



Cymru Wales



Llywodraeth Cymru
Welsh Government

All Wales Communication Standards between General Medical Practitioners and Secondary care



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September 2018

Section 1 - Standards

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Section 1- Standards

Standards Communication, referral and delegation standards	
1	Letters sent following an outpatient consultation should be addressed to the referring GP or Consultant. If sent to a referring consultant it should be copied to the patients registered GP.
2	Results of investigations remain the responsibility of the requesting clinician.
3	It is the responsibility of the requesting doctor to arrange for investigations to be carried out.
4	The referring GP should be informed in each case where the priority of a referral is altered by, from that assigned in the referral. The GP referral should contain all information which is used to determine the priority of the referral.
5	Onward referral of patients is the responsibility of hospital staff, where the condition is directly linked to the initial GP referral.
6	Patients who contact hospital staff in an attempt to expedite appointments should not routinely be advised to contact their GP.
7	Any doctor/specialist nurse referring a patient for a consultation with another specialist should ensure the patient understands the reason for the referral.
8	All correspondence between doctors in primary and secondary care should be dealt with promptly. This includes requests for further information by the receiving consultant.
9	GPs should not be asked to prescribe medication under shared care arrangements until formal agreement has been obtained by the requesting clinician.
10	The responsibility for issuing Med3 certificates lies with the clinician who advises the patient to refrain from work, and certificates issued should be of sufficient duration to cover expected work absence, subject to issuing guidance.
11	Where patients do not attend for out-patients appointments without giving notice, in line with WG guidelines for pathway management they will be discharged. Both the GP and patient should be advised of the discharge.
12	Patients should be offered a copy of referral and outpatient letters. Electronic letters can be sent when appropriate

Section 2 - Explanatory Notes

1. Standard 1

This standard comes from the Robert Powell enquiry (see below) but acknowledges that it is not possible in all circumstances.

It will occasionally not be possible to direct correspondence to a particular GP, e.g. when a locum refers, and in this case the Robert Powell enquiry states that practices must have a process in place to safely manage the situation. The standard as designated here also means that if the outpatient referral is from another hospital doctor the letter should go back to the referring consultant, though for completeness the letter should be copied to the registered GP.

Case illustration 1

Dr A refers a patient to OPD, who is seen by Consultant B; B replies by letter, however this is addressed to the registered GP, who on receipt of the correspondence has to look at the patient's record to determine which GP the letter needs to be passed on to. This may result in delays in patient treatment so should be avoided.

2. Standard 2

Case illustration 2:

A 56 year old man is referred by the GP to gastroenterology outpatients for the investigation of abnormal liver function tests. As part of the liver screen the patient has a blood glucose and lipid profile checked as risk factors for NAFLD. The patient is found to have a raised blood sugar and triglycerides. It is the responsibility of the requesting doctor to look at and act upon the test results. In this case acting upon the test results would then include informing both the patient and the GP and requesting the GP see the patient in the practice diabetic clinic.

The principle is that the requesting doctor is responsible for reviewing and acting upon the test results but the action may then include a referral either onwards or back to a GP. It is not appropriate however for results of hospital investigations to be faxed to the GP or vice versa without a prior agreement with the doctor receiving the results that they will contact the patient and act on the results.

3. Standard 3

Case illustration 3:

A 72 year old man is seen in his GP surgery complaining of progressive dysphagia and weight loss, he has little other medical history and is not a frequent attender at the surgery. The GP should refer to endoscopy for an open access endoscopy on a USC pathway; it would not be appropriate for the GP to refer to gastroenterology saying 'I would be grateful if you could arrange an endoscopy on this 72 year old man...'

The application of this standard will differ depending on the availability of direct access referral by GP.

Case illustration 4:

A 58 year old man: seen on the surgical acute intake after presenting to A&E with rectal bleeding which has happened on a number of occasions over the past few weeks. The bleeding is not immediately serious and the patient does not warrant emergency admission so the patient is discharged by the surgical team. The plan is that the patient needs a flexible sigmoidoscopy as an outpatient; it is the duty of the surgical team to arrange the flexible sigmoidoscopy, it would not be appropriate to ask the patient to see their GP to arrange the test.

However if the scenario were slightly different and the patient had had a single episode of fresh rectal bleeding on straining and the A&E doctor was satisfied this was a one off episode related to straining and rectal examination was normal, they might well advise the patient that if the bleeding reoccurs that they consult their GP with a view to direct referral to endoscopy for flexible sigmoidoscopy. In this case the GP must be notified that the patient has been given this advice

4. Standard 4

The assessment of priority of a referral can only be made on the basis of the information given on the referral letter and in many cases the priority classification will be based on national guidance. Thus the reason for request of urgent or USC must be clear in the referral letter. For further guidance on the information expected in a referral letter see BMA guidance 2007 and GMC guidance quoted below. If any doubt remains as to the appropriate priority further information should be sought from the referrer. Any change in the referral priority should be notified either automatically via referral portal or a standard letter stating the referral priority has been altered should be sent to the referring GP.

5. Standard 5

Case illustration 2 revisited

If the same 56 year old man is referred into the liver clinic and as part of the work up was found to have multiple gallstones and gall bladder inflammation with appearances suggesting recent passage of a stone then it would be the responsibility of the requesting consultant gastroenterologist to refer on to the surgical team.

If on examination this patient is found to have a longstanding problem with an eczematous rash on his back, he should be advised to see his GP routinely for this problem, not referred for a Consultant Dermatologist's opinion.

6. Standard 6

Patients frequently contact the hospital to expedite outpatient FU appointments and the response depends on the individual situation, If the patient is already passed the proposed appointment date i.e. they were due to be seen in 3 months and it is now over 3 months and the patient has not heard anything then the patient should have an appointment requested as soon as possible.

For some patient pathways there is an agreed mechanism where the secretary receiving the call can obtain advice for a specialist nurse or the patient can speak to a specialist nurse and they will expedite the appointment if clinically appropriate.

Where no such pathway exists the medical secretary will ask the responsible consultant if they are happy to expedite on the basis of the information given by the patient. If the appointment is agreed to be expedited the patient will be informed, if it is not felt to be clinically indicated the patient will also be informed.

If the patient disagrees with the decision they would be advised that they seek clinical review by their GP, if the relevant condition had changed, and if the GP felt expediting the appointment was appropriate on a clinical basis they would be expected to contact the consultant by letter or email to request an expedited appointment.

7. Standard 7

This standard is direct from the GMC guidance on referral (below). This ensures that the patient is expecting an appointment and if patients understand why they are being referred they are less likely not to attend. If there is information of a sensitive nature which the referrer does not feel it would be appropriate to share with the patient until information is more complete it may be appropriate not to give all the details but this would be expected to be a rare occurrence.

8. Standard 8

This standard required little further explanation except to reinforce the need for hospital departments and GP practices to have systems in place to ensure that urgent communications are dealt with during the absence of individual GPs and consultants e.g. annual leave or sick leave. With the increasing use of email for clinical queries it is imperative that when emails are not going to be checked eg for annual leave the doctor ensures that an out of office notice is posted to ensure any person emailing is aware that they will not get a response and that if they need an urgent response they will need to seek an alternative. Alternatively both practices and hospital departments could set up a central practice/department wide clinical email account with clear protocols for daily checking.

9. Standard 9

For specific medications where the GP GMS contract does not include prescription or monitoring of the medication all responsibility for the safe prescribing and monitoring lies with the initiating team until a shared care arrangement is agreed with the GP unless there are specific circumstances which might compromise patient safety and then there must be a direct contact between GP and hospital consultant/specialist and GP will only take responsibility if they agree and feel it is within their competence.

10. Standard 10

This is a reiteration of WG guidance. Patients in hospital should be given a Med3 certificate to cover the time in hospital and any expected recovery time before return to work. If there is uncertainty then a reasonable amount of time can be specified and only when this time expires should the patient return to the GP for reassessment.

Doctors are required to issue the Med 3 form, where appropriate, to patients for whom they provide clinical care. Guidance from the DWP makes it clear that this applies to all doctors including secondary care, tertiary/national centres, community hospitals, out patient departments and emergency departments.

Since the implementation of the new Med 3 (Fit note) in April 2010, the DWP has produced a range of guidance to support its usage and this includes guidance for hospital doctors: <https://www.gov.uk/government/publications/fit-note-guidance-for-hospital-doctors>

While in-patients are often issued with Med 10s, many hospital doctors are unaware that they should, when required, also issue Med 3s. Med 3s may be appropriate for social security and Statutory Sick Pay purposes for patients who are either incapable of work or who may be fit for work with support from their employer.

It is important that hospital doctors have access to Med 3 forms to issue when appropriate. Details on how to order stocks of the Med 3 forms can be found at: <https://www.gov.uk/government/collections/dwp-leaflets-and-how-to-order-them#healthcare-professionals--med-3-med-10-and-matb1>

Not issuing Med 3s denies patients the best care and leads to unnecessary duplication and stress for those who have to make an extra appointment with their GP to get one. GPs may not be the most appropriate clinician to provide advice regarding fitness for work related to certain conditions. The duty to provide a Med 3 rests with the doctor who at the time has clinical responsibility for the patient. When issuing a fit note, the advice should be about any functional limitations of the patient's condition on their fitness to work e.g. stamina, mobility, and effects of treatment. Doctors are not expected to have specialist knowledge of workplaces or occupational health.

Hospital in-patients

Form Med 10 should continue to be issued to cover any period that a patient is in hospital. On discharge from hospital, the doctor who has clinical responsibility for the patient should provide them, if appropriate, with a Med 3 to cover a forward period. This is to avoid unnecessary referrals to GPs solely for the purpose of sickness certification.

Hospital out-patients

Where out-patient care follows an episode of in-patient/day patient care, the hospital doctor should issue the Med 3 on discharge and a subsequent Med 3, if required, when a patient attends for out-patient review.

Where a patient has been referred to a hospital for an opinion or advice on their health condition, responsibility for issuing a Med 3 should remain with the GP.

Patients with complex chronic diseases who are attending hospital as out-patients are, in most cases, also likely to be attending their GP. In these cases, the GP should issue the Med 3.

11. Standard 11

If a patient has rung and cancelled an outpatient appointment in advance or on the day of the appointment for the first time, this should be noted on Myrddin and another appointment sent without having to be re-referred. WG patient pathway management dictates that patients who do not attend an agreed outpatient appointment without giving notice should be discharged.

There are a number of mitigating circumstances which many consultants will take into account and it may well be appropriate to send a second appointment particularly if the patient has had a short notice appointment. Once text and remind services are fully rolled out this should not be needed. If patients ring to cancel on the day twice in a row they will be discharged unless the consultant overrides this decision for patient safety reasons. On discharge from outpatient both the GP and the patient should be notified with a standard letter.

12. Standard 12

Patients should be routinely offered a copy of their referral or outpatient letters. This approach fits with the patient involvement theme in the Parliamentary Review and is already a routine approach in England.

Potential benefits of copying letters between professionals to patients

More trust between patients and professionals: Increased openness leads to greater trust and openness between professionals and patients.

Better informed patients: Patients and carers have a better understanding of their condition and how they can help themselves.

Better decisions: Patients are more informed and better able to make decisions about treatment options.

Better compliance: Patients who understand the reasons for taking medication or treatment are more likely to follow advice.

More accurate records: Errors can be spotted and corrected by the patient.

Better consultations: Professionals confirm that patients understand what is said during the consultation. Patients are better prepared and less anxious.

Health promotion: The letters can be used to reinforce advice on self-care and life styles.

Clearer letters between professionals: Letters written between professionals are clear and understandable to both professional and lay people.

(extract from Copying letters to Patients, Good practice guidelines, Department of Health, England 2003)

Section 3 - Documents referenced

- 1) GMC Guidance
http://www.gmcuk.org/Delegation_and_referral.pdf 68369115.pdf
- 2) NHS England Guidance <https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2016/03/discharge-standards-march-16.pdf>
- 3) Robert Powell enquiry
<http://gov.wales/docs/dhss/publications/121009rpactionplanen.pdf>
- 4) BMA Guidance <https://www.bma.org.uk/advice/employment/gp-practices/service-provision/duty-of-care-to-patients-regarding-test-results>
- 5) <http://www.brotaflmc.org.uk/improvingcommunicationtheexchangeofinformationandpatientcareoct2007>
- 6) RTT Patient Perspective -
<http://www.wales.nhs.uk/sitesplus/documents/866/Final%20RTT%20rules%20Patient%20perspective%20only%20April%202017.pdf>

GMC

The following applies whether you are delegating or referring:

- a You should explain to the patient that you plan to transfer part or all of their care, and explain why
- b You must pass on to the healthcare professional involved:
 - i) relevant information about the patient's condition and history:
 - ii) the purpose of transferring care and/or the investigation, care or treatment the patient needs.
- c You should check that the patient understands what information you will pass on and why. If the patient objects to a disclosure of information about them that you consider essential to the safe provision of care, you should explain that you cannot refer them or arrange for their treatment without also disclosing that information.

NHS ENGLAND

Guiding principles

Three important overarching principles guide this work.

The first is that the clinician who orders the test is responsible for reviewing, acting and communicating the result and actions taken to the General Practitioner and patient even if the patient has been discharged.

The second is that every test result received by a GP practice for a patient should be reviewed and where necessary acted on by a responsible clinician even if this clinician did not order the test.

The third is that patient autonomy should be respected, consideration given to reasonable adjustments for people with learning disabilities and mental health problems and, where appropriate, families, carers, care coordinators and key workers should be given the opportunity to participate in the handover process and

in all decisions about the patient at discharge. Use of interpreter services should be considered if the patient doesn't speak English.

ROBERT POWELL ENQUIRY

- i. General Practitioners need to be adequately informed, in writing, of the material facts and intended course of further investigation when a patient is discharged from hospital.
- ii. Correspondence of the type identified above needs to be addressed to the General Practitioner who made the referral. The current evidence is that this does not always occur.
- iii. All correspondence from a hospital should be considered by the General Practitioner who made the referral. If it is not addressed to that doctor but another doctor in the practice then the practice administration should ensure that it is brought to the referring doctor's attention or a designated doctor if the referring doctor is away from the practice; on holiday for example.

BMA

Duty of care regarding communication of investigation results.

We are aware that in some areas, some hospital doctors have been instructing GPs to find out the test results which the hospital had ordered.

Both the General Practitioner Committee and the Consultants Committee of the BMA agree this practice is potentially unsafe, and that the ultimate responsibility for ensuring that results are acted upon, rests with the person requesting the test. That responsibility can only be delegated to someone else if they accept by prior agreement.

Handover of responsibility has to be a joint consensual decision between hospital team and GP. If the GP hasn't accepted that role, the person requesting the test must retain responsibility.

This advice is in line with both National Patient Safety Agency guidance and the Ionising Radiation (Medical Exposure) Regulations.

Contact

Please direct all enquiries to Populationhealthcare@gov.wales