NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

# Primary and Secondary Care: Excellence in partnership working.

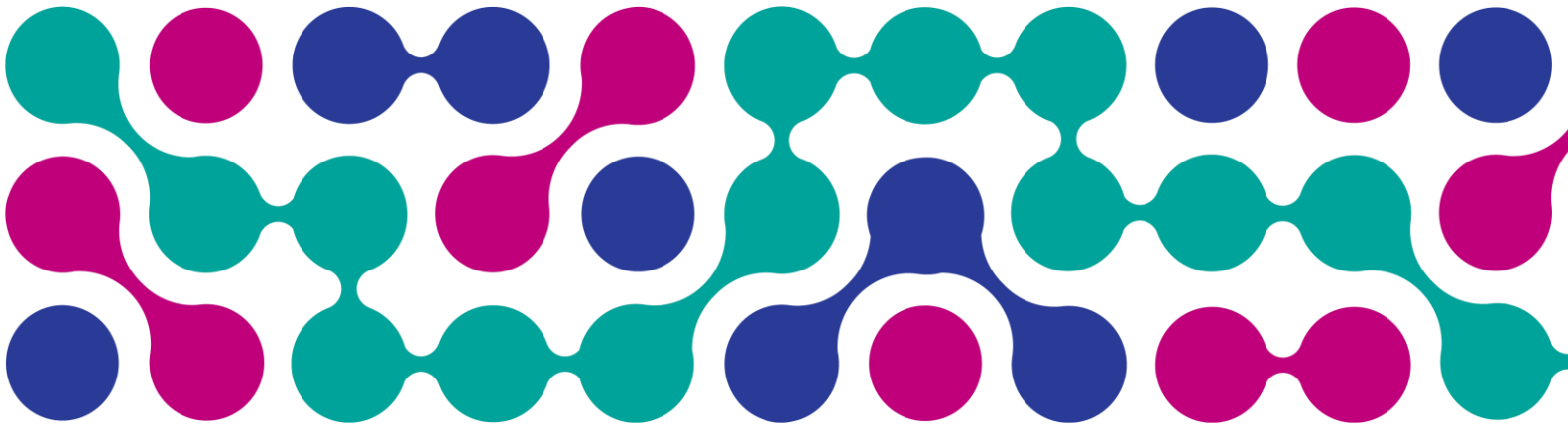
## To cover working in the following

## Primary Care Network areas:

**BaNES: Heart of Bath; Keynsham; Bath Independents; Minerva; Three Valleys; Unity**

**Wiltshire: Chippenham, Corsham and Box; Calne; Devizes; Melksham & Bradford-on-Avon; East Kennet; Sarum Cathedral; Sarum Trinity; Sarum North; Salisbury Plain; Sarum West; North Wilts border; Trowbridge; Westbury & Warminster**

**Swindon: Brunel 1-6; Wyvern Health Partnership; Sparcells**



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# Foreword

Dear colleagues,

This document sets out consensus principles to facilitate better joint working between primary and secondary care. As we move forward in our integrated care systems the importance of working closely together has never been more important. Given a chance, we ought to be able to redesign what we are doing, softening institutional barriers, and focusing on what matters to patients.

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 the patients we serve.

Together we can improve health outcomes for our population and deliver greater efficiency and innovation. Crucially we also need to make our system a sustainable and rewarding place to work, removing unnecessary bureaucratic niggles and burdens from all clinicians. Please take the time to read this document and consider how it might impact on your area of work. And most importantly let's continue to talk to each other.

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# 1. Principles of working together

## 1.1. General

Treat all colleagues with respect.

Remember to keep the patient at the centre of your actions.

A key focus is on population health, care closer to home and care pathways aligned to our integrated care system strategies.

- Have a broad view of all the patients in any pathway and agree on how they can be managed most efficiently and effectively, with clear measurable outcomes.

A Quality Improvement system is being established so that clinical leads, other clinicians, and GPs can actively and easily feedback to ensure service development.

Major service or pathway changes should be known and discussed by primary and secondary care before a decision is finalised.

Consider 'active waiting lists' or '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.

- Consider how can we support our patients to improve their health while they wait.

Ensure there are agreed clear lines of accountability in cases of multi-disciplinary teams and shared care working:

- avoid using abbreviations and acronyms.

## 1.2. Specifics

An underlying principle is that clinicians should seek to complete any required actions themselves without asking other teams to do this:

- Clinicians need to operate within the limits of their competency (but should aspire to be at the highest level possible). They are only able to undertake actions if they have access to relevant investigations or treatments.

The clinician who 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.

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 a directive to attend Accident and Emergency).

- Ideally this should be in a written format and referenced within the discharge summary or outpatient clinic letter.

Consider using 'Advice and Guidance' to contact colleagues if uncertain:

- Clinical queries can be raised through advice and guidance.

- Departmental telephone and email addresses should be available for ease of access by primary care for administrative issues such as appointment queries, and likewise General Practices should make 'backdoor' telephone number and email addresses known to secondary care.

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.

# 2. Secondary care working practices.

## Ensure clear and timely communication to the Practice team following patient contacts - both inpatient and outpatient – in line with national standards:

https://theprsb.org/wp-content/uploads/2018/02/Implementation-Guidance-Outpatient-Letter-Standards-2.0.pdf

- Use a template for outpatient letters to include as a minimum: Problem/ diagnosis; medication changes; follow up; GP requests; suggested actions.

- Highlight any changes to medication including those stopped with reasons.

- Be clear in discharge summaries that pending tests have been ordered and will be followed up – primary care may not know the reason for the test

- Be explicit about any requests/actions for the GP/ practice team.

- If you would like the GP to 'monitor' U&Es for example, 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, arrange this on ICE to avoid potential delays.

## Avoid asking General Practice to organise tests:

- If you would like the patient to have their blood test closer to home, please log this request using the local digital pathology system (eg ICE), if available to you.

- Document and advise the patient to make an appointment for a blood test having put on ICE. It does not need to go through the GP.

- If a clinician wishes the patient to have further tests prior to next review then book in advance (again, ask patient to book in themselves).

## If patients need a fit (sick) note, please provide one:

- Ensure this is for the likely period needed (e.g. if 3 months off work don't issue for 2 weeks).

- 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 a prescription is required **within** 14 days of clinic appointment, please prescribe it:

- If the advice is for a routine change of prescription advise the patient that they should wait at least 14 days for a letter to reach the practice.

- Advise patients that hospital prescriptions need to be issued by the hospital pharmacy and not taken to General Practice for them to do.

- In exceptional cases where an urgent prescription from primary care is needed, ensure there are clear written instructions. Urgent emails are preferable to handwritten notes which can be challenging to decipher and have no audit trail.

- The patient should be counselled regarding proposed medication, its side effects and potential interactions with other medications they are taking.

## Discharge and outpatient prescriptions for longer term medications should cover an initial period of at least 14 days:

- Important to check that the suggested medication is appropriate for the GP to prescribe and not a RED or AMBER drug – please check the Formulary (https://www.bswformulary.nhs.uk/ ) if you are unsure.

- use shared care documents for AMBER medications, if appropriate.

## Arrange onward referral without asking the GP when:

- The problem relates to the original reason for referral.

- An urgent problem comes to light, including with results of scans etc.

- If the problem is non-urgent and unrelated to the original reason for referral, this could be referred directly or ask the patient to contact their practice.

- Consider referring directly to community services if you require their input (rather than asking the General Practice team to do this on your behalf).

## 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, e.g. follow up in clinic could be arranged.

- This also includes providing appropriate discharge care and medication.

- It is important to understand and reflect on why care was declined.

## Ensure DNAs are not automatically discharged without clinical review:

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

- If patients are transferred to patient initiated follow up (PIFU) clearly reference the criteria to access a further appointment (SOS).

## Consider picking up the phone to speak to colleagues, if in doubt.

## 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. Particularly applicable to virtual consultations.

- It is the responsibility of the clinician requesting a test to review and interpret the result.

- The GP appointment system is patient driven - patients make their own appointments. So, when referring patients back to primary care ask them to make an appointment (not the GP to make an appointment for them).

# 3. Primary care working practices.

## 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 the reason for referral, and the specific question.

- Try to avoid phrases such as 'see my consultation notes' as this may be hard to find and not have a specific question.

- Ensure an up-to-date medication list is available along with test results.

- What are the patient expectations?

- If referring looking for a diagnostic procedure, check local pathways for open access opportunities (this could include endoscopy, cardiology investigations or paediatric blood tests).

## When referring to secondary care ensure appropriate Primary Care assessments have been made:

- Consider discussing referrals before making them with a primary care colleague (usually within the practice) if the indications or route of referral are not clear. Doing so will ensure that due consideration can be made to either initially manage the case within primary care or to make use of alternative pathways that the referrer may not be understand / know about. This is especially relevant to trainees, allied health professionals and advanced care practitioners.

- Check local pathways for pre-referral criteria and potential investigations.

- Consider clinical advice & guidance via Cinapsis and any other guidance (e.g. Ardens) first.

- Use of a referral proforma cannot be mandated to create a referral. However, it is encouraged if possible as it aids the transfer of information. Forms must be co-produced with General Practice input.

- Consider advising the patient that you are contacting a specialist which, in some cases, may result in written advice or the first contact may be a remote consultation, rather than being seen directly.

- Consider when face to face assessment may add value before referral (both elective and emergency), e.g. a face-to-face appointment for a physical condition such as a lump would be required.

- It can be helpful to have a face-to-face conversation with a patient who requires a 2-week-wait referral to ensure understanding of the pathway being used and to record physical/frailty status.

- It can be helpful if patients are seen face to face before being sent urgently into hospital with an accompanying letter (unless it is an emergency or related to a test result).

- Has the patient been seen elsewhere for the same condition before and are there any tests e.g. scans done somewhere else?

- Consider referring directly to tertiary centres where the specific clinical condition warrants a tertiary care assessment.

- Consider the use of patient leaflets (Easy Read or similar) to inform them about their condition.

- Use the Trust Pharmacy Service email for discharge medications.

## When referring with the expectation that an operative procedure may ultimately be required, try to optimise any Long-Term Conditions:

- Consider initiating a review with the Practice long-term conditions team.
- BP control for hypertensives, glycaemic control for those with diabetes etc.
- Do empower patients to optimise their own health enabling ‘active waiting’.
- Smoking cessation advice, weight management advice etc
- This will reduce the impact of last-minute cancellations in peri-operative clinic.
- Patients awaiting a new outpatient or elective surgical appointments remain under primary care.
- Triage processes or active management of waiting lists could be considered by secondary care.

*Thanks to **Cheshire and Merseyside Health and Care Partnership** upon whose document this is based on.*