Primary/Secondary care agreement

August 2018

1. Local access policies - Did Not Attends (DNAs)

All patients who DNA secondary care appointments should have their notes reviewed by a senior clinician. If follow up is required, at least one further attempt at contact should be made before notifying the GP. The clinic letters to the GP should contain the following wording to make this clear:

"The above patient has failed to attend two clinic appointments at the hospital. We have tried to contact the patient to understand the reasons behind this, but have not been successful in getting in touch with them. The patient has therefore been discharged from clinic. Please do re-refer the patient if the clinical condition is still persisting."

If the above process is not followed, GPs should respond with the **BMA template letter**.

Patients who are unable to attend appointments and who notify the hospital of this fact either before or soon after their appointment should be reappointed without further involvement of the GP.

2. Local access policies (onward referral of patients)

Referrals arising from out-patient, in-patient, or A&E attendances should be made without involving the GP in specific circumstances. The hospital clinician will make an onward referral to any other service, without the need for referral back to the GP where:

- The onward referral is related to the condition for which the original referral was made or which caused the emergency presentation, or
- The patient has an urgent need for investigation or treatment.

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.

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3. Clinic appointments (expediting letters)

Patients contacting medical secretaries enquiring about their appointment dates should not be referred back to the GP for 'expediting letters'. These letters serve no purpose apart from getting the patient off the phone with an unrealistic expectation that the GP can alter the appointment date. If the clinical condition changes, then it is reasonable for the patient to return to their GP to be reassessed. However, if the clinical condition does not change, only the hospital consultant knows how long the wait will be and how the urgency of the patient compares to others on the waiting list.

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4. Managing patient care and investigations

If a patient is referred to secondary care for a particular problem/condition, the secondary care providers must arrange and carry out all of the necessary steps in a patient's care and treatment related to that particular problem/condition rather than, for instance, requesting the patient's GP to undertake these within the practice. They will organise the different steps in a care pathway promptly and communicate clearly with patients and GPs. This will include notifying patients of the results of clinical investigations and treatments in an appropriate and cost-effective manner, eg, telephoning the patient. The responsibility of following up investigations rests with the clinician who has requested it.

If secondary care identifies an unrelated problem this should be communicated to the patient and to the GP for further assessment and management as appropriate. The clinic letters to the GP should contain the following wording to make this clear:

"The patient was also noted to have..., which is not connected to the problem that they were referred for. May I therefore pass this on to you to action as you feel appropriate?"

5. Clinic letters and discharge summaries

A clinic letter is not required after every single attendance. However, as a minimum, a clinic letter must be sent after any clinic attendance where the secondary care clinicians need to pass information to the GP so that they
can take action in relation to the patient's ongoing care. Providers must send clinic letters within seven days of th e patient's attendance. Clearly, if the GP does not receive a letter following an outpatient attendance, they will assume there is no action to be taken. It is stated as good practice 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 should:

- Be sent to the GP within 24 hours of discharge.
- Always have the name and contact details of both the author and the consultant.
- Make very clear the follow up arrangement in hospital.
- State the discharge location, noting if this is not the patient's normal place of residence.
- Be copied to the patient.
- Indicate new or discontinued medication.

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6. Medication requests

Providers will supply patients with medication following discharge from inpatient or day case care. Medication must be supplied for the period established in local practice or protocols, but must be for a minimum of seven days (unless a shorter period is clinically necessary).

Routine prescriptions arising from out-patients should be communicated to the GP including, where applicable, the rationale for the change in prescriptions. A seven day window from the practice receiving this communication and issuing a prescription is reasonable for non-urgent medication. Urgent prescriptions arising from out-patient attendances should be provided from the hospital pharmacy for urgent needs, or if out-of-hours, by utilisation of a hospital/FP10 prescription.

7. Shared care protocols

Shared care protocols, particularly with regard to the need for pre-prescribing counselling, investigation, and post-prescribing stabilisation, should be followed where the recommending doctor and receiving doctor are content with the shared care agreement. 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. Where a GP is not willing to take on the shared care responsibility, the LMC recommends a conversation is initiated with secondary care colleagues directly to explore ways of addressing the barriers. Read our Shared Care Protocol guidance for further information.

8. MED3 (FitNotes)

The statutory requirement that the doctor in charge of the episode of care has to offer MED3 certificates for the duration of the illness and acknowledged that this needs to be honoured. Where there is an appropriate opportunity (on discharge from hospital or at clinic), provider clinicians must issue fit notes to appropriate patients. Also their organisations must enable this, rather than expecting patients to make a separate appointment to see their GP simply for this purpose. The contract also requires that fit notes cover an appropriate period, that is, until the patient is expected to be fit for work (eg, following surgery) 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.

9. Follow up

The hospital needs a robust system for notifying patients of, and acting on, investigations that they have ordered either during in-patient care or arising out of out-patient or A&E attendances. Where patients have not received results of investigation that they were expecting, the hospital needs to have a system for patients to obtain the information that they need. If a hospital clinician initiates a test or investigation it is the hospital team's responsibility to follow up on the test result. At discharge, if no hospital follow up is planned, then the patient should be advised that follow up in general practice will be on an as needed basis rather than routine. The range of symptoms considered outside the "norm" during recovery (and requiring GP help) will be clearly communicated to the patient prior to discharge. Patients will from time to time contact either primary or secondary care following a visit or in-patient stay, if this query can be dealt with by the receiving clinician then this is in the patient's best interests. A blanket response that it is someone else's responsibility is not acceptable.

If follow up is needed by the GP or practice nurse, the responsibility for organising this should be given to the patient, and this fact made clear in correspondence with the GP. Recommendations in hospital communications to GPs (eg, about changes to medication or management plans) requiring patient contact with the GP, should make it clear that the hospital has asked the patient to contact the practice.

10. Communications with patients

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

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