Frimley Health NHS Foundation Trust

NHS Frimley

Frimley Health and Care

Frimley Health & Care

Frimley Health NHS Foundation Trust (FHFT) & Primary Care Collaborative Working – Reference Guide

A reference guide for Primary & Secondary Care clinicians outlining key clinical interface arrangements

Author	This document has been developed collaboratively with senior primary and secondary care clinicians within the ICS Clinical Interface Committee (CIC) and the ICS Elective Steering Group (ESG) including LMC members.

Audience	GP / Primary Care clinicians, hospital clinicians and supporting teams / managers.
Purpose	To strengthen interface arrangements and optimise patient care across Primary care and Secondary care by clarifying agreed ways of working for the different clinical professionals within primary and secondary care.
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Foreword

We in the Frimley Health & Care System recognise the importance of effective collaboration across the primary and secondary care interface in order to optimise patient care. As the demand for health care continues to grow, it is vital that these interface arrangements and pathways are clear and as patient–centred, joined-up and as efficient as possible.

The purpose of this document is to support strengthening the interface arrangements between Primary care and Secondary care (FHFT). The guide clarifies agreed ways of working for the different clinical professionals within primary and secondary care. These interface arrangements are focused on ensuring patients are supported in the most appropriate setting i.e., right care, right place, right time, with reduced duplication of workload.

This document is intended to be a summary reference guide useful to all parties and focused on ensuring patients remain at the centre of all our developments and processes. It is an update from the previous document called 'GP Workload' and draws upon other relevant guidance and protocols which are referenced throughout the document.

This guide covers a wide range of interface situations summarised and linked below:

Referrals, Advice & Guidance

- Referrals / A&G standards & responsibilities
- Suspected cancer referrals redirection process
- Expediting referrals process
- Onward referral of elective patients
- Onward referral of emergency/non-elective patients
- Evidence Based Interventions (EBIs)
- Military, overseas & private patients

Prescribing, Results & Discharge Preparation

- Management of results & treatment
- Prescribing incl. discharge medications
- Clinic letters & discharge summaries
- Fitness to work notes

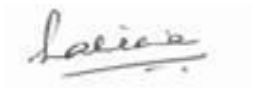
Further Support & Guidance / FHFT GP Centre

- FHFT GP Centre & Support Directories – www.fhft.nhs.uk/GPcentre
- FHFT/GP Interface Development Support Team: fhft.gpcommunications@nhs.net
- Support for FHFT staff contacting Primary Care
- Ensuring FHFT digital systems are kept up-to-date with GP change of details

We commend this Collaborative Reference Guide to you and ask that you discuss and adopt these principles within your teams in primary and secondary care.

Please continue to support us in removing any barriers between primary and secondary care and develop the feeling of a 'one team' approach. Please continue to reach out to colleagues to constructively build relationships and gain a greater understanding and appreciation for the challenges of respective roles (i.e., support in 'walking in each other's shoes') with the ultimate aim of improving the patient journey.

If you have any questions, or need support resolving thematic interface issues, please see section six for contact support details.



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1. Referrals and Advice and Guidance (A&G) [1]

1.1 DXS Referral Forms and Pathways

Collaborative working across Frimley ICS has enabled FHFT and senior clinical representatives from primary care to work with other key stakeholders to produce agreed integrated pathways, referral documentation and support guides. These are available to all primary care clinicians on the Frimley Health and Care DXS Landing Page (& on the system 'Ardens' for South Buckinghamshire practices).

These documents are intended to support primary care in signposting and supporting patients to the most appropriate setting. It will also support secondary care clinicians to triage 'referrals' to the most appropriate appointment type e.g., face to face, virtual, straight to test or provide management advice.

The ICS DXS landing pages will be clear and include access to referral forms; key condition management pathways; and inclusion and exclusion criteria for the various settings.

The DXS referral forms will be dynamic and auto-populate where appropriate from the primary care clinical management system (EMIS). The forms will include ICS-agreed key information / minimal data sets (MDS) for both primary and secondary care.

The ICS and all providers will ensure relevant information given to patients is clear, easy to read and in an accessible format, including consideration for patient demographics who may have digital barriers, learning disability, literacy and language challenges (www.england.nhs.uk/ourwork/accessibleinfo).

1.2 Routine Advice and Guidance (A&G)

Routine Advice and Guidance (A&G) should be used if a primary care clinician is unsure on how to manage a patient's pathway and there is no obvious guidance or pathways built on DXS. The link provides details of the Routine A&G services provided by FHFT: Routine advice | NHS Frimley Health Foundation Trust (fhft.nhs.uk). FHFT aims to respond to 'advice and guidance' within 5 working days. On the rare occasion where a consultant-specific enquiry has been raised this may be longer with an aim of 10 working days.

1.2.1 Clinical Responsibility for A&G Requests

In line with guidelines from NHS England and NHS Improvement, all clinicians are responsible for providing clinically sound advice within the scope of their competencies, but clinical responsibility for the patient's care remains with the GP unless a referral has been made. GPs will continue to have a duty of care if the patient's symptoms change and/or if new symptoms were to arise. Joint guidance for eRS has been published by NHS Digital and the BMA. [2a, 2b]

In 2021, eRS introduced a new functionality – where there is an appropriate level of information provided by the referrer, and with prior authorisation from the referrer, secondary care (FHFT) can now convert A&G requests to a **routine** or **urgent** secondary care referral / appointment.

If FHFT's advice is to refer a patient via the suspected cancer pathway, FHFT will continue to request that GPs undertake this process i.e., the request is returned to the GP with the advice to send a suspected cancer referral. It will appear in the "Advice and Guidance" eRS worklist. Primary care should continue to monitor these eRS worklists daily (as a minimum). This ensures the correct, robust suspected cancer referral process is followed. For example, this process includes a full discussion with the patient regarding their referral to a rapid pathway. It also ensures all the relevant referral information is made available to secondary care to appropriately manage the next steps for the patient.

1.3 Operational Standards for General Practice

- Become familiar with clinical pathways and guides available on DXS – ensuring patients are signposted to the most appropriate setting, including self-care, Tier 2 and community setting options (where available).
- Where available, the primary care referrer should use DXS pathways to guide them through sending a referral or requesting Advice and Guidance (A&G).
- Complete dynamic, auto-populated referral forms using DXS (where relevant & available).
- Where an assessment or physical examination of the patient's condition is required (i.e., for most patients prior to referral), primary care will ensure this is carried out prior to a referral being made. If this has not taken place, the referral may be returned for further information.
- Ensure ICS agreed minimum data sets are populated within referral forms - any primary care diagnostics / tests required prior to a referral will be clinically agreed as an ICS and built into current / future DXS pathway guidelines and referral forms and should be conducted prior to the referral.
- The referrer should detail any relevant actions / treatments tried with a patient within their referral or A&G request. This would also include confirmation that they have referenced DXS pathways etc.
- Ensure familiar with National EBI guidelines and local funded policies prior to referring (available on DXS) and ensure any primary care clinical management is conducted and described (including how the patient meets the criteria) within the referral.
- Endeavour to add a patient's referral to the correct eRS triage service (please note some specialties have more than one service available). Refer to the eRS Directory of Service (DOS) and pathways on DXS to ensure the correct service/pathway is being followed.
- If the referral is sent to the incorrect specialty on eRS this will be returned to primary care to re-refer to the correct service. If the referral is sent to the incorrect sub-specialty service on eRS but the specialty was correct, FHFT will seek to move the referral internally.
- Ensure that clinical referral information is added to eRS within the recommended timescales:
    - Suspected cancer and urgent referrals - within one working day
    - Routine referrals - within three working days
- Secondary care is unable to see and triage the referral until the relevant information is attached.
- Where a referral has been modified after submission to FHFT on eRS, or a referral has been returned to primary care for further information or action (including a change in priority), primary care are asked to create a new UBRN/referral on eRS. This is because once a referral has been submitted to FHFT for clinical triage, this information is automatically transferred from eRS to Epic within 24 hrs and a referral under the same UBRN will not trigger an update to the Trust. This is in line with the previously agreed ICS suspected cancer redirection policy (see section 1.7).

1.4 Operational Standards for Secondary Care – Triaging Elective Referrals

All referrals sent to secondary care are for a specialist opinion. The speciality clinicians will review and triage referrals and where appropriate management advice will be provided to the referrer. Triage will focus on the most appropriate setting for the patient i.e., right care, right place, first time based on the agreed DXS pathways (where available).

The triaging clinician will respond with one of the following responses (described in more detail in the diagram in Appendix 1):

1. Return to the referrer with management advice including signposting the GP to a Tier 2 or alternative service (if referred inappropriately/accidentally sent to secondary care)
2. Return to the referrer due to insufficient information or the incorrect speciality (according to the referral form / guidance etc). There will be a request for more information or clarification.
3. Straight to test / diagnostics (this might have several options).
4. Virtual clinic consultation (telephone / video clinics)
5. Face to face clinic consultation (where clinically required).

1.5 Clinical Responsibility for Referrals

The onward patient responsibility for all the above triage options sits with secondary care, except for ***referrals returned to primary care with management advice***. In this case, Primary Care would be responsible for informing the patient and ongoing patient management. The referrer will see the details on the e-RS worklist which should be checked at the least daily. This is in-line with the national e-RS workflow. [3]

Please note there are differences for the management of suspected cancer referrals; please see separate guidance on suspected cancer referrals re-directions in section 1.7, Appendix 2 and 3.

1.6 Returning with Management Advice

If a clinician is returning a referral with management advice or responding to a referrer's A&G request the clinician should ensure the advice is:

- Clear and concise with reasons for giving management advice
- Appropriate work to be undertaken in primary care and should not include recommendations about specialist investigations, complex prescribing or specialist management.
- Clear on dose and duration of any suggested medication. If management/drug recommended, make it clear if it is to be started regardless or dependent on tests.
- State any alternatives that could be tried in primary care as a second line.
- If the investigation is suitable for primary care to request or carry out (based on agreed pathways), this should still be accompanied with management advice.
- Detail the next course of action, if the management advice doesn't have the desired impact.
- References and signposts the clinician to the DXS pathways (if relevant and not followed appropriately).
- Where the secondary care clinician feels a FHFT additional diagnostic test is required this will be arranged by secondary care and the result administered by secondary care (as part of the developed CAS / RAS triage process).
- Ensure familiar with National EBI guidelines prior to triaging (available on the FHFT intranet https://ourplace.xfph-tr.nhs.uk/patient-care/ebi and Epic). Ensure the referrer has described how the patient meets criteria and redirect to primary care for more information if required.

If returning a referral with management advice to primary care, a clear message will be provided on the referrer's eRS worklist explaining that the referral has been returned to the referrer for x reason and a full dictated letter will be sent shortly (where appropriate). The referrer will review this and agree the next steps with the patient (as is the current process with returned referrals or A&G).

Where appropriate, the clinician will also send a letter to the referrer and copy in the patient / guardian (or vice versa). NB. Copying in a patient / guardian will continue to be at the discretion of the clinician writing the letter as there will be some situations where this is not appropriate, for example where there is safeguarding concerns etc.

If a primary care clinician requires clarity or further support on what is written within the management advice, the primary care clinician will be encouraged to contact the clinician via eRS A&G in the first instance or contact the service directly via the generic email addresses for each speciality (Referrals & key contacts | NHS Frimley Health Foundation Trust (fhft.nhs.uk)/FHFT Medical Secretaries/Admin Support e-mail addresses).

The specialist will also ensure the letter includes the services contact details which the referrer or patient can contact if they have further questions. The service will then be expected to arrange a discussion with the patient (virtually or face to face) if required.

If primary care has sent the referral to the incorrect specialty on eRS this can be returned to primary care to re-refer to the correct service. If the referral is sent to the incorrect sub-specialty service on eRS but the specialty was correct, FHFT will seek to move the referral internally.

Please note, where a referral has been returned to primary care for further information or action (including a change in priority), primary care are asked to create a new UBRN/referral on eRS. This is because once a referral has been submitted to FHFT for clinical triage, this information is automatically transferred from eRS to Epic within 24 hrs and a referral under the same UBRN will not trigger an update to the Trust (see section 1.3).

1.7 Suspected Cancer Referrals Redirection Process [4]

Suspected cancer referrals will be redirected to the referring GP from secondary care if any of the following apply:

- Suspected cancer pathway guidelines (NICE NG12 [14]) are not met
- Relevant blood results and investigation results are not provided (in line with agreed ICS pathways)
- The referral is inappropriate or incomplete with insufficient information to proceed on the suspected cancer pathway.

Appendix 2 outlines the process to be used in primary care to manage redirected referrals. Please note, the FHFT booking team will contact the patient to advise them that their suspected cancer referral has been redirected back to their GP. The GP practice will see the returned referral on their eRS worklist.

Appendix 3 outlines the process to be used in secondary care when managing referrals that need to be re-directed back to the GP practice. Secondary care will always try to make contact with the patient prior to sending the referral back to the GP to ensure they are fully aware of action taken/next steps.

1.8 Managing the Onward Referral of patients in the Elective pathway setting [1, 5]

Referrals that are directly associated with the condition that was the subject of the original referral should be referred directly from one FHFT consultant to another (where required), and/or where a patient has an immediate need for investigation or treatment.

For example, onward referrals should be made:

- where the treatment of a primary condition requires the input of another discipline e.g., pre-operative anesthetic assessment.
- where the treatment of the primary condition requires surgery under a different specialty
- where in the opinion of the consultant a delay in the referral would risk serious patient harm. In addition to life-threatening conditions, this also includes any situation where delay in referral would risk either long term morbidity or acutely distressing symptoms.
- where there is a cancer or suspected cancer.

Referrals for conditions that are not related to the condition for which the patient was initially referred, can be returned back to the GP.

Patients can be referred back to the GP if there is a locally / ICS agreed pathway for treatment in a community or primary care setting.

1.9 Managing the Onward Referral of patients in the Emergency/Non-Elective Setting [1, 5]

The basic principle is emergency and non-elective pathways should remain purely that (i.e., dealing with the emergency – treat and stabilise).

If the patient has an urgent issue or suspected cancer, FHFT should refer them internally but if the issue is not urgent and routine, the patient would be discharged, and it would be the responsibility of the primary care clinician to review and refer if required. This is to:

- Allow ED to focus on resolving the emergency situation in front of them. They would not be expected to know all the specialties elective pathway options across the ICS.
- Ensure there is no by-passing processes from ED to an elective pathway and the correct process is followed.
- Allow the GP to ensure they have undertaken any conservative management, primary care interventions or made connections to any enhanced primary care service available e.g., tier 2 interventions prior to a secondary care referral (if required).

1.10 Expediting Referrals

1.10.1 Process for expediting 'new' referrals / first appointments on clinical grounds

If a patient is waiting for a first outpatient appointment (i.e., a new referral to the Trust). FHFT will ask the patient to contact their GP if they feel their clinical condition has worsened. This enables the GP/primary care clinician to clinically assess the patient and decide if the referral type needs 'upgrading' and/or if further clinical support is required while waiting for their appointment e.g., change of medication, physio etc. In line with the referral process, primary care is asked where an assessment or physical examination of the patient's condition is required, to ensure this is carried out prior to requesting the referral is expedited.

See primary care expediting process available on FHFT's GP Centre: Referrals & key contacts | NHS Frimley Health Foundation Trust (fhft.nhs.uk). Please note this also includes the most up to date speciality contact details.

1.10.2 Process for expediting follow-up patients / patients who are already under the care of FHFT.

If 'follow up' patients (patients who are already under the care of FHFT) call the Trust explaining their clinical situation has changed and requires a sooner appointment/procedure. FHFT should escalate these within FHFT to the relevant clinical speciality (they should not be directed back to primary care for expedition). Patients can be directed to a dedicated page on our FHFT website 'Waiting for an appointment or procedure' Waiting for an appointment or procedure? | NHS Frimley Health Foundation Trust (fhft.nhs.uk) for further guidance and support.

Please note, our longest waiting patients are contacted by FHFT through our validation processes. Therefore, many of these patients will have been contacted direct by FHFT for ongoing support where required.

1.11 Supporting Private to NHS Referrals/NHS to Private

FHFT consultants can and should make this referral directly. The patient must be informed that they will join the relevant specialty NHS waiting list at the relevant point of access. The same is true of an urgent TWR case i.e., the patient can be referred into the relevant access point but in this case would join the TWR queue as an NHS referred patient would do.

If a consultant, acting in her or his private capacity, does refer a patient to the NHS for any stage of their treatment then best practice would recommend that they communicate this with the patient's GP through the usual means.

Patients already on an NHS pathway opting to move to private care must have the relevant episodes cancelled from the NHS system. If the patient is on an active elective pathway this will be removed, and the clock stopped.

1.12 Overseas Patients Support

Please see link for Department of Health guidance on providing healthcare to overseas visitors: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/977345/Main_Guidance_post_February_2021_v3.pdf.

1.13 Military / Armed Forces [5]

A veteran is someone who has served in the armed forces for at least 1 day. When servicemen and women leave the armed forces, their healthcare is the responsibility of the NHS. Being flagged as a veteran in the patients NHS medical notes will help to ensure that the patient is able to access dedicated services for those who have served in the UK armed forces. These include services for mental health and physical health conditions.

All veterans (including current armed force members) are entitled to priority access to NHS care (including hospital, primary or community care) for conditions associated with their time within the armed forces (service-related). But this is always subject to clinical need and doesn't entitle the patient to jump the queue ahead of someone with a higher clinical need. **For further information:** www.nhs.uk/nhs-services/armed-forces-and-veterans-healthcare/veterans-priority-nhs-treatment/

1.14 Evidence Based Interventions (EBIs) [13]

Evidence Based Interventions (EBI) is a nationally mandated programme which centres around value and patient outcomes (www.england.nhs.uk/evidence-based-interventions). These goals align with our principles as an integrated system and reinforce the need for evidence-based decision making which will reduce low value interventions to enable everyone within the system to deliver high value care to the right patients at the right time. As such the EBI workstream has the full endorsement from all partners and it is recognised this is now a national and local 'Must do.'

Primary and secondary care have been asked to support delivering these ambitions. All referring and triaging clinicians should ensure they are fully aware of the EBIs identified and how to support patients that present with these potential interventional requirements. An EBI FAQ sheet, EBI guidance and criteria can be found on the FHFT GP centre website Referrals & key contacts | NHS Frimley Health Foundation Trust (fhft.nhs.uk) and within DXS on the EBI landing page or within the relevant speciality pathways and referral forms.

1.15 Local Funding Policies

Primary and Secondary care managers and clinicians should familiarise themselves with the local funding processes and policies around treatments that are limited or require prior approval (http://www.fundingrequests.cscsu.nhs.uk). These are also reflected on the relevant pathways and forms on DXS.

2 Referring to Urgent & Emergency Services

2.1 Same Day Elective Care (SDEC Services)

For referrals to Acute Medicine/Medical Ambulatory Emergency Care (Medical SDEC) primary care are encouraged to call the referral numbers detailed in the link below prior to sending patients into either Wexham Park or Frimley Park. This ensures the patient is cared for in the most appropriate area.

Details of the SDEC services (including opening times, referral guidance and acceptance/inclusion criteria) can be found on the FHFT GP centre website SDEC (Including Ambulatory care) | NHS Frimley Health Foundation Trust (fhft.nhs.uk) or via the button on the DXS homepage or Frimley Health and Care Folder/ED and Urgent Care landing page.

2.2 The FHFT Urgent Advice Service Directory

Primary Care clinicians are encouraged to use the FHFT urgent advice directories for urgent advice and admission support: Urgent advice | NHS Frimley Health Foundation Trust (fhft.nhs.uk) (or via a link on DXS).

3 The Management of Results and Treatment [6]

It is widely agreed (including through the General Practitioner Committee and the Consultants Committee of the BMA), that the clinician who orders a clinical investigation / test is responsible for reviewing, acting, and communicating the result and actions taken to the referring clinician and patient even after the patient has been discharged.

The responsibility can only be delegated to someone else if they accept by prior agreement. Prior agreement does not constitute any communication requesting the GP (or other health care professional) to review the results without that person's consent. Handover of responsibility must be a joint consensual decision between the hospital team and GP. If the GP hasn't accepted that role, the person requesting the test must retain responsibility.

Please see next section (prescribing) for where secondary care has requested primary care to start a treatment.

4 Prescribing [6]

4.1 Discharge Medications

Medicines To Take Out (TTOs) will be available to the patient the day before discharge, wherever possible. The provider will ensure that an appropriate member of staff explains the purpose of the medicines a patient is given to take home with them, in a way that they understand. This includes how to take the medication and any side effects. The patient should be given clear written or printed information about their medication and, where applicable include why they are receiving TTOs and the arrangements the provider has made for further supply once the patient has reached their discharge destination.

Unless a risk assessment indicates otherwise, patients will receive the following quantity of medicines to take out (TTO's) on discharge:

- The total course for clinically indicated short courses (e.g., antibiotics, analgesia)
- Minimum 14 days' worth for new medication that is not considered to be a short course and has been prescribed whilst the patient is an inpatient
- At least 14 days for patients own medicines and medicines "dispensed for discharge" during the admission
- 7 days' supply if using a Monitored Dosage System with arrangements made by the provider for further supply already in place prior to discharge, as per discharge medicines standard operating procedure.

4.2 Anticoagulants

If the patient is prescribed anticoagulant drugs, the GP surgery will be sent electronically the detailed treatment care plan for them. A copy will also be given to the anticoagulant service. The information should be available at the GP surgery on day of discharge. Patients on Direct Oral Anticoagulant medicines (DOACs) are to be provided with an information card and patient information leaflet.

For patients transferred from another hospital the provider will ensure that the appropriate information is provided to the anticoagulation clinics across each site.

4.3 Dressings/Appliances

Sufficient supplies of dressings/appliances should be supplied to cover a minimum of 5 days (7 days for continence appliances), unless clinically indicated – this ensures that the patients' clinical needs are met until they can obtain supplies in a non-urgent manner from their GP surgery / community. Dressings/appliances will be consistent with local formulary.

4.4 Oral Nutritional Supplements (SIP feeds)

It is expected that a patient is discharged with at least 7 days' supply of oral nutritional supplements, where clinically appropriate. The SIP feeds issued should be in line with the recommendation in the relevant Clinical Commissioning Group medicines management oral nutritional supplement formulary. If not, the patient will be advised that they may be given a similar product in the community. The patient must be given patient information regarding their oral nutritional supplements.

4.5 MRI Sedation/Anxiolytic prescribing process [9]

Whoever requests the MRI should also prescribes the sedation (anxiolytic) – where required for patients suffering with anxiety/claustrophobia. If the requestor does not have prescribing qualifications, then it is their medical 'sponsor' (whether in primary or secondary care) who needs to write the prescription.

4.6 Pre-operative assessments - findings and treatment [6]

Specifically, in situations involving results or treatments arising from pre-operative assessments, the following general principles should normally apply:

A) The review of results of a pre-operative screening test, such as a urine or swab culture, and its subsequent management, such as antibiotic treatment, remain the responsibility of the hospital consultant and their team. In these cases, the hospital team should contact the patient, discuss the results of the test, and issue the appropriate prescription (either on a hospital pharmacy prescription or a hospital FP10) directly to the patient.

B) If at pre-operative assessment a new medical issue is identified, which has potential direct implications for the proposed surgery or anaesthetic, such as an abnormal ECG or a previously undiagnosed heart murmur, advice from or onward referral to the appropriate investigation/ specialty should be done directly and not referred to the GP (for example, referral for echocardiogram).

C) Situations may arise where a pre-operative investigation reveals an unexpected abnormal result not likely to be related to the proposed surgical procedure. An example is borderline low haemoglobin in an otherwise well young woman listed for tonsillectomy. In these instances, it would normally be clinically appropriate to refer to the GP for further assessment of the patient.

D) In situations where the patient awaiting surgery is found to have a sub-optimally controlled chronic medical condition, such as uncontrolled hypertension or poorly controlled diabetes, making the patient unsuitable for surgery, it is also appropriate to refer to the GP to optimise treatment prior to surgery.

5 Clinic Letters and Discharge summaries [6]

5.1 Letters following Outpatient Attendance

A clinic letter is not required after every 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 to enable ongoing care and treatment or which would necessitate the service user/s GP taking prompt action.

Hospitals should communicate clearly and promptly with GPs/primary care following outpatient clinic attendance (aim of 7 working days for outpatient letters).

Where applicable, clinic letters will contain the information detailed within the PRSB standard: https://theprsb.org/wp-content/uploads/2021/02/Outpatient-Letters-v2.1-01.02.21.xlsx. Clinic letters are sent out electronically via the Docman system, where feasible.

5.2 Discharge Summaries

Discharge summaries should be sent electronically to primary care for inpatient, day case or ED/A&E care within 24 hours of discharge, with local standards being set for discharge summaries from other settings. Discharge summaries from inpatient or day case care must also use the Professional Records Standards Body of the Academy of Medical Colleges endorsed clinical headings (https://theprsb.org/standards) so primary care clinicians can find key information in the summary more easily.

5.3 Statement of Fitness for Work Notes [6] [12]

Hospital clinicians are required to provide fit notes (Med 3). Fit notes must be provided for the whole period the patient is likely be medically unfit for work and should reflect a realistic estimate as to how long the individual patient is likely to be off. They do not have to provide a supplementary note if their initial estimate was overly optimistic (the GP would arrange an extension). The provider will supply fit notes to patients only where patients are part of their normal pathway. Specific clinic appointments will not be booked specifically for the purpose of a fit note review.

5.4 Patient Initiated Follow up (PIFU) [11]

Sometimes known as SOS or open access, PIFU is when a patient, or carer, can initiate follow up appointments as and when required, e.g., when symptoms or circumstances change. This helps patients access support when they need it and may also reduce the need for routine review appointments. PIFU can be offered to any patient that has previously received definitive treatment as an Inpatient/ Day case or outpatient setting. This option can also be given to patients that have been prescribed medication at their appointment or if the clinician feels that the patient does not need to be treated. It will be the clinician responsible who will decide whether a patient is suitable for PIFU and must be documented and clearly discussed with the patient. Generic guidance for a patient to be suitable for PIFU as set out by NHSEI NHS England » Patient initiated follow-up or visit the Trust intranet site Patient Initiated Follow Up (PIFU) (xfph-tr.nhs.uk) for more information.

6 Further Support and Guidance

Frimley ICS is continuing to strive for excellence and strengthen our Primary – Secondary Care interface in order to improve patient quality and experience. If teams within primary or secondary care have any further thematic concerns / interface improvement ideas, please raise these with our Interface development support team by emailing: fhft.gpcommunications@nhs.net. They will work with you to resolve, and where required, raise these for a wider discussion and resolution at our ICS-wide Clinical Interface Meeting (CIC).

6.1 FHFT GP Centre & Interface Support

For patient-specific clinical concerns, support is also offered via our ICB clinical feedback and concerns quality route, as well as through many resources on the: GP centre | NHS Frimley Health Foundation Trust (fhft.nhs.uk). This includes Urgent and Routine Advice directories, SDEC service details (including an AECU Directory), referral contacts and support. Links to the above are also available via the DXS homepage and the relevant speciality landing pages.

For full details of our main day-to-day interface support services please see Appendix 4.

6.2 Support for FHFT staff contacting Primary Care

Primary Care contact details, including FHFT GP 'Bypass' direct numbers and generic practice email addresses, are available for FHFT staff via the FHFT Intranet Site: Primary care engagement and business development (xfph-tr.nhs.uk).

It is vital that GP practice information is kept up to date, as it is used for communicating important clinical information (including Radiology Clinical alerts). Contact details are managed and maintained by Frimley ICS Primary Care Contracts Team (frimleyccg.primarycarecontracts@nhs.net). The team will update details as required and formally request practices validate their details every 6 months. Any changes will be communicated to the FHFT / Primary Care Interface Support team who will update the FHFT intranet site. Please see full details of how information is kept up-to-date within the Radiology Alert SOP: Radiology Department Standard Operational Procedure (fhft.nhs.uk).

6.3 Ensuring FHFT systems are updated with GP change of details (including new starters & leavers and locums)

It is imperative that FHFT's electronic patient record system called 'Epic' and the BSPS's ICE ordercomms system for radiology and pathology ordering, always have the most up-to-date GP and GP locum clinician details (including starters and leavers).

To support any changes, it is crucial that Primary care update PCSE (Primary Care Support England) with any GP change of details as soon as possible, as PCSE update the national Organisation Data Service (ODS). FHFT receives a monthly ODS feed into their electronic patient record (Epic).

In between the monthly ODS feeds to FHFT, practices are asked to complete a notification form (Appendix 5, 8.5) to notify FHFT and BSPS of any GP and locum changes. Please see full details on the FHFT/GP centre website (Epic EPR at Frimley Health | NHS Frimley Health Foundation Trust (fhft.nhs.uk).

Information regarding practice mergers and closures etc., is dealt with separately as part of the practice's discussions with their ICB Primary Care Place based team and Contracts Team. This team holds a directory of who to contact across the interface (including within FHFT) with any practice changes.

7 References

1. Frimley Health and Care - 2021
ICS operational guide: Referrals and Advice & Guidance principles and operating standards.

2. a) BMA NHS E-Referral Service Guidelines for Secondary Care Doctors – July 2021
https://beta-qa.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/primary-and-secondary-care/nhs-e-referral-service-for-secondary-care-doctors

2. b) BMA NHS E-Referral Service: A Guide for GPs - July 2021
https://beta-qa.bma.org.uk/advice-and-support/gp-practices/gp-service-provision/nhs-e-referral-service-a-guide-for-gps

3. GPC (England), NHS England and NHS Digital - 2018
https://digital.nhs.uk/services/e-referral-service/joint-guidance-on-the-use-of-the-nhs-e-referral-service-2018

4. Frimley Health Foundation Trust - January 2021
https://www.fhft.nhs.uk/media/4681/2ww-ers-redirection-for-gps-010221-final.pdf

5. Frimley Health and Care November - 2018
https://www.fhft.nhs.uk/media/3611/frimley-health-access-policy.pdf

6. Frimley Health and Care - 2019/20
Schedule 2 Part J Transfer of and Discharge from Care Protocols 19/20 (Currently under review for 21/22). Prescribing amendments locally agreed as an ICS via ICS Medical Optimisation Group, 2021.

7. NHS England and NHS Improvement - April 2022
Draft Specialist Advice and medico-legal information. Generic FAQs. April 2022.

8. Frimley Health Foundation Trust
Discharge medicines standard operating procedure

9. Frimley Health and Care - 2018
GP workload document (originated from 2017/2018 standard contract protocol, now within 19/20 protocol see ref 6 above (still in use).

10. Professional Records Standards Body of the Academy of Medical Colleges (https://theprsb.org/standards)

11. Frimley Health Foundation Trust Patient Initiated Follow Up
https://www.fhft.nhs.uk/pifu

12. Department of Health - Fitness for Work – A guide for hospital doctors - April 2022
www.gov.uk/government/publications/fit-note-guidance-for-hospital-doctors/statement-of-fitness-for-work-a-guide-for-hospital-doctors

13. NHS England in partnership with NHS Clinical Commissioners, the Academy of Medical Royal Colleges, NHS Improvement and the National Institute for Health and Care Excellence – November 2019. Evidence-Based Interventions: Guidance for CCGs, Version 2 11.01.2019

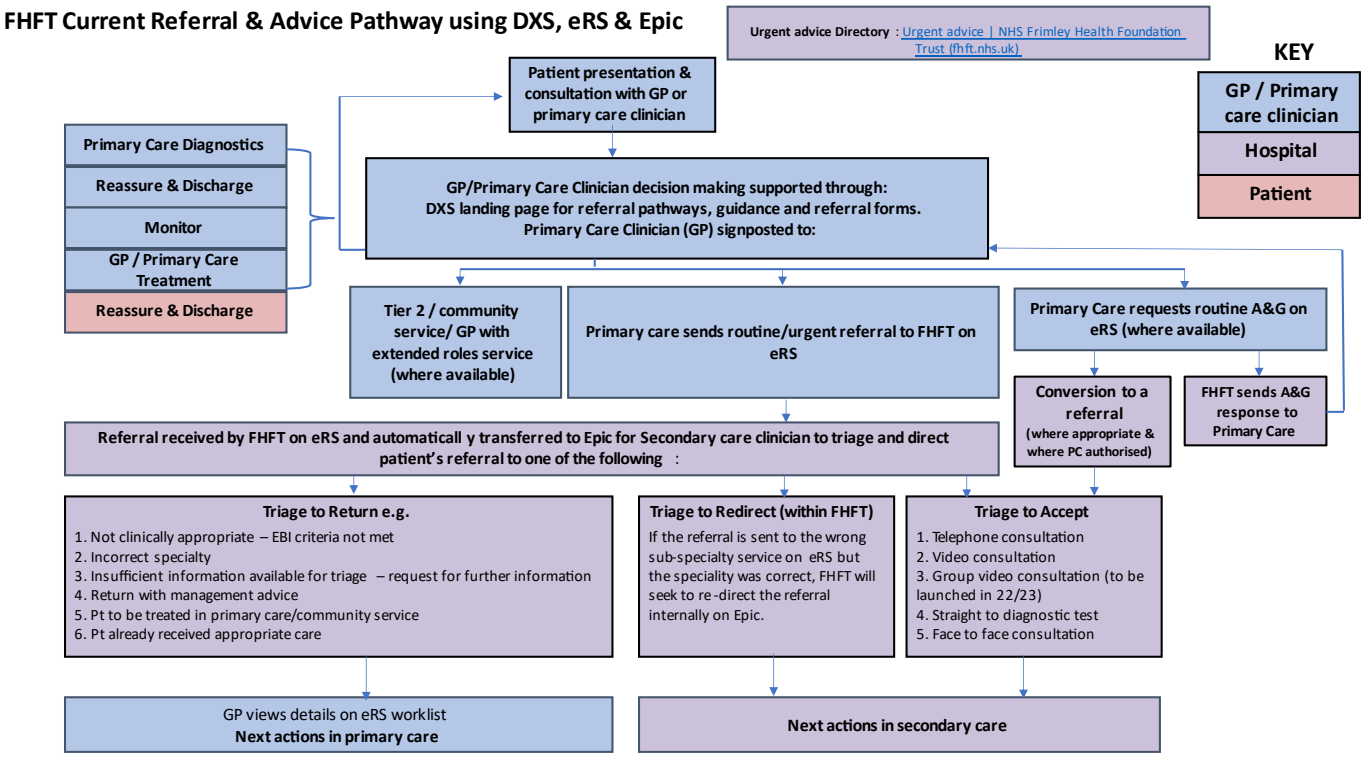
14. National Institute of Clinical Excellence - Updated December 2021
NG12 Guidelines Suspected cancer: recognition and referral www.nice.org.uk/guidance/ng12

15. BMA Guidance on Primary and Secondary Care Working Together – July 2021
https://beta-qa.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/primary-and-secondary-care/primary-and-secondary-care-working-together

16. NHS England Guidance on Primary and Secondary Care Interface – July 2017
https://www.england.nhs.uk/wp-content/uploads/2017/07/interface-between-primary-secondary-care.pdf

8 Appendices

8.1 Appendix One - Current Referral and Advice Pathway using DXS & eRS



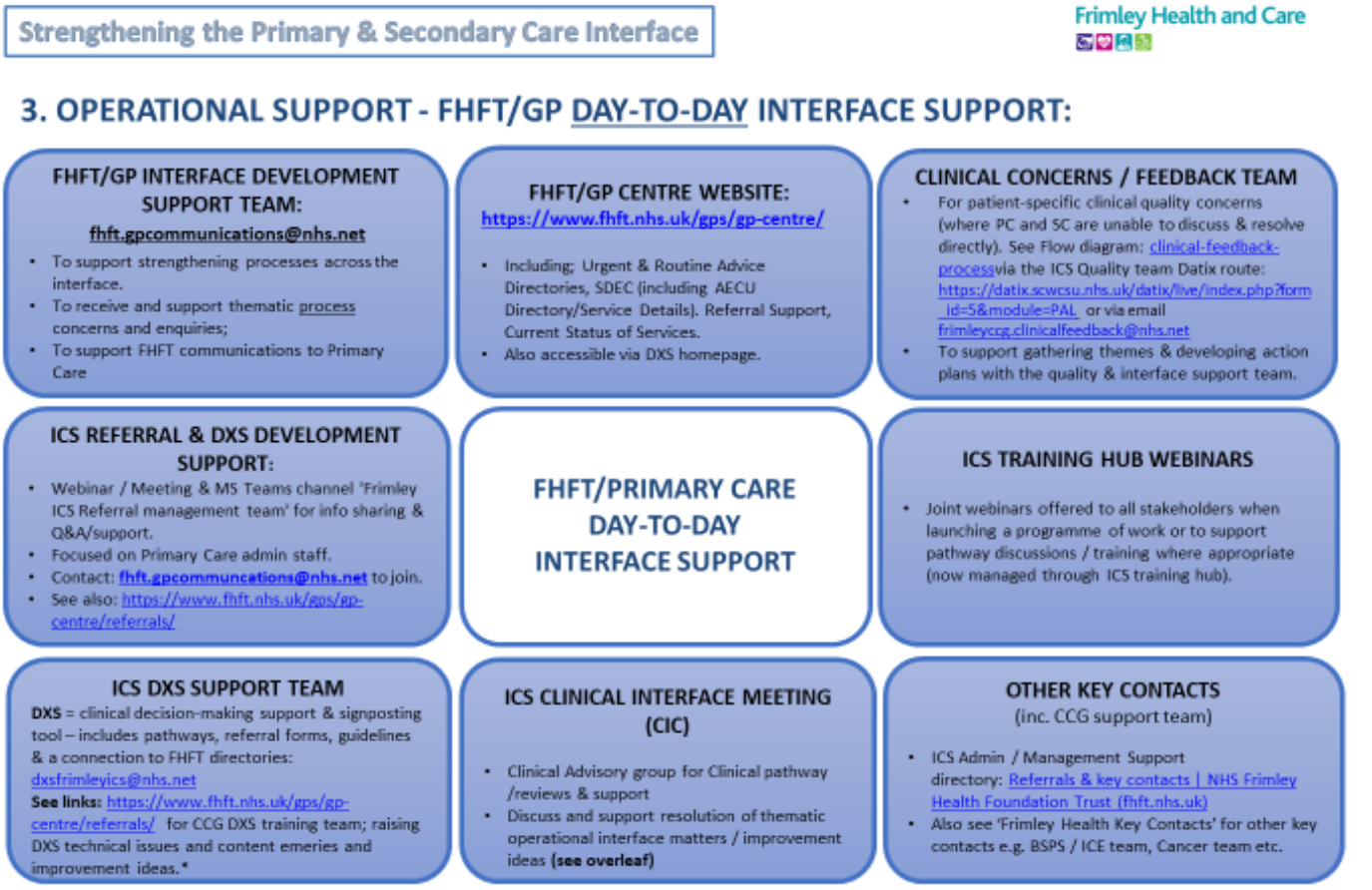
8.2 Appendix Two - Suspected Cancer Referral Redirection Policy for Primary Care

2ww-redirection-process-for-primary-care-october-2022-002.pdf (fhft.nhs.uk)

8.3 Appendix Three - Suspected Cancer Referral Redirection Policy for Secondary care

2ww-re-direction-policy-for-seconday-care-october-2022-002.pdf (fhft.nhs.uk)

8.4 Appendix Four - Day-to-day Interface Support Overview



8.5 Appendix Five - FHFT & BSPS: GP & GP Locum Change of Details Notification Form

Form can be found on the FHFT GP centre: Epic EPR at Frimley Health | NHS Frimley Health Foundation Trust (fhft.nhs.uk) - GP & GP Locum Change of Details Notification Form.

Please state if this is a change to an existing GP or GP Locum's details, or details for a new starter or leaver?	
Full name of GP / GP Locum:	
GMC number / Professional body code:	
Practice name:	
Practice address:	
Practice Code:	
Does the clinician need a drop down on ICE (i.e., requesting in their own name):	
Start Date of Change:	
End Date of Change (if applicable):	
****IMPORTANT ** Where applicable, please ensure PCSE (Primary Care Support England) have been updated of the change. This ensures the national ODS reports are updated (which in turn update the FHFT systems).**	
PLEASE RETURN TO: fhft.iceepicsupport@nhs.net and cc: frimleyicb.primarycarecontracts@nhs.net ***Please add in the subject line of the e-mail, if the request is for a New Starter, Leaver or for ICE Access***	