Final Interface Policy 1.0

Current version supported by the Interface Group 21.12.21

Version for providers to take through their governance processes and implement.

Review

This policy will be reviewed annually to consider any changes in the standard NHS contract.

1. Aim

- The aim of this policy is to clarify the roles and responsibilities of secondary care regarding the interface as specified in the NHS Standard Contract and GMC Good Medical Practise.
- This policy focuses on areas which sometimes cause confusion around the lines of responsibility. **This policy aims to clarify expectations for all relevant staff to ensure that we comply with the relevant national standards.**

2. Background (from the NHS Standard Contract)

- The Provider must provide the Services in accordance with the Fundamental Standards of Care and the Service Specifications. The Provider must perform all of its obligations under this Contract in accordance with the terms of the NHS Standard Contract, the Law and Good Practice.
- The Provider must, when requested by the Co-ordinating Commissioner, provide evidence of the development and updating of its clinical process and procedures to reflect Good Practice.
- The Provider (and other parties) must abide by and promote awareness of the NHS Constitution, including the rights and pledges set out in it. The Provider must ensure that all Sub-Contractors and all Staff abide by the NHS Constitution.

3. Investigations and filing on ICE

- SC12.1 Communicating with and involving service users, public and staff section of the national contract is clear that it is the duty of the clinician requesting a test to communicate its result to the patient and to take appropriate action. In practise, most tests are requested and reported on ICE.
- **It is therefore incumbent on the requesting clinician to check the results of any tests that they have requested, to communicate these results with the patient and GP where relevant (for example in accordance with shared care), take any appropriate actions with respect to these results, and to file them electronically on ICE.**
- This provides an audit trail to confirm who has received the result and that they have taken responsibility for auctioning that result. It is not acceptable to

pass this responsibility to primary care by asking the GP to “chase the results” of tests requested by the hospital at the point of discharge from hospital, or through a clinic letter.

- Tests which are not reported on ICE still generate a paper result**. It is therefore incumbent on the requesting consultant to have in place a mechanism to receive and review those results, and by signing the paper result and filing this in the notes, they are again confirming that the result has been actioned and communicated appropriately.**
- **Primary care must not be requested to interpret test results and relay those back to a patient where they have not requested the test in the first place.**

4. Responding to patient queries

- SC12.2 Communicating with and involving service users, public and staff section of the national contract is also clear that it is the duty of the hospital to provide patients with the means of raising queries with their clinical team. This is captured in our patient letters and on our public website.
- **However, it is also the duty of clinical staff to respond to those queries “promptly and effectively”, and wherever possible to deal with such questions directly and not by advising the patient to speak to their referrer.** In practise, this means that whenever a patient (or relative) contacts a clinical team with a query about their care, the team does have a duty to respond for example by phoning the patient, writing an explanatory letter, or bringing their appointment forward.

5. Communicating with Primary care: Discharge summaries and clinic letters

- SC11.5 Discharge summaries and clinic letters section of the national contract expressly requires the hospital to provide a discharge summary for all admissions/day case procedures or emergency department attendances in order to provide a timely hand over of information to the GP. This is usually in the form of an electronic discharge letter.
- **The contract makes clear that this should be issued within 24 hours.** This is vital for the safe onward care of the patient and so it is tracked by the hospital with lapses identified and shared with the divisional teams daily.
- Clinic letters are also required to summarise the care given when patients are discharged back to the care of their GP or transferred to another provider. **General clinic letters are also required to be timely, with the specific requirement for them to be received “as soon as reasonably practicable and within 7 days” if there are any urgent actions required by the GP.**

6. Medications on discharge and from clinics

6.1 Discharge medication

- SC11.9-11.10 Medication and shared care protocols of the national contract expressly requires the hospital to **issue at least 7 days medication** (or an adequate quantity where the clinical need is for a shorter course) when the patient has a clinical need for the medication on discharge from an admission, day case procedure or emergency department attendance.
- There is no need to issue medication that the patient already has a supply of, but there is a need to issue any new medications, or drugs which the patient has confirmed that they no longer have, as part of the TTO.

6.2 Outpatient medication

- Similarly, **where a patient has an immediate clinical need for a medication** identified at a clinic appointment, the hospital must supply that, to be at least sufficient to meet their immediate needs until the GP received the relevant clinic letter and can prescribe accordingly. **In practise, this has been agreed locally to be 14 days.**
- Patient to be advised where a medication is not urgent that this will be provided by their GP in the usual way.

6.3 Shared care

- Shared care protocols are currently agreed locally through the Norfolk and Waveney Therapeutics Advisory Group. **The initiating clinician must comply with their prescribing and monitoring responsibilities as set out in the relevant shared care document.**
- Clinicians initiating shared care medications should be familiar with the relevant shared care documents. They can all be found on the Knowledge Anglia website here.

6.4 Traffic light status of medications

- **Medication should be requested in line with locally agreed Therapeutics Advisory Group guidance and commissioning decisions, with reference to Trust formularies. Where medication requested is not in line with local commissioning and formulary guidance it will be directed back to the initiating clinician in secondary care.**
- Some medications have been classified as ‘red’ hospital only medicines or ‘double red’ not routinely commissioned. Red – hospital only medicines should only be prescribed by hospital clinicians. Double red medicines should not routinely be used and should not be requested for primary care to prescribe.
- To check the traffic light status of a medication, click here.
  Clinicians should also be aware of their own Trust formulary.

6.5 Unlicensed or off label use of medicines

- The term ‘unlicensed medicine’ is used to describe medicines which are not licensed in the UK, often referred to as a ‘special’.
- The term ‘off label’ is used to describe the use of a licensed medicine outside of the terms of their UK licence.
- Ordinarily, licensed medicines should be prescribed in accordance with the terms of their license wherever possible. Occasionally, it may be necessary to prescribe an unlicensed or off-label medicine if there is no licensed medicine available to meet the needs of the patient.
- If a clinician intends to prescribe unlicensed/off label medicines where it’s not routine or if there are no suitably licensed alternatives available, this must be explained to the patient/carer/guardian, providing the reasons for doing so.
- **The prescribing of an unlicensed/ off label medicine will generally be by a consultant. It should not be assumed that the prescribing will be transferred to primary care. If the GP is not familiar with the use of an unlicensed/off label medicine for the intended indication and does not feel competent to take on the prescribing of this it should remain with secondary care.**
- Further information can be found **here.**

7. Fit notes

- SC11.11 The fit notes section of the national contract makes it clear that where a patient is expected to require a period off work following an admission, procedure or emergency department attendance, **this should be issued by the hospital. In practise, if the patient is anticipated to need less than 7 days off work, there is no need for a certificate to be issued. If the patient is expected to need 7 or more days off, the consultant should issue a Med3 for the anticipated time.**
- If the patient subsequently requires longer than anticipated for their recovery, then according to the national contract, they should request that the further Fit note is also issued from the hospital team if the patient is still under our care eg via fracture clinic. However, if the patient has been discharged completely back to the care of their GP, and this is an unexpected request, then they should instead contact their GP.

8. Internal referrals

- Clinicians working for the provider should make an onward outpatient referral, without needing to refer back to the GP, **where it is directly related to the condition for which the original referral was made**, **or the patient has an immediate need for investigation or treatment.**

- However, if the patient requires or requests onward referral for an unrelated condition which is not life threatening, this should continue to be passed back as a recommendation to the GP, as the GP may wish to refer the patient to another provider or deal with that issue in primary care.
- For example, if a patient is seen regarding their GORD but they complain of headaches, they should be referred back to their GP for management or any onward referral as its not related to GORD. The only exceptions are if there is an immediate need for investigation or treatment (e.g. Patient has lost 6 stone and found to have a Hb of 6) or life-threatening conditions (e.g. they develop chest pain while in your clinic room).

9. Secondary care requests for primary care to carry out tests/investigations on their behalf

- If a secondary care clinician decides investigations/tests are necessary, then they should be carried out by secondary care with the responsibility for review and interpretation resting with the requesting clinicians as per section three of this policy.
- If for some exceptional reason this is not possible, then the patient should be clearly directed to make appointments for these investigations in primary care. It is not the responsibility of primary care to chase up the patient. Where appropriate, an ICE form must be provided to the patient.
- Responsibility for ensuring such appointments have been made should rest with the requesting clinician as should the review and interpretation of results. There must be in all cases clear and precise instructions to the GP regarding the purpose of the test and what action should be taken as a result of the test.

Appendix 1. Quick reference guide page 1/2

Area	Secondary care responsibility
Investigations and ICE	The requesting clinician is responsible for checking the results of any tests that they have requested, to communicate these results with the patient and GP where relevant (for example in accordance with shared care), take any appropriate actions with respect to these results, and to file them electronically on ICE. Tests which are not reported on ICE still generate a paper result. It is therefore incumbent on the requesting consultant to have in place a mechanism to receive and review those results, and by signing the paper result and filing this in the notes, they are again confirming that the result has been actioned and communicated appropriately.
Responding to patient queries	**It is the duty of clinical staff to respond to patient queries** “promptly and effectively”, and wherever possible to deal with such questions directly and not by advising the patient to speak to their referrer. In practise, this means that whenever a patient (or relative) contacts a clinical team with a query about their care, the team does have a duty to respond for example by phoning the patient, writing an explanatory letter, or bringing their appointment forward.
Discharge summaries	These should be issued within 24 hours.
Clinic letters	General clinic letters are required to be timely, with the specific requirement for them to be received **“as soon as reasonably practicable and within 7 days”** if there are any urgent actions required by the GP.
Discharge medication	The hospital is **to issue at least 7 days medication** (or an adequate quantity where the clinical need is for a shorter course) when the patient has a clinical need for the medication on discharge from an admission, day case procedure or emergency department attendance.

Quick reference guide page 2/2

Area	Secondary care responsibility
Outpatient medication	Where a patient has an **immediate clinical need** for a medication identified at a clinic appointment, the hospital must supply that, to be at least sufficient to meet their immediate needs until the GP received the relevant clinic letter and can prescribe accordingly. In practise, **this has been agreed locally to be 14 days.**
Shared care	The initiating clinician **must comply with their prescribing and monitoring responsibilities as set out in the relevant shared care document.** Clinicians initiating shared care medications should be familiar with the relevant shared care documents. They can all be found on the Knowledge Anglia website here.
Medication should be requested in line with locally agreed Therapeutics Advisory Group guidance and commissioning decisions, with reference to the Trust formularies. Where medication requested is not in line with locally commissioning and formulary guidance it will be directed back to the initiating clinician in secondary care.	
Fit notes	If the patient is anticipated to need less than 7 days off work, there is no need for a certificate to be issued. **If the patient is expected to need 7 or more days off, it is the responsibility of the consultant to issue a Med3 for the anticipated time.**
Internal referrals	Clinicians working for the provider should make an onward outpatient referral, without needing to refer back to the GP, where it is directly related to the condition for which the original referral was made, or the patient has an immediate need for investigation or treatment.
Secondary care requests for primary care to carry out tests/investigations on their behalf	If a secondary care clinician decides investigations/tests are necessary, **then they should be carried out by secondary care with the responsibility for review and interpretation resting with the requesting clinicians as per section three of this policy**. Only in exceptional circumstances should primary care be requested to support these requests. Responsibility for ensuring that appointments have been made should rest with the requesting clinician as should the review and interpretation of results

Appendix 2:

The national contract can be accessed by the following link

https://www.england.nhs.uk/wp-content/uploads/2020/03/2-FL-SCs-100320.pdf

Relevant exerts of the contract as referenced in the policy are included below:

SC12 Communicating with and involving Service Users, Public and Staff
12.1 The Provider must:

12.1.1 arrange and carry out all necessary steps in a Service User's care and treatment promptly and in a manner consistent with the relevant Service Specifications and Quality Requirements until such point as the Service User can appropriately be discharged in accordance with the Transfer of and Discharge from Care Protocols;

12.1.2 ensure that Staff work effectively and efficiently together, across professional and Service boundaries, to manage their interactions with Service Users so as to ensure that they experience co-ordinated, high quality care without unnecessary duplication of process;

12.1.3 notify the Service User (and, where appropriate, their Carer and/or Legal Guardian) of the results of all investigations and treatments promptly and in a readily understandable, functional, clinically appropriate and cost effective manner; and

12.1.4 communicate in a readily understandable, functional and timely manner with the Service User (and, where appropriate, their Carer and/or Legal Guardian), their GP and other providers about all relevant aspects of the Service User's care and treatment.

12.2 The Provider must:

12.2.1 provide Service Users (in relation to their own care) and Referrers (in relation to the care of an individual Service User) with clear information in respect of each Service about who to contact if they have questions about their care and how to do so;

12.2.2 ensure that there are efficient arrangements in place in respect of each Service for responding promptly and effectively to such questions and that these are publicised to Service Users and Referrers using all appropriate means, including appointment and admission letters and on the Provider's website; and

12.2.3 wherever possible, deal with such questions from Service Users itself, and not by advising the Service User to speak to their Referrer.

SC11 Transfer of and Discharge from Care; Communication with GPs

11.1 The Provider must comply with:
11.1.1 the Transfer of and Discharge from Care Protocols;
11.1.2 the 1983 Act;
11.1.3 the 1983 Act Code (including following all procedures specified by or established as a consequence of the 1983 Act Code);

11.1.4 Care and Treatment Review Guidance insofar as it relates to transfer of and discharge from care;

11.1.5 the 2014 Act and the Care and Support (Discharge of Hospital Patients) Regulations 2014; and

11.1.6 Transfer and Discharge Guidance and Standards.

11.2 The Provider and each Commissioner must use its best efforts to support safe, prompt discharge from hospital and to avoid circumstances and transfers and/or discharges likely to lead to emergency readmissions or recommencement of care.

11.3 Before the transfer of a Service User to another Service under this Contract and/or before a Transfer of Care or discharge of a Service User, the Provider must liaise as appropriate with any relevant third party health or social care provider, and with the Service User and any Legal Guardian and/or Carer, to prepare and agree a Care Transfer Plan. The Provider must implement the Care Transfer Plan when delivering the further Service, or transferring and/or discharging the Service User, unless (in exceptional circumstances) to do so would not be in accordance with Good Practice.

11.4 A Commissioner may agree a Shared Care Protocol in respect of any clinical pathway with the Provider and representatives of local primary care and other providers. Where there is a proposed Transfer of Care and a Shared Care Protocol is applicable, the Provider must, where the Service User's GP has confirmed willingness to accept the Transfer of Care, initiate and comply with the Shared Care Protocol.

11.5 When transferring or discharging a Service User from an inpatient or day case or accident and emergency Service, the Provider must within 24 hours following that transfer or discharge issue a Discharge Summary to the Service User's GP and/or Referrer and to any relevant third party provider of health or social care, using the applicable Delivery Method. The Provider must ensure that it is at all times able to send and receive Discharge Summaries via all applicable Delivery Methods.

11.6 When transferring or discharging a Service User from a Service which is not an inpatient or day case or accident and emergency Service, the Provider must, if required by the relevant Transfer of and Discharge from Care Protocol, issue the Discharge Summary to the Service User's GP and/or Referrer and to any relevant third party provider of health or social care within the timescale, and in accordance with any other requirements, set out in that protocol.

11.6A By 8.00am on the next Operational Day after the transfer and/or discharge of the Service User from the Provider's care, the Provider must send a Post Event Message to the Service User's GP (where appropriate, and not inconsistent with relevant Guidance) and to any relevant third party provider of health or social care to whom the Service User is referred, using the applicable Delivery Method. The Provider must ensure that it is at all times able to send Post Event Messages via all applicable Delivery Methods.

11.7 Where, in the course of delivering an outpatient Service to a Service User, the Provider becomes aware of any matter or requirement pertinent to that Service User's ongoing care and treatment which would necessitate the Service User's GP taking prompt action, the Provider must communicate this by issue of a Clinic Letter

to the Service User's GP. The Provider must send the Clinic Letter as soon as reasonably practicable and in any event within 7 days following the Service User's outpatient attendance. The Provider must issue such Clinic Letters using the applicable Delivery Method.

11.8 The Commissioners must use all reasonable endeavours to assist the Provider to access the necessary national information technology systems to support electronic submission of Discharge Summaries and Clinic Letters and to ensure that GPs are in a position to receive Discharge Summaries and Clinic Letters via the Delivery Method applicable to communication with GPs.

11.9 Where a Service User has a clinical need for medication to be supplied on discharge from inpatient or day case care, the Provider must ensure that the Service User will have on discharge an adequate quantity of that medication to last:

11.9.1 for the period required by local practice, in accordance with any requirements set out in the Transfer of and Discharge from Care Protocols (but at least 7 days); or

11.9.2 (if shorter) for a period which is clinically appropriate.

The Provider must supply that quantity of medication to the Service User itself, except to the extent that the Service User already has an adequate quantity and/or will receive an adequate supply via an existing repeat prescription from the Service User's GP or other primary care provider.

11.10 Where a Service User has an immediate clinical need for medication to be supplied following outpatient clinic attendance, the Provider must itself supply to the Service User an adequate quantity of that medication to last for the period required by local practice, in accordance with any requirements set out in the Transfer of and Discharge from Care Protocols (but at least sufficient to meet the Service User's immediate clinical needs until the Service User's GP receives the relevant Clinic Letter and can prescribe accordingly).

11.11 The Parties must at all times have regard to NHS Guidance on Prescribing Responsibilities, including, in the case of the Provider, in fulfilling its obligations under SC11.4, 11.9 and/or 11.10 (as appropriate). When supplying medication to a Service User under SC11.9 or SC11.10 and/or when recommending to a Service User's GP any item to be prescribed for that Service User by that GP following discharge from inpatient care or clinic attendance, the Provider must have regard to Guidance on Prescribing in Primary Care.

11.12 Where a Service User either:

11.12.1 is admitted to hospital under the care of a member of the Provider's medical Staff; or

11.12.2 is discharged from such care; or

11.12.3 attends an outpatient clinic or accident and emergency service under the care of a member of the Provider's medical Staff,

the Provider must, where appropriate under and in accordance with Fit Note Guidance, issue free of charge to the Service User or their Carer or Legal Guardian any necessary medical certificate to prove the Service User's fitness or otherwise to work, covering the period until the date by which it is anticipated that the Service User will have recovered or by which it will be appropriate for a further clinical review to be carried out.

11.13 The Parties must comply with their respective obligations under the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care and must co-operate with each other, with the relevant Local Authority and with other providers of health and social care as appropriate, to minimise the number of NHS Continuing Healthcare assessments which take place in an acute hospital setting.