Dudley Health and Care Partnership

Primary, Community and Secondary Care

Our principles for collaboration and partnership

Connecting communities and coordinating care to help citizens live longer, safer and healthier lives.

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Foreword

Contents

Dudley Health and Care Partnerships will do all that it can to optimise access to the right care and pathways to ensure that 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 has become commonplace, and we must grasp the opportunities within Dudley to address this.

We believe this 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 commit to 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 are 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.

The Covid-19 pandemic has led to significant excess demand across the entire NHS system. It is imperative we work together while tackling increasing presentations and lengthening waiting lists.

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. It is about cooperation and supporting one another and our teams.

We are aware that more detailed work will need to be done to bring the consensus to life locally and define what some of the principles mean in reality. 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 Dudley in line with the values that have been developed by the Dudley Health and Care Partnership Board. (see appendix)

Principles of Collaboration and Partnership

Treat all colleagues with respect
Remember to keep the patient at the centre of all we do

There is an underlying principle that clinicians should seek to undertake any required actions themselves without asking other teams or services to do this. 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 the management plan, and informing the patient.
- There may be some exceptions around shared care and potentially the Emergency Department (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.
- In the case of transfers of clinical responsibility following ED attendance, the expectation is that, wherever possible, primary care matters are followed-up in primary care and matters requiring secondary care intervention and/or advice are followed up in secondary care.
- Consideration needs to be given to the management of incidental findings, whether these need further investigation and if so, by whom. Generally, 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.

We will 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.

We will 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 the ED when clinically required)
- Ideally this should be in a written format and referenced within the discharge summary.
- If in doubt about the most appropriate course of action, consider the most effective means of communicating with relevant colleagues. This could involve:-
  - Secondary care to primary care contact via the GP Clinical Professional phone lines
  - Primary care to secondary care contact either direct to the relevant consultant or their secretary (using contact information from previous communications or as listed on www.dgft.nhs.uk/gps)

    or
  - making effective use of the Advice and Guidance process

Principles of Collaboration and Partnership

We will ensure patients referred to secondary care are kept informed about their waiting list status. As of February 2023, this is being done on a temporary and targeted basis in certain specialties via the patient portal. There is potential to roll this out further. Secondary care will communicate with the patients to ensure they know their referral has been received, how long the wait may be and what to do in the event of a deterioration in their condition.

The clinician who wishes to prescribe medication for the patient is asked to 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.

Please try not to commit other individuals or teams to any particular action or timescale without consideration with them beforehand.

In addition to bringing clarity to the discrete clinical responsibilities of primary and secondary care clinicians, respectively, there is also a need to recognise the existence of areas of shared responsibility around community services (e.g. Community Partnership Teams (formally ICTs) and virtual wards). The same principles and values described here also apply to such areas and there may need to be a discussion to clarify the nature of shared responsibilities in particular cases.

We will consider using all opportunities at Community Partnership Team meetings to discuss complex cases jointly, which may alleviate the need for a formal referral to outpatients and can facilitate step-up to a virtual ward where required. In a similar vein it can be the conduit for consultants to bring cases for step-down to primary care and as a safety net following discharge from a virtual ward.

Principles for primary care

When considering a referral to secondary care outpatients, we will ensure that:-

- Appropriate investigations are first undertaken in the community using the Integrated Clinical Environment (ICE) diagnostic system (e.g. community phlebotomy and diagnostics)
- The reason for referral is clear and in a suitable format
- The recipient understands what you are asking for – e.g. advice, diagnosis, or treatment
- The reason for referral is explicit – avoid 'please see GP summary/consultation'
- An up-to-date medication list is available along with investigations carried out to date
- The patient's expectations are clearly understood and communicated
- Up to date local pathways for open access diagnostics are used. Abbreviations and acronyms are avoided - these may be commonplace within your team but may not be understood in secondary care

When referring to secondary care we will ensure appropriate primary care assessments have been made and other processes reviewed as suggested below:

- Local pathways for pre-referral criteria and potential investigations
- Consultant advice and guidance.
- Other sources of help and guidance.
- Face to face assessment to add value before referral (both elective and emergency) e.g. 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 the physical/frailty status of the patient.

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

- At this current time as we recover from the impact of the Covid-19 pandemic advise the patient that waiting lists may be long and that first contact may be a remote consultation.
- Refer the patient to the portal to check current waiting times.
- Ensure you understand and document any communication needs of the patient and use suitable forms of communication e.g. easy reading leaflets. Also ensure this information is made available to secondary care.

When referring with the expectation that an operative procedure may ultimately be required, we will aim to optimise any long-term conditions:-

- BP control for hypertensives, glycaemic control for those with diabetes etc.
- Empower patients to optimise their own health in the waiting period e.g. smoking cessation advice, weight advice etc to reduce the impact of last-minute cancellations in pre-op clinic.

Principles for secondary care

We will 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.
- Highlight any changes in medication and reasons for those changes.
- Avoid the use of 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 outstanding test results will be reviewed.
- Be explicitly clear about any requests/actions for the GP.
- If you want the GP to monitor the patient clinically as part of their ongoing care, state 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 (up to 30 days), please arrange this to avoid potential delays.

We will 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 or domiciliary phlebotomy as required.
- 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) we will provide one and ensure that this is for an appropriate period rather than a standard 2 week note by default.

- Outpatients should be issued fit notes rather than the patient being sent back to the GP.
- Trusts should ensure fit notes are available for colleagues in outpatients.

If immediate prescribing is required from Outpatients or on discharge:-

- We will prescribe on the pink form for the patient to take to the hospital pharmacy for immediate supply or via FP10 (HP) when the pharmacy department is closed. Longer term discharge medications should cover an initial period of at least 14 days. We will make use of the Discharge Medicines Service, nationally commissioned from community pharmacy. 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.
- All electronic referrals made under this system contain the nationally agreed dataset and use the hospital's 'Sunrise' system The discharge medicines service toolkit references both high risk medicines and high risk patients appropriate to send information on – this should be the minimum. When recommending ongoing prescribing from the GP we will check the locally agreed Prescribing Formulary first:-
  - It is important to check that the suggested medication is appropriate for the GP to prescribe. The Integrated Care Board (ICB) formulary is under development which uses a traffic light system and is being released a chapter at a time:- dudleyformulary.nhs.uk
  - See also Dudley formulary website: blackcountryformulary.nhs.uk

Principles for secondary care

We will refer all patients discharged on a smoking cessation pathway from secondary care to the integrated wellbeing service currently provided by ABL Health.

We will ensure there are clear 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. We will ensure any do not attends (DNAs) are not automatically discharged without a review of ongoing clinical need.

- Any discharge should be communicated to the patient and GP with the 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.

Whilst past advice sought to limit consultant-to-consultant referrals, onward referral without referring back to the GP should be considered to ensure that patients are seen in an appropriate and timely manner.

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, the respiratory consultant should arrange the urgent referral to renal)

If the problem is unrelated to the original reason for referral, this can be passed back to the GP to consider (e.g. patient in respiratory clinic describes non-urgent abdominal symptoms). Any action necessary in relation to your last clinical contact with the patient should remain your responsibility within 30 days and this would include blood tests, prescribing and referral to other specialists as well as trying to sort out any complications from recent interventions. As such any follow up tests and results following discharge remain the responsibility of the hospital team. We will remind our juniors of the need to issue blood forms to patients and arrange x-rays rather than asking GPs to arrange. Similarly, if you are undertaking virtual clinics and intend to issue urgent new medication, please issue the medication as appropriate even if this entails sending the prescription by post or asking the patient to come to the hospital to collect.

Approach to Learning and Improvement

These principles will need to continue to evolve as circumstances change and further experience in gained.

Where it is felt that a clinical colleague has not acted in line with these principles, we invite the relevant colleagues to discuss this between themselves in the first instance. These are opportunities for learning – for the whole system – and discussions should reflect the values of the Dudley Health and Care Partnership (included in Appendix)

Our Primary, Community and Secondary Care Interface Group also provides a forum where the effectiveness of these principles can be reviewed and revised from time to time, so that we can continue to ensure we collaborate in providing timely, appropriate and effective care to our patients.

Issues can be escalated to the following:-

Director of Strategy and Integration

Medical Director

Place Clinical Lead

Dudley Health and Care Partnership

Connecting communities and coordinating care to help citizens live longer, safer and healthier lives.

@DudleyGroupNHS www.dgft.nhs.uk

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