Consensus on the NCL Primary & Secondary Care Interface

Interface Steering Group

North Central London Integrated Care System

Contents

This document was created in collaboration with the following groups and organisations:

- NCL Interface Steering Group
- University College London Hospital Clinical Interface Group
- Royal Free London Clinical Interface Group
- Whittington University Hospital Clinical Interface Group
- North Middlesex University Joint Planned Care Board & Clinical Interface Group

Owned and maintained by North Central London Integrated Care Board – Interface Steering Group (ISG).

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Foreword

The focus for the North Central London Integrated Care System is on providing care and support that improves the health and wellbeing of everyone living in our boroughs. North Central London Integrated Care system and Integrated Care Board were formally established in July 2022. Despite the challenges of the past few years, we continue to build stronger partnerships, relationships, and develop new ways of working as a system. There is more we can do to establish joint working arrangements and empower clinicians to collaborate better across primary and secondary care. Moreover, we believe that these joint arrangements will reduce administrative workload across the system, freeing up professionals' time and improving patient experience.

Trust and effective communication between professional colleagues across organisational boundaries is a key requisite in creating this system, in order to build confidence in our expected behaviours and actions. This personification of trust and mutual accountability is contained within this document, and it should be seen as a starting point for local conversations. Through creating local connections and relationships, we hope to recognise and eliminate the gaps between our services. Our patients rightly expect us to work collaboratively as one team, and this will only be achieved through developing ever closer working relationships over time.

This document is split into three sections, with recommendations for both Primary and Secondary Care clinicians. We have been excited to hear enthusiasm from other sectors, such as Tertiary Care, Community, and Mental Health sectors for a similar consensus that enables closer working across all organisations within our wider system and hope to use the lessons learnt from this Primary and Secondary Care Consensus to replicate the process elsewhere.

This document is not exhaustive, and there will at times be clinical scenarios which do not fit neatly into one of examples below. To that end, we continue to rely on clinicians' professional judgement in managing these cases. Moreover, these principles should not be viewed as 'rules' to be strictly followed, but instead as best practice recommendations that help us to keep the patient at the centre of all we do, especially during the transitions back and forth between organisations.

We hope that this Consensus document, and its Summary version, prove to be useful to front-line staff in delivering collaborative and seamless care between Primary and Secondary services. We also hope that it serves as a useful stimulus for local teams to consider their response and how they may work more closely together moving forwards.

At times these changes will feel tricky and challenging. With ever increasing competing priorities it is key we treat each other with kindness and compassion and find ways to improve the patient and workforce experience.

I am immensely grateful to all the colleagues involved in the development of this shared Consensus document and to Dr Jay Mehta and Sophie Donellan for their support. Thank you particularly to all the chairs of Clinical Interface groups, LMC, GPPA, Medicines team and Dr John McGrath for their endorsement, contributions and leadership.

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Why Are We Doing This?

What Is It?
The Consensus is a set of principles to guide NHS staff in North Central London working in primary and secondary care.

These principles should form our baseline expectations of each other and are not expected to supersede any existing local agreements.

Who Are We?
The North Central London Integrated Care Board (NCL ICB) is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the ICS area.

The Interface Steering Group (ISG) is a group of senior clinicians brought together by the ICB that represent primary and secondary care organisations across North Central London.

Why Are We Doing This?
We believe that, as a system, we can deliver the best care for our population and patients when we are able to collaborate and work together across organisational boundaries and disciplines.

This consensus is a key starting point for building these local relationships: by setting out the principles and behaviours that we believe are essential to deliver safe and sustainable patient care, we hope to build trust, mutual accountability and confidence in our expected behaviours and actions.

How Can I Help?
We want as many primary and secondary care staff in North Central London to engage with this consensus and together drive better collaboration across the primary and secondary care interface.

We expect that this will not be a one-off or static process; as clinical medicine changes over time and our expectations of each other change, we must continually reinforce and update this consensus to meet current needs.

We therefore recommend all staff to embed the principles of this consensus into their regular clinical ways of working, and continually give us feedback on the areas that need updating.

What about other sectors?
This consensus only covers the interface between the primary and secondary care sector in NHS North Central London.

We will take the lessons learnt from the development and implementation of this consensus, and hope to replicate this process for tertiary care, mental health providers, community care providers, social care and further sectors over time. If you would like to volunteer to be part of this work, please contact us.

The following principles are supported by clinical and non-clinical staff across North Central London. 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 of the patients we serve.

This document should be used as a starting point for us to consider our own norms and ways of working, and initiate conversations across the system. It is expected to form our guiding principles, standardising the way we work across the NCL. This is work in progress and where local agreements are already in place, we expect those agreements to supersede this consensus and, over time as relationships strengthen and priorities align, we expect this to be adopted as the new standard.

Principles for all

1. **Treat all colleagues with respect.**

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

3. **There is an underlying principle that clinicians should seek to undertake any required clinical actions themselves, without asking other teams to do this.**
    a. 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.

4. **Whoever requests a test is responsible for the results of that test.**
    a. This includes 'chasing' the results, receiving the results, actioning the results/determining management plan, and informing the patient of the results.
    b. Consideration needs to be given to the management of incidental findings, whether these need further investigation and if so, by who. We urge local organisations to clarify such pathways to avoid duplication, inappropriate investigation, or failure to further investigate where appropriate. In line with GMC guidance, we expect the requesting clinician to take responsibility for informing the patient of the findings and managing these, if within their competency. If urgent action is required, we would not expect this to be passed onto another clinician.

5. **Emergency Departments (EDs) responsibility for tests.**
    a. Generally, EDs should not ask GPs to chase acute investigation results.
    b. Non-acute abnormal findings in ED should generally be referred to primary care for onward management.
    c. We recognise that transfers of care from ED attendances are a particular area of potential difficulty and would suggest that Royal College of Emergency Medicine (RCEM) guidance on this topic is implemented.

6. **Ensure robust systems are in place for patients to receive results of investigations, and that they understand what is going to happen.**
    a. Secondary Care should avoid directing patients to GPs for results and vice versa, unless agreed otherwise in a local pathway or shared care protocol.
    b. Organisations should ensure processes are in place for patients to directly receive their results, instead of asking another clinician to follow them up.

7. **Ensure patients are kept fully informed regarding their care and 'what is going to happen next'.**
    a. 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 ED when clinically required).
    b. Ideally this should be in a written format and referenced within the discharge summary, clinic outcome letters or consultation notes.
    c. However, patients should not be the main communication vehicle for medical information between teams and should not replace clinical communication.

8. **Consider speaking to or messaging colleagues if in doubt.**
    a. Organisations should consider how they might facilitate easy, prompt access to communicating with clinicians between different services.
    b. This may include telephone calls, or asynchronous methods such as email (via a *secure nhs.net account*), Advice and Guidance, Consultant Connect and other models.
    c. Practices and departments are encouraged to make their specific communication details clear on their correspondence, and to make their non-public/bypass telephone numbers available on the NHS Service Finder.

9. **Consider a process of 'Waiting Well' for patients referred to secondary care.**
    a. As a Gold-Standard, 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.
    b. This will likely require work at Place level across Primary and Secondary Care so that this process can start at the point of referral with the Primary Care clinician empowered with knowledge of what to expect and red flags to watch out for, and Secondary Care teams who have awareness of their waiting lists empowered to be able to deliver regular and timely updates on the wait.
    c. Consider Making Every Contact Count in all pathways, e.g., smoking cessation.

10. **When referring a patient to the Emergency Department, please ensure the patient is expected by, or has at least been signposted to a speciality team.**

11. **The clinician who wishes to initiate a prescribed 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.
    b. If prescriptions are to be continued by another clinician (e.g., a GP continuing a repeat prescription), the clinician initiating the medication should communicate the information above in a timely manner.
    c. There may be some exceptions/agreements around shared care (e.g., in mental health).

12. **Try not to commit other individuals or teams to any action or timescale.**

13. **Use standardised referral forms and IT systems (e.g., Swiftqueue, T-Quest and eRS) where available.**

14. **It should be understood that patients do not always fit into pathways and secondary care should not automatically refuse a referral if it does not appear to fit the pathway.**

Principles for Primary Care

15. **When referring to secondary care please ensure you are clear in your 'ask'.**
    a. Why are you referring this patient? Are you looking for advice, diagnosis, treatment? And what are the patient's expectations?
    b. Please clearly articulate the reason for referral, and don't just put 'please see GP summary/consultation'.
    c. Ensure an up-to-date medication list is available along with investigations.
    d. Ensure patient contact details are up to date and highlight any vulnerabilities they may have in accessing care.
    e. Please avoid unnecessary information in referrals, including all relevant test results and documentation and referring to shared health records for further detail.
    f. If referring looking for a diagnostic procedure, please check local pathways for open access opportunities (e.g., endoscopy, MRI etc.).
    g. Please avoid using abbreviations and acronyms. These may be common within your team but may not be understood in Secondary Care.
    h. Please use standardised referral forms where available and if not possible, ensure that all necessary information is provided in an appropriate format to avoid referral rejection.

16. **When referring to secondary care please ensure appropriate Primary Care assessments have been made.**
    a. Check local pathways for pre-referral criteria and potential investigations (e.g., NCL Website).
    b. Refer to Single Points of Access (SPOAs) where available for enhanced triage.
    c. Consider advice and guidance, advice and refer and/or consultant connect.
    d. Consider other sources of help and guidance.
    e. Consider when face to face assessment may add value before referral (both elective and emergency).
    f. Remember, 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 physical/frailty status of the patient.

17. **When referring to secondary care please clearly communicate to the patient who you are referring them to, for what and what to expect (if known).**
    a. Please advise the patient that waiting lists may be long and that first contact may be a remote consultation.
    b. Consider the use of Easy Read patient leaflets (where available) to inform patients about their condition.
    c. Consider giving patients the contact details to be able to chase appointments themselves.

18. **When referring with the expectation that an operative procedure may ultimately be required, please consider optimising any Long-Term Conditions, and directing patients to waiting well resources.**
    a. BP control for hypertensives, glycaemic control for those with diabetes etc.
    b. Please do empower patients to optimise their own health in the waiting period, e.g., smoking cessation referrals, weight management advice etc.
    c. This will reduce the impact of last-minute cancellations in pre-op clinic.

Principles for Secondary Care

19. **Ensure clear and timely communication to GPs & patients after patient contacts.**
    a. This applies to both Outpatients and on discharge from Inpatients and ED.
    b. Please highlight any changes in medication and reasons for any changes.
    c. Please avoid using abbreviations and acronyms. These may be commonplace within your team but may not be understood in Primary Care.
    d. Be clear about what follow up is required, how it will be provided and how any outstanding test results will be reviewed.
    e. Where feasible, local agreements on how best to keep GPs informed and sighted on patient progress is encouraged.
    f. Be explicitly clear about any requests/actions for the GP:
    i. If you want the GP to 'monitor' U&E for example, please say why, how often, for how long and what your expectations are if abnormal.
    ii. If you need a repeat test within a short period of time i.e., 2 weeks or less, please arrange this directly to avoid potential delays.

20. **Avoid asking General Practice to organise tests necessary for the hospital team's management of the patient.**
    a. If you want the patient to have their blood test closer to home, please do not ask GPs to request this.
    b. Trusts are encouraged to ensure that access to community phlebotomy/diagnostics is available and understood by hospital colleagues.
    c. If a clinician wishes the patient to have further tests prior to next review or pre-operatively, they should look to undertake these investigations themselves.
    d. Surveillance tests should not generally require a new referral (e.g., 3-yearly endoscopy).

21. **If a new, acute fit note (sick note) is indicated (e.g., following surgery), please provide it instead of directing patients to their GP.**
    a. Please also ensure this is for an appropriate time period.
    b. Trusts should ensure fit notes are available in wards and clinics, and that clinicians are familiar with issuing them.
    c. EDs are only expected to issue fit notes when it is expected that the patient will require more than one week off work. Patients can initially self-certify as sick for seven days.
    d. Where there is uncertainty about long-term fit notes, or reviewing fitness to return to work, please follow national guidance or refer back to the GP.

22. **If immediate prescribing is required from Outpatients, please prescribe.**
    a. We would suggest work on electronic prescribing for hospitals to community pharmacies (e.g. the Electronic Prescription Service) is accelerated.
    b. If EPS is not available, a hospital out-patient prescription should be provided to the patient and arrangements made for them to receive this if the appointment is virtual.

23. **Discharge medications and outpatient prescriptions should cover the minimum duration (14 days) specified in the NCL Interface Prescribing Guidance**

24. **Make use of the Discharge Medicines Service, nationally commissioned from community pharmacy**
    a. 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.
    b. Ensure all electronic referrals made under this system contain the nationally agreed dataset.
    c. The toolkit references both high risk medicines and high-risk patients appropriate to send information on – this should be the minimum.

25. **When recommending ongoing prescribing from the GP please ensure this is in line with NCL Interface Prescribing Guidance first**
    a. Please check the suggested medication is appropriate for a GP to prescribe. *See NCL Red List*
    b. Document and communicate to General Practice your discussion with the patient on rationale for treatment, including benefits, risks & alternatives, and any monitoring requirements, to avoid GPs repeating this consultation.

26. **Please consider follow up plans in place for inpatients who self-discharge.**
    a. 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 required.
    b. This also includes providing appropriate discharge care and medication.

27. **If a patient does not attend an appointment (especially vulnerable patients), the decision to discharge or re-schedule should be made by a clinician who can review the reason for referral and judge the potential severity of disease.**
    a. Consider whether the requirements of the Access Policy have been met in the arrangement of the appointment, including adjustments required for those patients requiring additional support.
    b. Ensure consideration has been taken regarding reasonable attempts for virtual appointments.
    c. Please ensure any discharge is addressed to the patient with the reason why and the trust's contact details, copied to the GP for information. Patients should be informed of the most appropriate contact details to rearrange within the leeway time offered rather than directed to their GP.
    d. If patients are transferred to patient initiated follow up (PIFU) or seen on symptoms pathways, please ensure you clearly reference the criteria and instructions on how to access a further appointment.

28. **Please arrange onward referrals without referring back to the GP where appropriate (excludes non-acute referrals within ED)**
    a. A hospital clinician should be expected to arrange an onward referral for patients based within North Central London 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 refer to cardiology.
        ii. A serious and very urgent problem comes to light, e.g., CT chest ordered by respiratory team shows a renal tumour, the respiratory

consultant should arrange the urgent referral to renal.

b. Please see the NCL Consultant to Consultant (C2C) Referral Pathway for further details.
c. If the problem is unrelated to the original reason for referral and is not urgent, or if the patient is not based within North Central London, please write back to the GP to consider appropriate investigations and follow up e.g., patient in respiratory clinic describes abdominal symptoms.

Reference documents used to inform these principles

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Version History

Version	Summary of Changes	Date	Actioned By
0.1	First Draft	07/10/2022	Dr Jay Mehta, GP Registrar
0.2	Foreword and first review comments	20/10/2022	Dr John McGrath and Sophie Donnellan
0.3	Why Are We Doing This section added	09/11/2022	Dr Jay Mehta and Rachel Leuw
0.4	Feedback from consultation	08/06/2023	Dr Jay Mehta
0.5	Review on consultation update	22/06/2023	Dr Sonali Kinra and Sophie Donnellan
0.6	Formatting changes, incorporating feedback	29/06/2023	Dr Jay Mehta
0.7	Review and updated forward	13/07/2023	Dr Sonali Kinra and Sophie Donnellan
0.8	Feedback from LMC		Dr Sonali Kinra and Sophie Donnellan
0.9	Formatting changes and final checks	23/10/2023	Dr Sonali Kinra and Sophie Donnellan
1	Formatting changes and final checks	January 2024	Dr Sonali Kinra
1.1	Formatting changes. Links updated to NCL Interface Prescribing Guidance 2024/25 v13. Links updated from NCL MON website to NCL Health and Care website.	03/10/2024	Dr Sonali Kinra