all the above is no, it would be appropriate for the secondary care clinician to pass the decision on whether to refer to the GP.

- When a hospital clinician decides they are not making onward referral because there is not a directly related condition/complaint and there is no immediate need, they should provide explanation of that in their communication to primary care and should not commit the GP to a specific course of action (i.e. referral or referral to a specific provider) in their communication to the patient but instead identify the issue that they consider might warrant further referral while leaving the decision on further action to the GP.

Reference sources used to inform this consensus statement

GMC Good Medical Practice.
Good medical practice - professional standards - GMC (gmc-uk.org)

GMC Good Practice in Prescribing and Managing Medicines and Devices.
Good practice in prescribing and managing medicines and devices - professional standards - GMC (gmc-uk.org)

GMC Good Practice in Delegation and referral.
Delegation and referral - professional standards - GMC (gmc-uk.org)

BMA guidance on Primary and Secondary Care working together.
Primary and secondary care interface (bma.org.uk)

NHS England guidance on Improving how Secondary Care and General Practice work together.
NHS England » Improving how secondary care and general practice work together

NHS Standard Contract
NHS England » 2023/24 NHS Standard Contract

Academy of Medical Royal Colleges Guidance on Onward Referral
AOMRC-Guidance-on-onward-referral_210518-v3.pdf

Producing this statement was stimulated by a consensus statement produced by the Cheshire and Merseyside Health and Care Partnership
consensus-on-the-primary-secondary-care-interface-full-version.pdf (cheshireandmerseyside.nhs.uk)

Document Control

Document History

Date	Version	Description
21st June 2023	1.0 Draft	Document initially presented to DB/DJ prior to sharing
28th June 2023	2.0 Draft	Applicable wording amended, a section adjusted to reflect local process, and a section reflecting timeliness added in
13th July 2023	3.0 Draft	Version 3 ready for PSCIG
18th September 2023	4.0 Draft	Final draft document for complete governance process
21st May 2024	4.0 Final	Final document

Document Governance

Date	Version	Description	Governance Forum	Outcome
12th June 2023	1.0	Document first discussed at PSCIG, as part of the GP recovery plans	PSCIG	Decision made to go ahead and produce the document
28th June 2023	2.0	Document circulated to a selection of GPs in North and North East Lincolnshire, LMC and for PSCIG Secondary Care Clinical Representation for NLaG for comment	PSCIG	Comments back: Use of abbreviation addresses, shared care addressed, and communication addressed
13th July 2023	3.0	Document – No major adjustments from version 2, only change are that weblinks were added	PSCIG	First draft to PSCIG 20th July 2023
20th July 2023	3.0	On the agenda for PSCIG for comments	PSCIG	
8th August 2023	3.0	Document sent to NLaG for OMG, DMD and CL meetings	Secondary Care Governance forums	No comments received
14th September 2023	3.0	Document taken to a Clinical Leads meeting in NLaG as part of discussions around expediting patients and onward referrals of patients		
18th September	4.0	Final draft forwarded to NLaG for final Secondary Care Governance	Secondary Care Governance forums	No comments received

2nd November 2023	4.0	Final draft at PSCIG for sign off	PSCIG	Sign off not achieved due to delay with the Secondary Care Governance Process
7th November 2023	4.0	Document taken to LMC Committee meeting	LMC Governance	Queries tabled
6th February 2024	4.0	Document presented at the LMC with regards to queries raised in November (Dr Lee presented)	LMC Governance	Document signed off
6th March 2024	4.0	Document discussed at PSCIG as part of the action log, as to how we mobilise the Secondary Care Governance for this document, as there have been significant delays	PSCIG	Document given to Peter Sedman to review on behalf of NLaG and take through relevant outstanding governance
16th May 2024	4.0	Consensus document approved	PSCIG	LMC, PC, and SC governance signed off
		ICB Clinical Executive Team to explore wider interest		