Cornwall and Isles of Scilly
Integrated Care System

Strengthening our primary and secondary care interface

Contents

This document borrows the One Devon interface document and adapts it for use in Cornwall & Isles of Scilly. The work has been led by the System Interface Group which includes the following members:

- Kernow Local Medical Committee
- Royal Cornwall Hospitals Trust (RCHT)
- University Hospital Plymouth (UHP)
- Cornwall Foundation Trust (CFT)
- Cornwall & Isles of Scilly Integrated Care Board (ICB)
- Kernow Health CIC
- Collaborative Board

Foreword

Based on the successful implementation of an interface document for primary and secondary care colleagues in Devon, we were keen to develop adapt this for health and care organisations in Cornwall & Isles of Scilly. The intention of the document is to set out some key principles that support a productive working relationship between colleagues across sectors of our system.

We believe the following principles support better coordination and collaboration to improve the safety, effectiveness, experience, and outcomes for the care we provide together:

- Provide a personalised approach to health and care: 'joined-up' packages based on individual need.
- Support our workforce: to ensure people are able to do their best work. To do this we need to ensure the infrastructure is in place to enable staff to work to maximum efficiency and check the governance supports cross sector and organisation working.
- Ensure shared decision-making: consistently applied across all services.
- Use high-value interventions: consistently and earlier in pathways and stop providing health and care that does not add value and may be causing harm.
- Reduce our environmental impact.
- Tackle unwarranted variation in practices, outcomes and inequality.
- Manage risk across the system: ensuring that decisions made in one place do not increase the risk in another and addressing challenges from a whole population perspective.
- Spread improvement and innovation, sharing best practice.
- Develop a culture of stewardship – i.e. changing the way we think about and practice leadership.

Embedding these principles and developing excellent communication channels between health and care professionals will help us to eliminate gaps in and between the services we provide. After 75 years of the NHS, we know that siloed working is sadly a reality, and we have a great opportunity to change this together.

We are grateful to Devon colleagues for sharing their work and we have tried not to make too many changes to their document as around 20% of our population access hospital services in Devon.

The document covers a wide range of situations including prescribing, fit notes, diagnostics and more. We hope that these will provide clarity around the actions and responsibilities as our care becomes increasingly multidisciplinary and spans organisational boundaries.

Chris Reid

Chief Medical Officer NHS Cornwall

Executive Summary

The purpose of this document is to outline key principles for communication between primary care, secondary care and patients.

Throughout the document we have used the term primary care rather than general practice. It is recognised that the majority of referrals and interactions are currently between general practice and secondary care and that primary care also covers the disciplines of pharmacy, optometry and dentistry. However, rather than change the term to general practice, we have kept the term primary care as our ambition is that these principles might be adopted by colleagues working in those other primary care sectors as a way of promoting good communications with secondary care to support the patient journey.

By using, reviewing and improving these principles we hope that we can bring benefits to those receiving care, and those providing it across health and care settings.

This document describes in detail the principles for all, for primary care and for secondary care to follow.

Establishment of single routes for primary and secondary care teams to communicate rapidly, with direct lines and clear times to call.

If a patient has been seen virtually in secondary care and further examination is required to assist the diagnosis, this needs to be done in secondary care, unless there is an exceptional agreement with primary care.

The quality of the referral for advice and guidance should abide by robust governance and the advice include the next steps, help with interpretation of tests or when to refer.

Where clinically appropriate the use of advice and guidance as an alternative to referral should be considered in all patients unless there is a clear pathway for referral established.

Whoever requests an investigation (whether primary or secondary care) is responsible for interpreting and communicating the result to the patient.

Patients who are under secondary care need a clear route to contact the secondary care team, including when they have concerns about worsening of their condition.

Secondary care providers should refer a patient on to another service, if related to the presenting condition, without referral back to the primary care team.

A clear map and outline of responsibilities is explained to patients to enable them to get appropriate help when needed, including what is going to happen next and how they can prepare.

Primary care should prepare a patient for an initial secondary care appointment in accordance with referral management or Devon referral support service.

Introduction

The Covid-19 pandemic has led to significant increased demand across the entire health and care system.

It is imperative we work together while tackling increasing workload and lengthening waiting lists.

The following principles are supported by clinical leaders in both primary and secondary care.

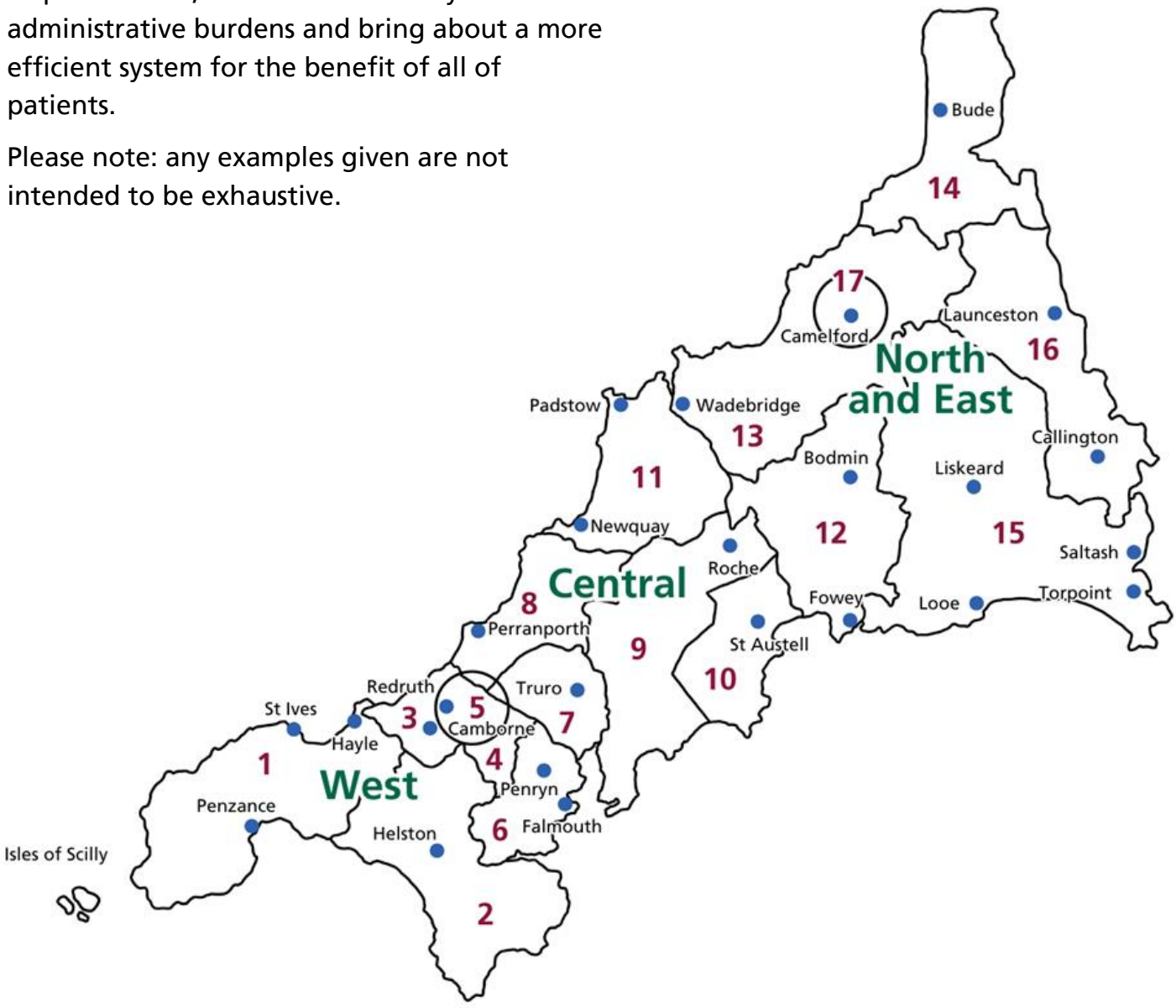
These aren't rules to follow and there will be exceptions. Clinicians are trusted to make appropriate decisions based on individual circumstances.

The aim of this document is to improve relationships between colleagues, clarify responsibilities, remove unnecessary administrative burdens and bring about a more efficient system for the benefit of all of patients.

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.

Further work will now need to be undertaken to define how this document is implemented in practice both at locality and system level.



Cornwall and Isles of Scilly Integrated Care System

Principles for All

Treat all with respect

Patients should be at the centre of all we do

Individuals should seek to undertake any required actions themselves unless there is added value to engaging other teams or services

Principles for All

Whoever requests a test retains the responsibility for any subsequent action relating to the test and robust systems must be in place for communication.

- This includes chasing results, receiving results, actioning results/determining management plan, and informing the patient of the results.
- There may be some exceptions around shared care. When blood tests are requested as part of a shared care protocol, the responsibility for the tests should be outlined in the agreement.
- Tests should only be requested in ED if helping diagnostically for the acute problem or assisting direct onward referral and the general principle is that the requestor is responsible for the results.
- Consideration needs to be given to the management of incidental findings. Local systems are urged to clarify pathways to avoid duplication, inappropriate investigation, or failure to further investigate where appropriate. As a general rule, we expect the requesting clinician to take responsibility for informing the patient of the findings and dealing with these, including outcomes from multidisciplinary meetings (MDTs), if within their competency. If urgent action is required, this should not be passed onto another clinician.

Ensure patients are kept fully informed regarding their care and what is going to happen next.

- If a patient is waiting for an initial review, the patient should inform the referrer if there is a change in condition.
- Once seen within a service, there should be clear advice about how they should raise concerns about clinical deterioration that should avoid directing them to other services unless clinically necessary.
- Ideally this should be in a written format and referenced within the discharge summary or clinic letter with clear contact details, or explained to the patient at the point of referral into secondary care.
- If patients are in a secondary care service, there should be clear signposting to patients about how to get clinical advice in between appointments.

If clinically appropriate, clinicians should phone directly to speak to colleagues.

- Organisations should consider how they might facilitate easy, prompt access to enable this.

Any clinician who wishes to prescribe medication should undertake appropriate pre-treatment assessment and counselling.

- They are responsible for communicating the rationale for treatment, including benefits, risks and alternatives, arranging any follow-up requirements that might be necessary, and documenting all of this in any related correspondence.
- Particular note of documentation is expected when this drug is amber, red or unlicensed within the Cornwall Formulary.

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

Case Study

Mr C was seen by in Liskeard community hospital with osteoarthritis of his right hip by Lucy, a physiotherapist. Mr C and the physio decided that an onward referral should be made to the local orthopaedic team for consideration of a routine hip replacement.

Lucy explained to Mr C that she would make the referral and he asked when he could expect an appointment.

She advised him that waits were longer than usual at present, but explained that she could not give him a firm timeframe as to when he will receive an appointment for assessment.

Principles for Primary Care

Principles for Primary Care

For all referrals and requests for advice and guidance from secondary care, ensure the request follows ICB Clinical Referral Guidelines and policies.

Requests should follow the principles of a good referral including:

- Clear reason for request.
- Recent medication list.
- Any recent investigation relating to the problem including attaching any imaging test results performed outside of the local provider.
- If a GP feels a photographic image would be helpful for referral, ensure this is included.
- If there are any key anomalies in investigations, highlight these in the body of your referral/request.
- Use referral templates that will prompt necessary requirements https://rms.cornwall.nhs.uk/rms/primary_care_clinical_referral_criteria/lessons_from_the_kings_fund
- Check the Cornwall Formulary and Referral website booking section to ensure the appropriate service has been selected https://rms.cornwall.nhs.uk/primary_care_clinical_referral_criteria
- Patients should be informed that a specialist opinion has been sought and that this might be enough to manage their condition without the need for an appointment.
- If you are happy for the receiving trust to convert an advice and guidance request to an appointment, if necessary, ensure your admin/secretarial teams tick the box authorising conversion when the request is submitted.
- If a primary care provider remains unsure about operating outside of clinical competence, they continue to have the choice to refer for an appointment.
- Written advice and guidance service should not be used for anything which requires urgent same-day advice. Direct phone contact with the department should be used.
- If referring for a diagnostic procedure, 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.
- If possible, indicate within the referral any reasonable adjustments the patient may require or whether this patient is suitable for a virtual appointment.

Consider using advice and guidance as an alternative to referral for the following indications:

- Diagnostic uncertainty that will affect safe and effective management of patient.
- Uncertainty around clinical management or as a pathway to referral if unsure about the need and there is no Clinical Referral Guideline recommended pathway.
- Support to interpret primary care diagnostics (e.g. ECG) that will affect management.

Expediting referrals:

- When communicating with secondary care about a patient who is already under a service, contact the consultant or other healthcare provider directly rather than through e-RS advice and guidance, unless a service has specifically requested otherwise.
- To help prioritise the patient appropriately, ensure that the impact on the patient (employment, mobility, mental health, caring obligations) is clear, along with frailty assessment. If consideration is needed to expediating the referral, see the guidance.

When referring to secondary care, clearly communicate to the patient who you are referring them to, what for and what to expect (if known).

- Advise patient that there may be a long wait. Information on waiting times is available online https://royalcornwallhospitals.nhs.uk/waiting-times/
- Some patients will contact primary care to ascertain when their appointment is (or to expedite their appointment) in secondary care. Primary care should assess patients by whatever means they feel appropriate. If their condition has deteriorated appropriate action to expedite the patient's appointment should be taken. Secondary care will include information on acceptance of referral regarding waiting times and contact details whilst waiting.
- Advise the patient that the first contact by secondary care may be a remote consultation by video or phone. Further information is available: https://royalcornwallhospitals.nhs.uk/patients-and-visiting/outpatients/types-of-appointment/
- Consider signposting patients to Healthy Cornwall https://www.healthycornwall.org.uk/

Consider a process of 'waiting well' for patients referred to secondary care.

- Set patient expectations around possible wait times and encourage patients to optimise their own health in the waiting period
- Smoking cessation advice, weight advice, etc. is available online: https://www.healthycornwall.org.uk/
- If an operation is a possible outcome from the referral, patients should be advised to optimise other long-term medical conditions e.g. weight, hypertension, diabetic control and smoking. A clear explanation can be communicated to patients that this can avoid delays, cancellations, and lead to better outcomes.

Case Study

Mrs B, 65, was referred three months ago to her local respiratory team for a routine assessment of chronic cough, shortness of breath and had a normal chest x-ray. The practice more recently received an electronic consultation form from her to say that she is experiencing more shortness of breath and has been coughing up small amounts of blood intermittently. She is seen face- to-face by her GP for assessment.

Her vital signs are fine, but her GP notices she now has finger clubbing and is concerned that she may have a malignancy. The GP makes a two week wait referral so she can be assessed in a more appropriate and timely manner.

Principles for Secondary Care

Principles for Secondary Care

For response to advice and guidance:

- Secondary care should publicise ways of getting advice and guidance and the operating hours, prior to or instead of referral.
- The full name and title of the person providing advice and guidance must be on the response to primary care.
- Use local Electronic Patient Record (EPR), Picture Archiving and Communication System (PACS) to supplement the information given to you by the GP.
- Tests requested in primary care as part of the advice and guidance should be within their usual scope of practice, and advice should be directed towards how to interpret the results or get further advice on the results if abnormal. If returning with advice, offer an individualised step wise plan for management, including criteria for future referral.
- Convert to a referral where appropriate. This must meet the minimum criteria set up through the Clinical Referral Guidelines (CRGs) or commissioning policy in the formulary prior to converting.
- If converting to a referral, organise pre-clinic tests where possible (with results returned to secondary care for interpretation), and use locally commissioned phlebotomy services where possible. The only exception to this would be where there are pre-agreed pathways, when it is reasonable to expect the investigations in primary care.
- If a patient has been triaged 'straight to test' without a clinic appointment, a clear interpretation of the results by the requester or letter explaining the results in the context of the patient's symptoms is necessary, in addition to simply the test result. A normal result should not automatically lead to discharge back to primary care as further investigations or action might be required to get to a diagnosis and management plan.

For response to advice and guidance:

- Link to guidance where appropriate and develop FAQs. Templated responses with additional educational material should be developed for common conditions, fitting the Clinical Referral Guideline criteria for referral.
- Request further information, if needed, to help either give advice or convert to referral (remember not to close the conversation).
- Ensure you have allocated resource to check Advice and Guidance daily and achieve the five-day turnaround time including backfill for leave (with optimal of 48 hours).
- Appropriate advice and guidance should:
    - Include interpretation of test results
    - Include next steps
    - Educate where appropriate to encourage learning while ensuring the clinical question has been answered
    - Provide clear documentation of the name and designation of the respondent
    - Include reasons for converting to a referral if that is felt to be necessary
- Consider setting up MDTs and other communication platforms to facilitate shared care, advice and further learning, benchmark advice and guidance amongst colleagues, perform audit of performance and use standard texts when able.

- If an advice and guidance request does not meet the basic standard, this can be politely fed back. The quality of responses should be audited.

All triaged referrals should meet the agreed standard from established Clinical Referral Guideline guidance.

- Referrals should be triaged for urgency to ensure appropriate timely review.
- Specialists need to be aware of relevant Clinical Referral Guidelines and policies.

Avoid asking general practice to organise specialist tests or examinations.

- If a blood test is required closer to home then secondary care clinicians should request through locally agreed services so the result goes back to requestor.
- If the first contact is a virtual review but the patient needs an examination, this should happen in secondary care, unless there are exceptional circumstances agreed (or this would have been an expectation prior to referral). This includes minor invasive procedures such as rectal examinations.
- If a clinician wishes the patient to have further tests prior to next review, these should be undertaken within secondary care, unless a shared care agreement is in place.
- It is not necessary to inform primary care of all the investigations and findings – this can create confusion about the responsibility for the findings. A summary of findings and outcomes is sufficient.

If patients need a fit note (sick note) then please provide one.

- Ensure this is for an appropriate period (i.e. if three months is required off work, complete the fit note for the whole duration). Fit notes should be proportionate to the patients activity tolerance. Extensions beyond that point are the responsibility of primary care after reassessment, where appropriate.
- Issue fit notes from all settings, including outpatients and ED, if these are required, rather than sending back to the GP. Trusts should ensure fit notes are available for colleagues in inpatient and outpatient settings.
- It is good practice for clinic or discharge letters to GPs to make clear where fit notes have been issued by the provider, the reasons given and the exact dates covered.

Ensure clear and timely communication to the referrer in primary care.

- This applies to all patient contacts including outpatients, discharge from admission and ED. Discharge summaries and summaries relating to ED attendance should be received by primary care within 24 hours. Letters relating to outpatient appointments should be received by primary care within seven days and letters should be in digital format.
- Consider corresponding directly with the patient, or otherwise correspondence should routinely be copied into the patient, unless an express wish not to be or sensitive information makes sharing inappropriate.
- Highlight any changes in medication and reasons for any changes.
- Avoid using abbreviations and acronyms (and include full names, not initials). These

may be commonplace within hospital teams but may not be understood in primary care.

- Be clear about what follow up is required, how it will be provided and how any outstanding test results will be reviewed.
- Be explicit about the patient's awareness of the criteria for further contact on clinical deterioration and a clear route to contact while waiting for a treatment.
- Be explicit about any requests/actions for the GP from discharge:
- If you need a repeat test within a short period of time e.g., two weeks, follow locally commissioned phlebotomy services. with the practice (bearing in mind that the practice may have a wait of longer than two weeks for bloods) to avoid potential delays.
- Following up on inpatient episodes for resolution is primarily the duty of secondary care e.g. repeating a chest X-ray for resolution of a pneumonia, unless ongoing care for a chronic condition, with results being communicated to the GP and patient.

If medication needs to be started from outpatients within the next two weeks, a prescription should be provided rather than passing back to primary care. It should be a sufficient supply to cover for e.g. the entire post-op period or at least 28 days.

- If asking primary care to provide any prescriptions, it should be explained to patients that this will take up to 14 days after receiving correspondence. Prescribing should be according to Cornwall formulary guidance.

Call and recall

- For patients under their care, secondary care organisations should establish their own call/recall systems for patients for follow-up tests or appointments. This means that patients will have a clear route to contact secondary care and will no longer have to ask their practice to follow up on their behalf.

Discharge medications

- Patients requiring analgesics post-operatively should be issued a sufficient supply (quantity and strength) to cover the entire post-op recovery period.
- For longer term medications, discharge supply should cover an initial period of at least 14 days.
- If needing monitoring for Warfarin (with potential new drug interactions), this should be monitored from hospital for the first seven days unless confirmation that primary care can pick this up sooner.

Make use of the Discharge Medicines Service, nationally commissioned from community pharmacy.

- This should be used for all patients when appropriate to ensure they benefit from this essential service and that safety improvements are realised upon transfer of care.
- Ensure all electronic referrals made under this system contain the nationally agreed dataset and use the electronic platform.

The toolkit references both high risk medicines and high risk patients appropriate to send information on – this should be the minimum: https://www.england.nhs.uk/publication/nhs-discharge- medicines-service-essential-service-toolkit-for- pharmacy-staff-in-community-primary-and-secondary- care/

When recommending ongoing prescribing from the GP, this should be in line with Formulary guidance and should be appropriate for GPs to prescribe.

If a patient has a drug prescribed under shared care, the shared care agreement needs to be completed in advance of the first prescription being administered in primary care. Patients should also be stabilised on an appropriate dose before primary care takes on the prescribing responsibility.

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 declined inpatient treatment, but they are still in need of care, which may mean appropriate follow up in clinic is offered.
- This also includes providing appropriate discharge care and medication.

Ensure any people who don't attend (DNAs) are not automatically discharged without clinical review by a senior clinician.

- Any discharges should be made in line with the relevant access policy in place at the time.
- All patients should have an attempt to be contacted by phone, if appropriate. If unable to contact and they haven't attended, one further attempt at contact or appointment should be attempted before consideration of discharge.

If a patient is discharged from a service, the reason should be communicated to the GP, along with any criteria for re-referral.

- If patients are transferred to patient initiated follow up (PIFU) or seen on symptoms pathways, ensure the criteria to access a further appointment and how to contact the department is clearly referenced. The patient should be encouraged to contact the specialist directly if they have a concern relating to their condition.
- Patients who cancel their appointment and rearrange should not involve the GP unless a clear clinical reason exists.
- Patients discharged from inpatient services should have clear documentation about signposting patients for further action e.g. suture removal, infective complications.

Arrange onward referral without referring back to the GP, where appropriate.

- if a patient has been referred into secondary care and they need another referral, for an immediate or a related need, the secondary care provider should make this for them, rather than sending them back to general practice which causes a further delay. **This includes onward referrals for two week wait (2WW) appointments where the clinician knows that an onward referral is required.**

Clear points of contact

- Secondary care providers and departments should provide single routes for general practice and secondary care teams to communicate rapidly e.g. single outpatient department email for GP practices or primary care liaison officers in secondary care.
- Currently practices cannot always get prompt answers to issues with requests, such as advice and guidance or referrals, which results in patients receiving delayed care.

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.
- If an operation is a possible outcome from the referral, patients should be advised to optimise other long-term medical conditions e.g. weight, hypertension, diabetic control and smoking. A clear explanation can be communicated to patients that this can avoid delays, cancellations and lead to better outcomes.
- Present patients with a realistic expectation around procedure cancellations and that cancellations for their own health may occasionally be necessary (such as if they have Covid-19 infection, or uncontrolled comorbidities).

Case Study

Miss O, 23, was seen in the rheumatology department and diagnosed with rheumatoid arthritis. The rheumatologist wanted her to start methotrexate and counsels her accordingly. He explained that he will provide initial prescriptions for methotrexate and arranged initial blood monitoring via locally commissioned phlebotomy services.

He sent a letter to the GP asking them to agree to shared care prescribing. The GP agreed to this and returned the completed paperwork to the rheumatologist. At this point Miss O was on a stable dose of methotrexate and the rheumatologist explained to her that her GP practice will now take over prescribing and blood monitoring.

Case Study

Mrs R, 45, works as a carer and was admitted for a vaginal hysterectomy due to uterine fibroids. The procedure was uncomplicated. She remained an inpatient overnight and was discharged home the following day from the gynaecology ward.

The gynaecology team felt that she would require six weeks off work due to the physical nature of employment so she was issued a fit note for the entire six period and two weeks' worth of post-op analgesia on discharge.

She made an uneventful recovery and returned to work six weeks later without needing further appointments with her GP practice for fit notes or further analgesia.

Reference Documents

PCCC Primary Secondary Provider Interface (2020) Cornwall.

GMC Good Medical Practice:
https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice

GMC Good Practice in Prescribing and Managing Medicines and Devices:
https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices

GMC Good Practice in Delegation and Referral:
https://www.gmc-uk.org/professional-standards/professional-standards-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/getmedia/72d38d18-fd96-4a14-b763-f6fbc6d6062d/RCGP-principle-leaflet-2019.pdf

Royal College of Emergency medicine Guidance when discharging patients to General Practice

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

Outpatient Recovery and Transformation Programme

Specialist Advice Services

- Specialist Advice and Clinical Responsibility
- Frequently Asked Questions (FAQs)

Specialist Advice Services Medicolegal coverage and liability Frequently Asked Questions (FAQs)

- Reference Cheshire document.
- Ref: PCCC Primary Secondary care interface (2021)

Delivery plan for recovering access to primary care (NHSE May 2023)

Royal Cornwall Hospitals NHS Trust
https://royalcornwallhospitals.nhs.uk/waiting-times/

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