Primary / Secondary Care Interface Policy

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DOCUMENT CONTROL		**POLICY NO.**	166
Policy Group:	Corporate		
Lead Author:	D&G Interface and Pathway lead		
Lead Executive:	Medical Director		
Scope: (Applicability)	Board wide	**Version no.**	1.0
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Approved by:	Board Management Team	**Approval date:**	March 2026
Equality Impact Assessed:	Yes	**Equality Impact Assessment date:**	October 2025
Data Protection Impact Assessed:	No – Not required	**Data Protection Impact Assessment Date:**	October 2025

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Summary & Aim	Key Requirements
• To provide clear, consistent standards for communication and transfer of responsibility between primary and secondary care in Dumfries & Galloway. • To improve **patient safety**, reduce **avoidable workload**, and support a **collaborative, patient-centred approach**. • Builds on national guidance and addresses local issues identified in the 2024 Interface Communication Survey.	• **Tests and results:** The clinician who orders a test is responsible for ensuring results are reviewed, actioned, and communicated. • **Prescribing:** Prescriptions for new urgent medicines to be issued by secondary care (provide appropriate script to the patient). Specialist medicines to remain with secondary care unless covered by a shared care protocol. • **Private care:** Patients monitored by private providers to continue private prescriptions. GPs not to prescribe specialist medications in shared care with a private provider. • **Referrals:** Consultants to complete onward referrals directly (with limited exceptions) where this is their management plan. Primary care referrals to meet DGRefHelp standards and include frailty/functional status where appropriate. • **Advice requests:** Consultants to respond within 1 week, with cover during leave. • **Discharge communication:** Letters to include diagnosis, rationale for medication changes, clear follow-up plans including any investigations requested and pending. • **Patient communication:** Patients to receive clinic/discharge letters in clear language and be told how and when results will be provided. Patients not be redirected to GPs for results or to upgrade a referral. • **Outpatient communication:** Clinic letters should clearly state Plan for Patient, Plan for GP, Plan for Specialist Team

Target Audience	**Previous Names**
• All **primary care clinicians** (GPs, ANPs, GP clinical pharmacists, practice nurses). • All **secondary care clinicians** (consultants, specialty doctors, resident doctors, ANPs, CNSs). • **Managers and governance teams** responsible for ensuring compliance. • **Private providers** seeking to transfer patients into NHS care.	N/A

Equality and Diversity Statement
NHS Dumfries and Galloway recognise that some communities within society are more likely than others to experience discrimination, prejudice and inequalities. The Equality Act 2010 specifically recognises the protected characteristics of **age, disability, sex, race, religion or belief, sexual orientation, gender reassignment, pregnancy and maternity, and marriage and civil partnership**. The Fairer Scotland Duty, also requires NHS Dumfries and Galloway to actively consider how socio-economic disadvantage can be reduced when making strategic decisions. The New Armed Forces Covenant Statutory Duty places an expectation on NHS Dumfries and Galloway to consciously consider the Armed forces Covenant when developing, delivering and reviewing policies and decisions which may impact the Armed Forces community and help improve their access to public services. Consideration on all of the protected characteristics, the Fairer Scotland Duty and the Armed Forces Covenant are included within the Equality Impact Assessment process and documentation, which must be completed as part of the Policy Development Process. NHS Dumfries and Galloway is committed to promoting and advancing equality, removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those who do not. This applies both in the provision of services and as our role as a major employer. NHS Dumfries and Galloway believe that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discrimination practice.

CONTENTS

1. PURPOSE AND RATIONALE

1.1 This policy sets out mandatory standards for safe, effective and consistent communication and responsibilities across the primary–secondary care interface within NHS Dumfries and Galloway.

1.2 It aims to enhance patient safety, improve efficiency, reduce unnecessary workload, and promote a collaborative, patient-centred approach.

1.3 The policy responds to findings from the 2024 Interface Communication Survey (Appendix 1) and incorporates national guidance (GMC Good Medical Practice, RCGP interface guidance, NHS England interface standards).

2. POLICY AIMS

2.1 To ensure clear and consistent allocation of responsibility for tests, results, prescribing, referrals, and discharge communication.

2.2 To standardise communication between primary and secondary care, reducing duplication, delay, and risk.

2.3 To clarify expectations of both primary and secondary care clinicians, reducing unnecessary transfers of work.

2.4 To strengthen shared care arrangements, with explicit protocols for prescribing and monitoring.

2.5 To embed patient-centred communication, ensuring patients are informed, receive timely results, and have clarity about their care pathway.

2.6 To provide a framework for monitoring, audit, and governance of interface communication across NHS Dumfries and Galloway.

2.7 To provide a framework that all new or temporary colleagues can follow to maintain consistent and safe care.

3. POLICY SCOPE

3.1 This policy applies to all primary care clinicians (including GPs, ANPs, GP Clinical Pharmacists, and practice nurses) and all secondary care clinicians (including consultants, resident doctors, clinical nurse specialists), and management/administrative teams working in Dumfries and Galloway.

3.2 The scope of this policy includes referrals, investigations, prescribing, results management, discharges, shared care arrangements, and transfer of care from private providers (UK or overseas) into NHS care.

4. DEFINITIONS

4.1 ACRT
- Active Clinical Referral Triage, used to determine urgency and need for investigations before outpatient appointments.

4.2 Advice referral
- Referral for written advice rather than face-to-face review, submitted via SCI-Gateway.

4.3 CHI
- Community Health Index number. Unique patient identifier used in NHS Scotland.

4.4 Clinical Director
- Senior medical lead responsible for giovernance and performance within a secondary care specialty.

4.5 Community Treatment and Care services (CTAC)
- Board provided service providing phlebotomy, dressings, chronic disease measurement within the community as required for patients, requested by Primary or Secondary care.

4.6 DGRefHelp
- Website which hosts locally agreed referral pathways and guidance. Hosted on the national Right Decisions Service.

4.7 Equivalent Care
- Care delivered by a private provider that is of equivalent standard to NHS care, determined by national or regional service assurance.

4.8 Interface Team
- The Primary-Secondary Care Interface Team responsible for oversight, advice and resolution of interface issues.

4.9 Patient Advocate
- A person nominated by the patient to support them in understanding or engaging with their care. This may include a family member, carer, guardian or legally appointed representative.

4.10 Practice Lead GP
- The nominated GP responsible for interface governance within the practice.

4.11 Private Prescription
- A prescription issued outside NHS arrangements and funded privately.

4.12 Private Provider
- Any non-NHS organisation delivering healthcare services to a patient.

4.13 Shared Care Arrangement

- A formal agreement between primary and secondary care outlining shared prescribing and monitoring responsibilities, supported by an approved Shared Care Protocol.

4.14 Shared Care Protocol

- A locally agreed written document defining responsibilities for prescribing and monitoring between primary and secondary care.

4.15 Specialist Medication

- A medication requiring specialist initiation, monitoring, or ongoing review as defined by local formulary or ADTC guidance.

5. DUTIES / RESPONSIBILITIES

5.1 NHS Dumfries & Galloway Board

- Provide governance and oversight to ensure safe communication across the interface.
- Ensure resources, training, and systems are in place to support efficient interface working, including:
  - IT systems
  - Community Treatment and Care (CTAC) service capacity to allow access to primary and secondary care
  - DGRefHelp guidance
  - Include policy in induction for all newly appointed staff

5.2 Senior Managers / Clinical Directors

- Ensure that practice relating to the management of primary/secondary care interfaces of all health services complies with this policy.
- Monitor adherence to the policy through audit and incident reporting.
- Support escalation and resolution of interface issues.
- Notify clinicians of delays to services.

5.3 Secondary Care Clinicians (Consultants, Specialty Doctors, ANPs, CNSs, Resident Doctors)

Secondary care clinicians shall:

- Take responsibility for tests they request until completed and acted upon.
- Provide clear, timely communication to primary care following patient contact.
- Issue initial prescriptions for urgent medications and outline follow-up arrangements.
- Make onward referrals directly if it is part of the specialist management plan. If the cause of symptoms is unclear, it is preferable to refer back to the GP for re-assessment, but do not return a patient to the GP solely to request a referral to another specific specialty.

5.4 Primary Care Clinicians (GPs, ANPs, Pharmacists, Nurses)

Primary care clinicians shall:

- Take responsibility for tests they request.
- Ensure referrals follow DGRefHelp guidance and contain adequate clinical information.

- Inform patients about the reason for referral and expected pathway.
- Participate in shared care arrangements where agreed protocols are in place.
- Decline tasks that fall outside primary care responsibility while ensuring patient journey is not compromised.

5.5 Patients or their advocates

Clinicians can expect patients to:

- Engage with their care pathway, including attending appointments and tests.
- Highlight any barriers that may make engagement more challenging.
- Inform clinicians if there is a patient advocate.
- Inform clinicians if results or communication have not been received within agreed timeframes.
- Take responsibility for booking CTAC appointments when advised to do so.

5.6 Private Providers

Private providers are expected to:

- Retain responsibility for prescribing and monitoring until a formal NHS transfer is agreed.
- Make transfer arrangements to the appropriate specialist service directly to ensure safe handover of care.

5.7 Escalation of Responsibilities

- Where there is uncertainty or disagreement regarding responsibility for a patient's care, the clinician identifying the issue shall escalate promptly rather than allow ambiguity to persist.

- Escalation shall follow this order:
  1. **First point** – direct discussion between the primary and secondary care clinicians involved.
  2. **If unresolved** – Contact the Primary-Secondary Interface team (dg.interface@nhs.scot).
  3. **If still unresolved** – Interface team will refer to the relevant **Clinical Director** (secondary care) or **Practice Lead GP** (primary care).
  4. **If still unresolved** – escalation to the **Associate Medical Director** for the specialty or the **GP Sub-committee** representative.
  5. **For urgent patient safety concerns** – escalation directly to the **on-call Consultant/Medical Manager**.

- All efforts shall be made to ensure the patient journey is not adversely impacted by any escalation process.

- The Board Clinical Governance structures shall monitor recurring issues to identify system gaps and support service improvement.

- Interface Team has Caldicot approval to access patient records where required to investigate and resolve interface issues and to obtain data for audit and monitoring purposes.

- NHS mail shall be used for secure communication. Patient identifiable information should be kept to the minimum necessary – CHI and initials.

- Communication around interface issues shall not routinely be recorded within the patient's clinical record unless directly relevant to patient safety or care.

6. PROCESS / PROCEDURES

6.1 Referrals

- Referrals from primary to secondary care shall:
  - Follow DGRefHelp guidance, including required investigations.
  - Check past outpatient history to prevent duplicate referrals or referrals for issues already addressed.
  - Contain clear clinical details, functional status, and frailty where relevant.
  - Be explained to the patient, including the reason for referral and likely pathway.
  - Avoid referring to multiple specialties simultaneously for the same issue. Where this is required ensure the referral letter makes it clear another specialist is involved.

- Secondary care clinicians shall:
  - Complete onward referrals to other specialists directly, where this is part of your management plan, unless a specific local agreement states otherwise.
  - Where requirement for onward referral is not clear, it is preferable to refer back to the GP for review but do not refer back to the GP solely to request a referral to another specialty.
  - Notify the referring clinician when a referral has been downgraded or redirected, and whenever possible provide safety-netting advice.

- All referrals shall be made using the SCI Gateway referrals system.

6.2 Advice Referrals

- Primary care clinicians may submit advice requests via SCI Gateway where a face-to-face referral is not required.

- Using telephone contact rather than advice referrals is more appropriate where urgent investigation or admission may be needed.

- Secondary care teams shall:
  - Respond promptly to advice requests (aiming for reply within 7 calendar days from receipt).
  - Provide the requestor with a reply to the advice request in every instance, even when the patient is added to a waiting list**.**
  - Notify primary care if the service is unable to reply within 14 calendar days.

- Service managers shall:
  - Ensure advice requests and ACRT is able to be managed effectively and within the timeframe agreed above during periods of leave or absence.

6.3 Investigations and Test Results

- The clinician requesting an investigation retains responsibility for:

  - Receiving, reviewing, and acting on results.
  - Communicating results to the patient or handing over clearly to another clinician.

- CTAC services may undertake investigations at the request of primary and secondary care clinicians.

- Requests for blood tests shall be entered on the electronic ordercomms system by the requesting clinician to ensure the correct tests are performed and the results return to the requester.

6.4 Prescribing and Medicines Management

- Specialists to provide the initial 28-day supply/prescription (or full course if shorter) for any new urgent clinic medicines.

- For medications where there is no immediate urgency, the recommendation can be made in the clinic letter and the patient advised to order it with their next prescription. Advise them to allow up to 14 days after the clinic letter is sent.

- Where a prescription is required urgently and the patient is remote from the specialist and there is no other practicable way to provide the prescription, the specialist shall email the practice with full details and rationale for the request and telephone the practice to make them aware and confirm when the prescription will be available and contact the patient to inform them.

- Specialist-only medicines require ongoing specialist review unless a shared care protocol is in place.

- Shared care arrangements are documented in Appendix 1; practices may opt in or out.

- Private providers retain responsibility for prescribing until formal NHS transfer is completed.

- GPs not to enter into shared care arrangements with private providers for specialist medication.

- See also *NHS D&G Dumfries & Galloway Guidance for Shared Care Prescribing and Transfer of Care from Private to NHS*.

6.5 Discharge / Outpatient Communication

- Discharge and clinic letters:
  - Include diagnosis, rationale for medication changes, and clearly specified follow-up arrangements.
  - Specify clearly who is responsible for each outstanding action.
  - Letter formatting to include clearly highlighted Actions for patient, Actions for GP, Actions for specialist team.
  - Document whether follow-up tests/appointments have been arranged.

- To be written or copied to patients unless there is a clinical reason not to do so or the patient actively opts out.

- Requests for GP review to include a clinical handover plan with enough information to allow the GP to take over care.

6.6 Patient Communication

- Patients shall:
  - Be told at the time of referral or testing how and when results will be communicated.
  - Receive a copy of clinic and discharge letters in plain language (or with included patient summary aiming for reading age 12), unless there is a clinical reason not to do so or the patient actively opts out.
  - Not be directed to GPs obtain specialist test results.

- Avoid advising patients to see their GP to request an upgrade to their referral status where there has been no significant change in their condition

- Departments shall provide primary care and patients with clear criteria for referral upgrades and accurate information on expected waiting times.

6.7 Escalation (linked to 5.7)

- Any disputes or ambiguity about responsibility should be escalated following the escalation ladder described in Section 5.7.

7 CONSULTATION

7.1 Development of this policy has involved wide consultation with clinical staff and statutory committees.

- The draft Primary–Secondary Care Interface Policy was reviewed by the **Medical Staff Committee** and the **GP Subcommittee of the Area Medical Committee**.

- The Shared Care Prescribing and Transfer of Care guidance was reviewed and endorsed by the **Area Drugs and Therapeutics Committee (ADTC)**.

7.2 Feedback from these groups has been incorporated into the current version of the policy.

7.3 In line with the NHS Dumfries & Galloway **Policy Management Policy**, the draft policy will also be circulated for wider consultation, including:

- Board Management Team (BMT) members.
- Area Partnership Forum (APF) members.
- Staff Side representatives.
- Health and Social Care Partnership leadership team.

7.4 A two-week minimum consultation period will be undertaken. Comments received will be collated in the Document Development Checklist, with an explanation of how they have been addressed.

8 TRAINING AND SUPPORT

8.1 Awareness of this policy will be raised through:

- Publication on the NHS Dumfries & Galloway intranet (Beacon) and DGRefHelp.
- Communication via Medical Staff Committee, GP Subcommittee, and Area Drugs and Therapeutics Committee.
- Briefings to senior clinical teams and practice managers.
- Teaching, support and feedback to doctors in training completing Immediate Discharge Documents.
- Highlighting the policy during induction of new clinical staff.

8.2 Clinicians are expected to familiarise themselves with the standards set out in this policy as part of their professional responsibilities.

8.3 No formal training package is required; however:

- Key messages will be highlighted at staff meetings, Grand Rounds, GP Subcommittee meetings, and departmental teaching sessions.
- Specialty teams introducing new shared care arrangements must provide supporting guidance and induction to relevant GP practices.
- CTAC services will ensure staff are aware of their role in community investigations as outlined in this policy.

8.4 Ongoing support is available from:

- Primary–Secondary Interface Team.
- GP Subcommittee and LMC for primary care queries.
- Associate Medical Directors and Clinical Directors for specialty-specific advice.
- Area Drugs and Therapeutics Committee for prescribing-related matters.

9 MONITORING

9.1 The monitoring arrangements for this Policy are set out in the table below.

Element to be monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
Quality and timeliness of discharge and clinic letters	Annual audit of a sample of discharge/clinic letters across specialties, checking for: diagnosis, rationale for medication changes, clear follow-up, and whether letters reach GP within 7 calendar days	Clinical Governance Team	Quality Safety Board	Annual

Element to be monitored	Monitoring Methodology	Reporting		
		Presented by	Committee	Frequency
Quality of GP referral letters	Annual audit of a sample of GP referral letters across specialties, checking for: clear reason for referral, DGRefHelp suggested workup completed if applicable, overall information enough to make triage decision.	Clinical Governance Team	Quality Safety Board	Annual
Advice referral response times	Quarterly audit of SCI Gateway advice requests, measuring % responded to within 7 calendar days	Health Intelligence	Clinical Directors	Quarterly
Patient Communication	Patient experience survey results (including receipt of letters, understanding of results)	Patient Experience Team	Healthcare Governance committee	

10 EQUALITY IMPACT ASSESSMENT

10.1 As part of the process for reviewing and developing this policy an Equality Impact Assessment was undertaken, which did not highlight any issues or actions that had to be progressed.

10.2 All Equality Impact Assessments are published on our external website, which can be accessed by clicking here.

11 DATA PROTECTION AND CONFIDENTIALITY IMPACT ASSESSMENT

11.1 This policy does not create any new systems for collecting or storing personal data. It defines responsibilities for communication between primary and secondary care using existing NHS Dumfries & Galloway systems. Therefore, a full standalone DPIA is **not required**.

12. DOCUMENT CONTROL SHEET

12.1 Document Amendment History

Version	Section(s)	Reason for update
1.0	All	New policy developed for implementation.

12.2 Distribution

Name	Responsibility	Version number
Corporate Business Manager	Place on policy register	1.0
Communications Team	Place on internet and in 'Staff News'	1.0
Corporate Business Manager	Disseminate to all Managers and Directors	1.0

12.3 Associated documents

Not applicable

12.4 Action Plan for Implementation

Action	Lead Officer	Timeframe
Dissemination to senior staff through line management	Corporate Business Manager	May 2026
Raise awareness and inform staff	All line managers	May 2026
Use policy	All staff	May 2026

Report on Primary Secondary Care Interface Survey 2024

Background and Purpose

Dumfries and Galloway's health system is subject to rising demands and unprecedented pressure. We know that failures of communication across the primary/secondary care interface are common and result in inefficiencies and irritation. More importantly communication failures at the primary-secondary care interface are known to impact patient safety, as highlighted by the GMC in 2018 (General Medical Council, 2018).

As part of the Interface project, led by Dr Fergus Donachie and Dr Gwyneth Jones, feedback was sought from both primary and secondary care clinicians working in Dumfries and Galloway in an attempt to capture both the themes of repeated issues and the scale of communication issues in day-to-day practice.

Feedback was received from 13 practices directly, from all the practice pharmacy teams across the region and from secondary care clinicians. Over 200 individual incidents were reported.

Using this feedback as well as drawing from similar work elsewhere a set of communication standards will be created. The aim being to enhance patient safety, efficiency, reduce unnecessary workload, and promote a collaborative, patient-centred approach. This report will highlight the findings from the feedback survey and make recommendations as to how these can be addressed.

Note that the report will use GP as a shorthand for all primary care clinicians – GPs, ANPs, GP Clinical Pharmacists etc. And consultant will be used as shorthand for secondary care clinicians including consultants, resident doctors, clinical nurse specialists etc.

It should be noted that there were numerous examples of good communication and best practice processes which have informed the recommendations.

Reference

General Medical Council. A scoping review of evidence relating to communication failures that lead to patient harm [Internet]. London: General Medical Council; 2018 [cited 2025 Mar 26]. Available from: https://www.gmc-uk.org/-/media/documents/a-scoping-review-of-evidence-relating-to-communication-failures-that-lead-to-patient-harm_p-80569509.pdf

Key Communication Themes from Primary and Secondary Interface Survey

The feedback from GPs and secondary care practitioners highlights several recurring themes.

1. Follow-up and Onward Referral Responsibility

Both GPs and consultants reported uncertainty about follow-up actions and referrals, particularly where letters lack clarity on whether primary or secondary care should manage specific tasks. There was also lack of clarity in where there was a local agreement in place that GPs would provide ongoing monitoring on a shared basis.

Examples

- Clinic letter to GP asking them to refer on to another specialty – confusion around onward referrals to pain clinic or psychology.
- GP asked to arrange further tests but without clear plan for the results.
- Clinic or discharge letter where it is unclear if further review will be arranged.

Recommendations

1.1 Consultants should make an onward referral to another specialist themselves if they feel it is required rather than asking the GP to make the referral. This reduces the risk of the referral being missed and ensures the relevant information is in the referral.

1.2 Consultants should refer patients back to their GP if they feel they may need an onward referral, but it is not within their area of expertise, and they are not sure. They should advise the patient to book an appointment with their GP along with an indication of the urgency (usually a routine appointment). They should document this in the letter - 'I have advised the patient to book a routine appointment with you to discuss...'

1.3 Local agreement is that consultants should not refer directly to the pain clinic or psychology (referrals to Health Psychology can be made direct). Patients should be advised to contact their GP practice to discuss their pain management/mental health. Patients should NOT be advised to attend their practice to obtain a referral to the pain clinic or psychology.

1.4 Clinic and discharge letters should clearly state who is responsible for arranging follow up, the expected timeframe and explicitly confirm if this has been scheduled.

2. Medication and Prescription Management

GPs often receive requests to initiate or adjust medications without clear instructions, such as dose or follow-up requirements. Consultant feedback highlighted uncertainty where it was appropriate to ask GPs to manage medication titration and where that should be managed directly by the consultant.

Examples

- GP asked to prescribe specialist only medication with no indication of ongoing specialist follow up.
- New medication started in letter, but no dose or duration indicated
- Consultant suggests lipid management but GP declines suggesting this should be managed by the consultant.
- Patient appears at reception looking for the 'urgent' medication the specialist suggested but no letter available.

Recommendations

2.1 Specialist medications can be issued in the community, but ongoing specialist review and responsibility is required unless a formal shared care arrangement is in place.

2.2 A list of specialist initiated medications should be collated and published to clarify which medications require ongoing specialist oversight.

2.3 A list of agreed shared care protocols should be available in an accessible area for reference.

2.4 Specialists starting new medication required to commence within two weeks should provide patients with a prescription sufficient for the first month and clearly document that a prescription has been issued in the clinic letter with explicit dosage instructions.

2.5 For medications not needing immediate initiation (within two weeks), specialists should instruct patients to allow a two-week period for the GP practice to process and issue prescriptions, clearly stating this in the clinic letter. The specialist should email the prescription request to the practice generic email if there is likely to be any delay to the clinic letter being sent.

2.6 It is reasonable to expect GPs to manage cardiovascular risk management - lipids, hypertension, and type 2 diabetes where these are identified in clinic.

3. Results Management

Test results requested by secondary care are sometimes sent to GPs for action without prior agreement, creating additional follow-up tasks. GPs also report delays in patients receiving important test results or having patients follow up with GPs for results that were not communicated by secondary care. Results of tests carried out in primary care may not be forwarded to the requesting consultant.

Examples

- Result of a CT scan arranged by secondary care copied to GP with no further information.
- Comment on discharge letter for GP to 'chase' outstanding results from the admission.
- Patient contacts practice for result of consultant organised test – says they were advised to do this by the secretary.
- Abnormal result of test organised by GP visible on portal but no way of knowing if actioned by GP.

Recommendations

3.1 It is the responsibility of the requesting clinician to ensure the result is directed back to them and actioned.

3.2 It is the responsibility of the requesting clinician to ensure the result is handed over to the patient or clearly handed over to another clinician.

3.3 It is the responsibility of the requesting clinician to clearly explain to the patient what tests have been arranged and why, and when and how they will receive the results.

4. Discharge and Care Handover Gaps

GPs highlighted gaps in discharge communication, where the diagnosis and management plan were not clear. It was sometimes unclear if a test or follow up had been arranged or was expected to be arranged by the GP. Not enough information was given where there was a request for a GP to review a medication or repeat a blood test after discharge.

Examples

- Request on discharge to review furosemide but unclear why it had been started.
- Request to repeat chest xray after 2 weeks but had actually been booked by hospital.
- Discharge letter showed patient started on apixaban with duration of 1 month but no indication. Required calls to the ward to clarify.

Recommendations

4.1 Requests/suggestions of review by the GP after discharge for medication or blood tests should clearly justify the reason.

4.2 Where medications have been started in hospital for a defined duration this needs to be clearly stated – the number of days field on the discharge prescription is unclear and often refers to the quantity issued.

4.3 Where follow up investigation are needed following discharge, these should be arranged by the hospital clinician.

5. Document Clarity and Accessibility

Both primary and secondary care professionals identified challenges with unclear documentation, including handwritten notes, ambiguous terminology, and generic letters addressed to the registered GP rather than the referrer. Consultants were unsure who to address letter to, particularly if the referrer was an ANP and were concerned that their letters may not be read by a GP.

Examples

- Clinic letter littered with abbreviations and initialisations that were indecipherable to the GP and patient.
- Carbon paper, handwritten discharge summary impossible to read any text at all.

Recommendations

5.1 All communication should be in clear unambiguous language.

5.2 Where possible, letters should be addressed to the referring clinician. Practices have processes in place to ensure letters are dealt with if the referrer has moved on or is away.

5.3 All discharge summaries should be created using the digital system

5.4 Abbreviations/initialisations should be avoided except where thesse are universally used and understood across primary and secondary care and would be clear to patients.

6. Referral Quality

Consultants highlighted that they sometimes received referrals which could have been avoided by following established guidance. Referrals were sometimes made simultaneously to several departments. The information included in referral letters was variable and did not always include enough information to allow the consultant to make a triage decision. In particular, information around frailty or ceiling of care was missing. It was felt that on occasions referrals from trainees or ANPs may have been avoided if an experienced GP had been involved.

Examples

- Referral to specialist for a simple condition by an ANP that would not have been referred by an experienced GP.
- Referral for the same patient to three different specialties at the same time. Letter did not highlight the other referrals.
- Patient seemed unaware of the reason they were referred to clinic and did not want any surgical management when offered.

Recommendations

6.1 Before referring, GPs should ensure that local guidance on DGRefHelp has been considered.

6.2 Referrals to several specialties for the same symptoms should rarely be necessary and where it is felt to be appropriate it should be made clear on the referral letter the other specialties involved.

6.3 Referrals should include enough information to allow the consultant to make a triage decision, particularly information about frailty and level of day-to-day functioning.

6.4 If there is a colleague with more knowledge in a clinical area, it would be reasonable to discuss with them before referral.

7. Advice Referrals

GPs value the advice received by SCI Gateway advice referrals but highlighted that sometimes a timely answer was not received, and sometimes no answer was received at all.

Examples

- Advice request done to specialist to highlight significant worsening of symptoms and requesting upgrade. Response only received months later; they had subsequently required admission.
- Advice request sent to specialist but no reply received. On chasing the secretary, it transpired that the patient had been added to the waiting list for outpatient review but GP and patient were unaware.

Recommendations

7.1 Advice requests should be dealt with by consultants with the same priority as urgent referrals.

7.2 A response should be sent to an advice referral within 1 week, with arrangements made to ensure that absence is covered.

7.3 A response should be sent to an advice request even when the decision is made to review the patient in a clinic appointment.

8. Arranging Community Investigations

Consultants were unclear how to arrange investigations needed for outpatient treatment between face-to-face outpatient appointments. GPs highlighted that they were often tasked with arranging investigations meaning the results came back to them, resulting in extra work and risk the result didn't get back to the consultant. Sometimes it was unclear if there was ongoing review in place. Different practices responded differently to requests for investigation with some declining to arrange them and others agreeing.

Examples

- Consultant requested blood tests to be done in the community with the required tests on ordercomms but received letter from the practice to decline.
- Low white count result phoned back to practice; chemo patient. Following several phone calls, chemo nurse was already aware and managing but time spent chasing.

Recommendations

8.1 There needs to be an agreed process, consistent across the region to facilitate blood tests and other basic investigations to be carried out in the community with results going back to the requesting consultant.

9. Referral Triage (Active Clinical Referral Triage - ACRT)

Referrals for outpatient review were sometimes 'downgraded' to advice, sometimes with a list of suggested investigations to carry out and report back. Although this was often helpful for the patient journey, GPs felt it added a burden of specialist management of the patient's condition to them; they may not have familiarity or expertise with the treatment to allow informed shared decision making with the patient.

Letters were sometimes received by GPs to arrange investigations in the meantime, so the results were available for clinic. Again, helpful for patient journey, but additional tasks for GPs and the results of those investigations were then received by the GPs, often requiring discussion with the patient (without any knowledge about what the management may be or when they will be seen), forwarding on to secondary care.

Examples

- Letter received from specialist to request a radiology test while waiting for outpatient appointment. It was felt this would be more appropriate to arrange in house.
- Referral to specialist returned with management suggestions. Patient was upset they were not getting to see a specialist as agreed. Treatments suggested were not appropriate for this patient; referral resent.

Recommendations

9.1 Investigations considered necessary on ACRT before first outpatient appointment (which are not part of an agreed referral pathway) should be organised by the clinic and the patient should be notified by the clinic that they will get an appointment for the test along with detail of how and when they will receive the result.

9.2 If investigations required by an agreed pathway on DGRefHelp have not been completed before referral then the referral can be passed back to the GP.

9.3 Consultants should consider writing to the patient as well as the GP if downgrading a referral to advice only unless the referral was inappropriate according to an agreed pathway on DGRefHelp.

10. Patient Experience

Practices were frequently contacted by patients looking for the results of investigations carried out by or arranged by consultants. Patients reported long waits to receive the results of investigations, sometimes having to wait for long delayed outpatient clinic appointments. Patients sometimes had to contact their GPs to find out the outcome of an outpatient appointment because they did not receive a copy of the clinic letter. Consultants reported that patients were sometimes unaware of the reason for referral.

Patients often contacted appointments or department secretaries to find out how long their wait for an appointment would be. Often they were unable to get this information. Sometimes they were advised to contact their GP to write a letter to upgrade their referral.

Examples

- Patient makes appointment with GP. Awaiting operation and when phoned outpatients told should get GP to write a letter to upgrade. Patient is deteriorating but in the same way as all the others waiting. Result either upset patient because GP does not write or pointless loop where the GP writes and the consultant writes back to say doesn't meet criteria for urgent.
- Patient makes appointment with GP. Was advised to do this at hospital clinic but they don't know why and no letter available.
- Patient contacts practice for result of their hospital arranged CT scan. They had contacted the secretary and told to get their GP to 'look on Portal'.

Recommendations

10.1 Results of investigations should be handed over to patients by (or on behalf of) the clinician ordering the test.

10.2 Patients should be told how and when they will receive the results of tests at the point the tests are arranged.

10.3 Patients should receive a copy of clinic and discharge letters. Letters should be written in language the patient can understand.

10.4 Patients should be able to access an accurate estimate of waiting time for their hospital appointment.

10.5 Patients should not be directed to their GP to upgrade a referral because of long waiting time.

10.6 It would be helpful for departments to develop criteria where they feel it would be appropriate to upgrade a referral so these can be applied consistently.

10.7 Patients should not be directed to their GP for results of tests arranged by hospital clinicians.

Impact on Time

From the results of the survey, it is possible to extrapolate - approximately 550 communication issues per week are estimated across Dumfries and Galloway, amounting to a conservative estimate 46 hours weekly (assuming each issue took 5 minutes to resolve).

Many of the issues require no extra time to eliminate, just increased clarity of communication, along with clearly stated responsibilities.

Moving Forward

A communication standards framework will be developed based on these results which will aim to build on existing good practice to improve clarity, reduce duplication, and promote a collaborative approach to patient care across primary and secondary care services. Patient safety and effective communication are inextricably linked and lead to efficiency and the best outcomes for patients.

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