

The interface between primary
and secondary care

Key messages for NHS clinicians and managers

In partnership with:



**NHS England and
NHS Improvement**



Royal College of
General Practitioners



Good organisation of care across the interface between general practice and secondary care providers is crucial in ensuring that patients receive high-quality care and in making the best use of clinical time and NHS resources in both settings. This briefing document describes the key national requirements which clinicians and managers across the NHS need to be aware of. These are set out in the new NHS Standard Contract for 2017-19, under which clinical commissioning groups (CCGs) commission health services from providers, which came into effect on 1 April 2017 and which will remain in place until 31 March 2019.

NHS England updates the content of the NHS Standard Contract periodically. The next major review is likely to take place during 2018. If you wish to give views on the contract requirements set out in this document, please email england.contractsengagement@nhs.net

Referrals into secondary care

It is important, in terms of patient experience and service efficiency, that GP referrals to providers are clinically appropriate for the service referred to, are made in accordance with any agreed clinical pathways and referral protocols, and include all the necessary clinical and administrative information. The contract requires CCGs to ensure that this is what happens in practice.

Managing DNAs and re-referrals

Where providers automatically discharge all patients who do not attend a clinic appointment back to their GP, this can create inconvenience and delays for patients and cause significant additional work for practices in simply re-referring many of the patients. Provider procedures for managing DNAs are set out in local access policies, which are published on their websites. The contract requires that a provider's local access policy must not involve blanket administrative policies under which all DNAs are automatically discharged; rather, any decisions to discharge are to be made by providers on the basis of clinical advice about the individual patient's circumstances.

Managing onward referrals

It is important that there is clarity about situations in which provider clinicians may make onward referrals. Where a patient has been referred to one service within a provider by the GP, or has presented as an emergency, the contract allows the provider clinician to make an onward outpatient referral to any other service, without the need for referral back to the GP, where:

- either the onward referral is directly related to the condition for which the original referral was made or which caused the emergency presentation (unless there is a specific local CCG policy in place requiring a specific approach for a particular care pathway);
- or the patient has an immediate need for investigation or treatment (suspected cancer, for instance).

By contrast, the contract does not permit a hospital clinician to refer onwards where a patient's condition is non-urgent and where the condition for which the referral would be made is not directly related to the condition which caused

the original GP referral or emergency presentation. In this situation, the contract requires the hospital clinician to refer back to the patient's GP. If the GP agrees, the onward referral can then be made (either by the provider clinician or by the GP but the GP may instead choose to manage the patient's condition him/herself or to refer into a different service.

Managing patient care and investigations

CCGs have a key role in commissioning services and designing care pathways so that they operate in, a clinically appropriate, efficient and convenient way for patients. Depending on local commissioning arrangements, different secondary care providers and general practice may each have a role to play in delivering a particular care pathway. However, the contract makes clear that, within the context of the elements of the service which it has been commissioned to provide, a secondary care provider must itself arrange and carry out all of the necessary steps in a patient's care and treatment rather than, for instance, requesting the patient's GP to undertake particular tests within the practice.

Communicating with patients and responding to their queries

It is important that providers take responsibility for managing and responding to queries received from patients. There are instances where providers simply refer questions about a patient's secondary care to the GP, and the contract makes clear that this is not acceptable. It requires the provider to:

- put in place efficient arrangements for handling patient queries promptly and publicise these arrangements to patients and GPs, on websites and appointment/admission letters and ensure that they respond properly to patient queries themselves, rather than simply passing them to practices to deal with;
- communicate the results of investigations and tests carried out by the provider to patients directly, rather than relying on the practice to do so (except in the case of GP direct access diagnostic services). (Note that all clinicians, whether in primary or secondary care, retain

clinical and medico-responsibility for the results of investigations which they personally request; sending a result on to another clinician does not absolve the original requester of that responsibility).

Discharge summaries and clinic letters

Communication between provider and GP, which is unclear or not timely, may cause inconvenience to patients and create inefficiency in how staff time is used. It is obviously essential for good patient care that there is clear and prompt communication on discharge from hospital, and also at key stages during an outpatient pathway. For this reason, the contract sets out clear requirements on providers in terms of the provision of discharge summaries and clinic letters to GPs.

- A discharge summary must be sent to the GP within 24 hours after every discharge from inpatient, day case or A&E care.

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- A clinic letter is not required after every single attendance but, as a minimum, one must be sent after any clinic attendance where the secondary care health professionals need to pass information to the GP so that he/she can take action in relation to the patient's ongoing care. Where required, providers must send clinic letters within 10 days of the patient's attendance (this reduces to seven days from 1 April 2018). (Clearly, if the GP does not receive a letter following an outpatient attendance, he/she will assume there is no action to be taken. And it is good practice, though not a specific contract requirement, for a letter to be sent where there is a material change in the patient's condition or its management, even where there is no need for the GP to take specific action as a result)
- Discharge summaries following inpatient or day case admission must already be sent electronically as structured messages of coded clinical information using standardised clinical headings. From 1 October 2018, this requirement also applies to clinic letters and to discharge summaries after A&E attendance.
- As a matter of good practice, clinicians in both primary and secondary care should consider the content of communication carefully; a good way of assessing the quality of a letter/summary is to review it in the eyes of the recipient.

Medication and shared care protocols

It is important that the responsibilities of providers and practices are clear, in terms of supply of medication to patients following hospital admission or attendance. Provision of insufficient quantity of medication from secondary care can mean that patients run out of medication, with adverse effects for their care, and have to make avoidable extra appointments with their GP, and the GP will not be able to prescribe appropriately if he/she has not received up-to-date information from the hospital about the patient's care.

The contract allows the period for which the provider must supply medication to be determined in a local policy, but this must at least cover a minimum period.

- For medication on discharge following hospital admission, the minimum period is seven days (unless a shorter period is clinically appropriate).
- Where a patient has an immediate need for medication as a result of clinic attendance, the provider must supply sufficient medication to last at least up to the point at which the clinic letter can reasonably be expected to have reached the GP and the GP can prescribe accordingly.

Shared care protocols can enable care to be provided more conveniently and closer to home for patients. Such protocols are for agreement locally, and introduction of a new protocol may sometimes require the CCG to commission a new local service from practices. However, the contract makes clear that the hospital must only initiate care for a particular patient under a shared care protocol where the individual GP has confirmed willingness to accept clinical responsibility for the patient in question. Where this is not the case, the ongoing prescribing and related monitoring will remain the responsibility of the secondary care team.

Fit notes

It is important that fit notes are issued to patients in a way which is convenient for them and which is efficient in how clinical staff time is used. Where there is an appropriate opportunity (on discharge from hospital or at clinic), provider clinicians must issue fit notes to appropriate patients, and their organisations must enable this, rather than expecting patients to make a separate appointment to see their GP simply for this purpose. The contract includes a requirement to this effect.

The contract also requires that fit notes cover an appropriate period, that is, until the patient is expected to be fit for work (following surgery, for example) or until a further clinical review will be required. (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.)

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