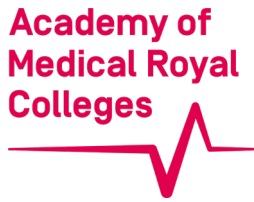


March 2023



# General practice and secondary care

Working better together



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# Foreword

Barely a day goes by without another apocalyptic headline declaring that the NHS is at, or close to, breaking point. But the never ending stream of grim statistics can mask the lived patient reality that behind every single number is a person waiting to be diagnosed or treated, frequently fearful or in distress, within our remarkable but increasingly creaky health and care system.

And as well as these patients, our NHS workforce is struggling to deliver the best possible care in the face of the most extraordinary pressures. Like so many frontline clinicians, I too find it deeply frustrating because no matter how hard we try, the situation rarely seems to improve. I see more demand from patients today in my GP surgery than I think I have ever seen during in my professional career. The need for appointments and care seems to be rising inexorably which is why waiting lists are increasing not falling.

By any measure, one of the issues that contributes to this backlog and to a smooth and efficient patient journey is the well-documented friction that commonly occurs at the interface between general practice and secondary care. Not only does it damage the patient experience and sometimes jeopardise safety, but it invariably causes additional personal stress for all parties and unnecessary work for clinicians and administrators. Indeed, the Academy wrote a well-received report in 2018 which set out how the so-called 'cultural barriers' between the two domains could be overcome through improved communication.

It is against this backdrop that this report has been researched, written and presented to NHS England. The starting point in September 2022 was clear — *find as many examples as possible of ways the friction has been reduced or removed*. There were two other caveats. First, the solutions need to be able to be implemented at low or no cost, and second, they should already be proven to work across the general practice and secondary health and care landscape.

I am very pleased to say it does just that — with each of the over 50 vignettes either directly improving the quality of care or reducing the burden on clinicians and other NHS staff and in many cases — both. Of course, we do not pretend to present all the answers here — the timing and scope of this project were strictly limited, but I sincerely hope this document will be viewed as a snapshot of great opportunities already at our disposal, where local systems can learn from each other.

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It has long been the Academy's private mantra that it should be part of the solution and not just amplify problems. This work, I hope exemplifies that philosophy and I must thank my Academy colleagues who have put this report together.

I am also immensely grateful to the hundreds of dedicated healthcare staff from across the UK who took the time to contribute to this report, not just for their input to the focus groups or the follow-up interviews, but because in many cases they are the people who have gone beyond the call of duty to make the changes that are clearly delivering so many of the benefits documented here. Thank you. because between us we can and will improve the NHS for the benefit of everyone.

A handwritten signature in black ink, appearing to read 'HSL', with a stylized flourish at the end.

**Professor Dame Helen Stokes-Lampard**  
Chair, Academy of Medical Royal Colleges

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## Author's note

Much has been written about the challenges that occur at the general practice and secondary care interface. Some feel the problem almost pre-dates the NHS itself, while others point to the internal market and the purchaser provider split of the 1990s, others to the Lansley reforms of 2012. 'Perverse incentives' was also a frequent theme we heard in making this report, as too were the ways general practice and secondary care receive payment for the work they do.

This report, some may say thankfully, does not seek to address any of those issues. Instead, what is set out here is a compendium of practical and workable solutions designed by local systems to reduce the friction that inevitably occurs across this divide.

Many are astonishingly simple and help improve patient experience and reduce the burden on clinicians and other NHS staff. We are grateful to all those who told us how they had implemented change and what it meant locally.

There are numerous formats we could have used to present these findings, but for ease we have put the examples into three broad themes: Culture, Communication and Clinical process. At the back of the report there is also an index which groups the examples by operational themes.



**Culture** — which ranged from a 'we've-always-done-it-this-way' philosophy to sometimes outright distrust of those on the other side of the divide. More than one contributor told us of hours, sometimes days, of valuable clinical time wasted blaming others rather than simply fixing the error.



**Communication** — it could be argued that this is something of a catch-all definition, but for the purpose of this report we have used the word in a narrow technical context, meaning the methods healthcare professionals use to communicate with each other be that email, telephone or even encrypted messaging platforms.



**Clinical process** — meaning the way patient pathways have been shaped by historical, technological, cultural and institutional constraints creating inflexible referral and discharge processes which do not allow for nuance, and which have not adapted to effectively manage patients with increasingly complex needs.

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Some initiatives improve more than one domain. Where this is the case, the icons above are included with the example.

Of course, many initiatives across the country cover similar areas but are badged under different banners. Where this is so, we have focused on one or two initiatives and named others below them.

Except in notable cases, we have not named individuals connected to the project or programme. However, all of our contributors have said they are happy for us to share their details with other NHS staff on request. If there is anything contained in this report you would like more information on please get in touch with the interface team at [psci@aomrc.org.uk](mailto:psci@aomrc.org.uk) and we will pass on your details.

And finally, this report has been researched, written and produced very much in the interests of knowledge transfer. You are under no obligation to implement any of the initiatives outlined and some may be wholly inappropriate for your local context. Some, however, may just give you that solution you've been looking for to help improve the care you provide and reduce the burden on staff. And it is with that spirit that they are set out here.

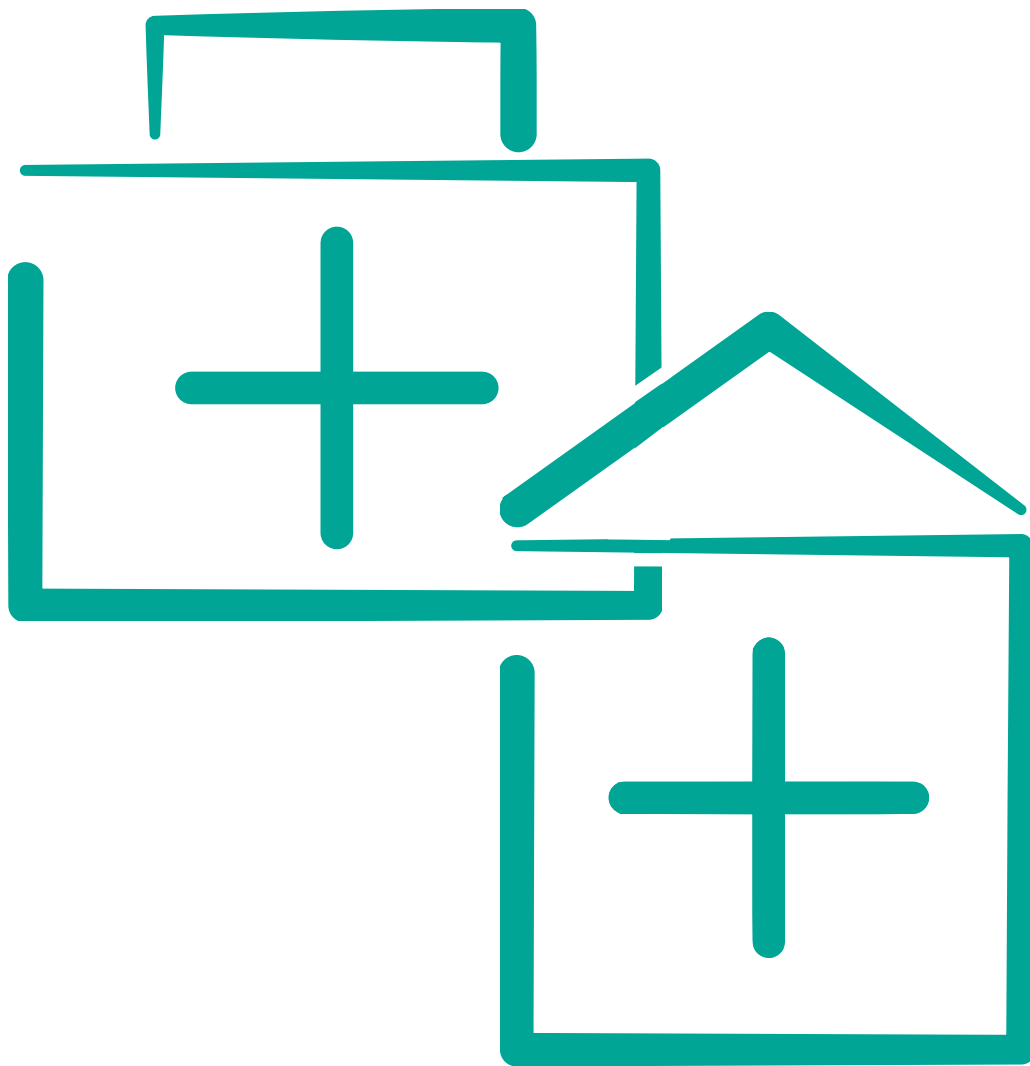
## How we gathered the information

During October and November 2022 the Academy of Medical Royal Colleges hosted 10 focus groups and online forums. More than 200 doctors, health service managers and patients contributed. On top of this, the report team conducted a series of one-to-one interviews with people at all stages of their careers and throughout all four nations of the UK.



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# Culture



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# Introduction

As in the world outside healthcare, culture has many different meanings and can be interpreted in many different ways. In healthcare it is typically taken to mean the way a system distributes services and roles, how clinical pathways have historically been designed, and how staff are divided and treated. It also means shared ways of thinking, norms, beliefs, values and the reasoning behind current practice. Although that list is by no means exhaustive, the concepts underpin the shared assumptions that are the unconscious roots of an organisation's dialogue and day-to-day clinical practice — these form early, go deep and are often so entrenched they are close to impossible to change.

The aim of all healthcare professionals and the system is to deliver effective, efficient, equitable, and safe patient-centred care. The reality is that the current structure is fragmented with the patient's journey split across different organisations, which are driven by different priorities, metrics, outcomes and budgets. Healthcare failures and poor quality are often linked to a poor culture, which often describes the softer, less visible aspects of an organisation. For the NHS to deliver its best care, every aspect of it must understand the spectrum of cultures within it.

Clashing cultures or tribalism allows silo working and a 'them and us' environment to develop. With the COVID-19 pandemic bringing increased demand and pressures, the divides across the interface have, for many, come to feel even greater. Change and the implementation of 'solutions' are often scuppered because the buy-in is not present — that can be because organisations simply don't understand what matters to others and can't or won't communicate effectively.

The examples presented in this report often target a specific issue faced by a local team, but their success and impact are underpinned by an improvement in culture and inter-professional working across the interface. Time and again when speaking with contributors we heard how their projects improved understanding between clinicians, how they found it enjoyable to speak with colleagues across the interface, and how the connections and networks improved their workload and satisfaction in the job. Altering culture can be the hardest of all things to do but it is fundamental to success and is often why solutions work in some places more than others.

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Some contributors told us of projects they have established to specifically improve networking and culture across the interface, such as shared education, 'speed dating' sessions, and monthly meetings dedicated to airing issues faced by those across the interface and looking for solutions. Inter-professional and multidisciplinary working were vital to break down silos and barriers, exposing healthcare professionals to perspectives they may not have appreciated before, ensuring that the patient's journey and clinical experience was the central agenda.

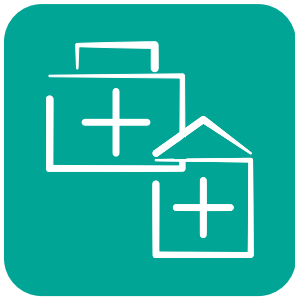
Sometimes what changes culture is simply seeing that new approaches can exist. Our hope is that this report is itself a contribution to improving the culture of our NHS.



## Elderly Care Team Phone line and clinic (RADAR)

Cambridge

### The challenge



GPs can find it difficult to contact geriatric consultants directly about concerns they have regarding elderly multimorbid patients. Therefore, these patients may end up in A&E or routinely referred to clinic, which may not be the appropriate pathway or timeline. To prevent future avoidable admissions, using specialist input, GPs decide when a patient's progression makes it look like in the future they might be admitted — hence the name RADAR — and what can be done now to avoid that.



### The solution

Ten years ago, one of the consultant geriatricians in Addenbrookes bought a pay-as-you-go mobile phone and gave the number to local GPs. This was to answer queries and help create shared care plans for patients. He analysed the calls he'd had and the impact of this service on the patient journey. On the back of this work and a business case, the hospital gave the service space in the newly formed ambulatory care clinic and paid for one full-time equivalent consultant.



Currently there are two consultants that share the role across the week. This medical clinic is supported by nurses in ambulatory care, and can access radiology, other specialities and therapists (Early Intervention Team). During a call with a GP, they discuss the patient and make a decision about care. The majority of the cases are solved through discussion. If they decide the patient needs to be seen, the consultant books them directly into RADAR clinic.

The clinic is designed so that patients can be seen the same day/week. This triage is important and is vital to the running and success of the clinic. It is important that the right patients are brought in at the right time.

RADAR is a bit like a one-stop-shop. The consultant can access the GP notes using GP connect (read only version of Electronic Patient Records [EPR]), fully review the patient, do investigations and scans, make a diagnosis and create a treatment plan. RADAR can

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follow-up patients in clinic (as continuity for these patients is vital and it prevents loose-ends) and/or transfer care back to the GP, depending on the case. If patients are or become unwell, they can arrange direct admission.

The service has been spread by word of mouth, the GP liaison team, through teaching and on discharge letters.

## The outcome

The dialogue and two-way communication this service provides improves understanding of the needs of the patient and as a result improves the quality and timeliness of care. It also improves the connection and networks between community and hospital clinicians. GPs surveyed found the service very helpful to gain rapid, specialist advice that was pragmatic and holistic.

A review indicated that GPs mainly referred medically unwell patients where there was diagnostic uncertainty or unmanageable symptom burden, those with abnormal investigations of uncertain significance, or those with significant functional decline. Roughly 66% of patients referred had more than one presenting complaint, with weight loss, shortness of breath and confusion being the top three complaints. Approximately 8% patients are admitted from clinic and 13% are admitted within 30 days of their RADAR appointment. The clinic has a 3% 30-day mortality rate.

The service does have some limitations. First, the funding is only for one full-time consultant. This results in occasional gaps which can be hard to cover as other consultants and registrars do not have protected time to cover the phone. However, data indicates this is still a rapid service with an average length of time from referral to review of 2.7 days (range same day to 15 days). Second, the set up means that only ambulatory patients can be seen, meaning those most frail and vulnerable are not able to access this service.

It is difficult to collect robust data as this is about preventing admissions/A&E attendances in the future. It is subjective to say that patients who attend clinic would not have instead ended up in A&E or on a ward. And for those that do end up admitted, it is hard to quantify how clinic involvement impacted the severity of the patient's problems and therefore complexity/length of stay. However, a survey of GPs using the service found that 96% thought their discussion with RADAR had helped avoid the patient's admission. Anecdotal feedback from secondary care and general practice is always positive, in terms of improving care and communication across the interface. Being provided with clinic space, resources and protected consultant time is considered a vital part of elderly care services.

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## General practice-secondary care interface groups

One recurring theme that emerged throughout the engagement process is the growing presence of 'interface groups'. These take multiple forms but commonly bring together local GPs and secondary care consultants to discuss interface issues. They have tended to evolve organically based on the specific local circumstances, and therefore unsurprisingly vary considerably in size, membership, regularity and where meetings occur [virtually vs face-to-face]. Many began during the COVID-19 pandemic but their ability to build trust and make a real difference to patients and clinicians mean that they continue to thrive across the country. Set out below are examples which build a picture of how groups have been tailored to local needs and show how one size does not fit all. The examples are by no means exhaustive but represent a sample of the types of meetings that are held.

## Example 1 – Joint working

### RCGP Scotland

#### The challenge

Clinicians often lack knowledge of the specific pressures experienced in other care settings. Misunderstandings of this kind can lead to poor patient care and create 'tribal' divisions between hospital and general practice. The importance of this issue and its negative impact on workload and morale was made all too clear in Scotland in 2016 following a Government report looking at improving sustainability of general practice.

#### The solution

On the back of this, the Scottish government commissioned the Royal College of General Practitioners in Scotland to undertake a nationwide project aimed at bringing general practice and secondary care closer through the establishment of interface groups at health board level.

#### The outcome

Four years on, eight of the 14 boards now have well established groups, with these varying in shape and size, but all including representation from general practice and secondary care. Encouragingly, there have been some important successes. For example, in Ayrshire & Arran and Forth Valley, a work shadowing scheme for GPs and secondary care consultants received high praise from all the participants. In NHS Forth Valley, the interface

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group successfully developed 'referral out' criteria to help secondary care doctors transfer the care of inpatients back to general practice safely. Another health board pioneered 'covid clinical advice meetings', hosted by a respiratory consultant over Zoom, where GPs were provided with important clinical updates about the pandemic.

The parallel evolution of groups has been important in identifying key themes underpinning success. For example, the best groups have had a good balance of clinicians from both general practice and secondary care and included individuals of adequate seniority to enact change at a regional level. Furthermore, ring-fenced funding, administrative and IT support as well as an effective action log have been key to success. Groups have seemed to thrive where the clinical workforce is consistent and in regions of moderate size (as opposed to rural areas or very large conurbations). Unsurprisingly, groups have tended to struggle where the tone has been overly political. Future work will look to develop groups in the remaining health-boards and consolidate the success of the last four years.

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## Example 2 – Integration meetings

### North Central London

#### The challenge

There is tension between general practice and secondary care when establishing where workloads sit. This can lead to strained working relationships between doctors and poorer patient care.

#### The solution

North Central London Integrated Care Board set up integration committees at borough and board level. These one-hour, monthly meetings give an opportunity for grievances to be aired and solutions worked out. Half the meetings focus on customer service issues, and the other half focuses on real-world initiatives that are making an impact on the interface. These include paediatricians working in Primary Care Networks (PCNs) and the heart failure pathway that was co-designed between cardiology and general practice.

The committee is chaired alternatively by the Medical Director (MD) of the trust and a GP. It is balanced 60:40 in favour of general practice and includes:

- General practice representatives, including providers, commissioners and Local Medical Committee (LMC) members
- Hospital representatives, including the top two tiers of leadership, communications, and operational management (to solve customer service issues).

Administrative support is provided by the ICB and medical directorate from the Trust, with the Medical Director's secretariat support present at the meetings.

In between meetings there are two pre-meetings:

- One for the trust to ensure that promises are being kept
- One for the chairs to ensure actions had been captured and preparation for the next meeting.

The committee also hosts a clinician from the 'other side' [reciprocal visits], with GPs going into hospital and consultants going into general practice for a session to network and gain experience.



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## The outcome

The committee has a good turnout, which is crucial as its success relies on partnership, better communication and better networks. It is about improving the relationships and culture as well as the transactions.

Its explicit function is to sort out problems, which it takes seriously. By doing so they have built up trust, improved relations and celebrate good partnership. The focus on the customer service part of the meeting has got shorter over time as issues have been resolved.

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## Example 3 – Clinical Interface Group

North London

### The challenge

There is widespread recognition that many issues at the interface are the result of a lack of communication and rapport between the individuals involved. Furthermore, many problems are not addressed properly simply for lack of time and the opportunity to communicate across the divide to discuss solutions.

### The solution

Whittington Health NHS Trust have hosted an active Clinical Interface Group (CIG) for over ten years, in which leading figures from hospitals and GP surgeries come together to discuss their experiences and explore potential solutions together.

One of the group's particularly impactful creations was the GP-Consultant Exchange, in which a consultant and GP are paired to shadow each other for sessions in both general practice and the hospital. The doctors are then required to complete a reflective template of their experience.

### The outcome

There have been many successful outcomes since the CIG was established, but most importantly, those involved feel it has driven some very positive cultural changes. In particular, the reflective template completed by participants of the GP-Consultant Exchange has led to a better understanding and appreciation of the pressures and demands that exist on both sides of the interface. It has also helped to reaffirm the crucial fact that everyone is working together to secure the best outcomes for patients.

Other ideas that were implemented by the CIG include:

- More effective use of prostate-specific antigen reporting by working with the urology and pathology departments to add a comment, 'check if patient has history of prostate cancer' for clinicians
- Using a 'traffic light' system on the Trust's GP website to indicate which hospitals and community services are running. This was praised by GPs during the pandemic.

The group has also held a celebratory evening to acknowledge their achievements and to continue to get to know one another.

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## Example 4 – Local Delivery System (LDS)

### North Hampshire

#### The challenge

In North Hampshire, GPs felt after the COVID-19 pandemic that it would be useful to connect with secondary care colleagues to share experiences and build understanding about the challenges each were facing.

#### The solution

A fortnightly online meeting was set up within North and Mid-Hampshire for GPs and secondary care colleagues to share their experiences of working during the pandemic and the issues they are currently facing. The meeting has now expanded to focus on interface issues, with a strong emphasis on finding shared solutions.

#### The outcome

The meeting has received positive feedback from colleagues across general practice and secondary care as a new way to foster better relationships and resolve operational issues. Many topics have been discussed at the meetings, including:

- How to deliver new services, such as hot hubs, virtual care and home visits
  - End of life care planning and use of ReSPECT forms
  - Ethics discussions
  - Two-week rule referrals
  - How to use digital technology in and out of hospital to improve communication and services
  - How to effectively use advice and guidance solutions
  - How to manage the growing demand for diagnostics.
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## Example 5 – 'Medical Council' bringing together GPs and Secondary care physicians

Gloucestershire

### The challenge

GPs and secondary care doctors can often lack a clear understanding of the practical reality of each other's roles. This can lead to misunderstandings and tensions at the interface.

### The solution

The Gloucestershire Medical Council brings together local GPs and secondary care consultants, providing a non-confrontational forum where important interface issues can be discussed and solutions co-created.

### The outcome

The Medical Council has been instrumental in building strong working relationships between local senior leaders in general practice and secondary care, driving a marked cultural shift in the region, and providing a strong foundation for change initiatives.

During the research for this report, numerous informal forums came to light. They typically shared a common theme of coming together to get to know one another and gain understanding and insight into the pressures and daily realities being faced. In Surrey Heartlands, for example, monthly webinars were set up at the start of the COVID-19 pandemic to provide a space for teams across the health system to ask questions about current issues and hot topics. Run jointly by Surrey Heartlands ICB and Sussex LMCs, these webinars have between 30 and 70 attendees each month and hundreds of retrospective views.

Likewise, Surrey Heartlands have also set up a 'speed dating' event before the pandemic for clinicians in general practice and secondary care to get to know each other in a more informal setting. Colleagues were brought together in a room and invited to move between tables, with a bell being rung every five minutes signalling when it was time to move on. More of these events are now planned for the area.

In Nottinghamshire GPs and hospital consultants hold an online Grand Round each month to specifically discuss managing problems at the interface. It is open to all and is unashamedly solution focussed with each group able to describe the challenges they are facing and elicit help from colleagues on the other side of the divide.

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# Creating new opportunities for mid-career GPs in secondary care

Derbyshire

## The challenge

General practice is facing particular workforce retention challenges. Part of this is related to career satisfaction, which is often driven by GPs' desire to explore opportunities that enable them to diversify their skillset.

## The solution

Derbyshire ICB is currently looking at introducing a pilot scheme for mid-career GPs to undertake one-year placements of weekly sessions within a secondary care speciality to enable them to develop a new specialist skillset, and also to foster new relationships with secondary care colleagues. The pilot will be hosted by the Derbyshire GP Task Force, with the involvement of both the Local Medical Committees and medical directors across the ICB.

The pilot scheme has not yet commenced, but presents an exciting opportunity for mid-career GPs to develop new skills, enjoy greater job satisfaction, and to harness stronger relationships with their secondary care colleagues. By its very nature, the scheme would also bring specialist knowledge into the general practice setting, enable GPs to knowledge share locally and more easily navigate complex patients within the community.

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# Breaking down barriers through leadership

## County Durham

### The challenge

Against the backdrop of changes to local commissioning structures and the intensifying pressures on the workforce, relationships between general practice and secondary care in the Northeast, as elsewhere, were strained. At times, it could feel like the 'patient was lost at the centre' according to doctors working in the Trust. Often, if an issue was flagged it would lead to confrontation. It became clear there was limited appreciation about what it was like to work on the other side of the interface.

### The solution

In conversation with the CCG, County Durham and Darlington NHS Trust agreed to create a new role on their senior leadership team for a director of primary care. This role was intended to serve as a link to local GPs, and a dedicated email was established to provide a route for GPs to feedback to the Trust. Given its seniority, the role ensured better representation for GPs in strategic decisions made by the Trust and to provide a platform for closer collaboration.

### The outcome

Culture is difficult to change and the role was initially met with a degree of suspicion from both GPs and hospital doctors looking for 'an ulterior motive'. Furthermore, changes to behaviour are often subtle and therefore difficult to objectively measure. In the end, progress was made by 'helping people see the perspective of others' and reminding doctors, on both sides of the interface, that 'they all used to share a drink when they were training'.

Slowly, opinions have shifted, and this has provided a springboard for new initiatives. For example, the community hospital model was overhauled so that GPs now lead care provision in the six local facilities. This is commissioned separately, provides local GPs with increased job variety and has been an important step in breaking down the traditional boundaries between hospital and general practice. At the local acute trust, GPs have been brought to the front door with the establishment of a Primary Care Hub in the Emergency Department.

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Where appropriate, care traditionally delivered in hospital has been moved closer to patient's homes. The diabetes team now run several consultant-led clinics in local GP surgeries and there is a well-established 'consultant advice line' that provides timely GP access to advice from senior hospital clinicians. Pathway redesign has helped to reduce the administrative burden at the interface. For example, Allied Health Professionals are now able to refer directly to hospital teams, rather than via GPs where this is appropriate, freeing up valuable time for direct clinical care.

The fundamental ingredient underpinning success has been a shift in culture, which is well captured by the recent formation of a formal partnership between County Durham and Darlington Foundation Trust and a local exemplar GP surgery. This has turned on its head the traditional model of acute trusts 'taking over struggling practices' by instead building on excellence at the interface to drive future improvements.

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# Complex Educational Intervention

## Grampian

### The Challenge

Many of the tensions that exist between primary and secondary care are due to a lack of understanding of the differences in the practical reality of working on the other side of the interface. Shared learning is a recognised method for building trust and establishing strong relationships that can benefit patient care.

### The Solution

With this issue in mind, GPs and secondary care physicians in the North of Scotland worked together to create a Complex Educational Intervention in partnership with an organisation called Practice-based small group learning (PBSGL). This intervention brings GPs and hospital specialists together in small peer groups to discuss real-world clinical cases and their practical implications, a strategy that is known to be effective at changing 'real-world' practice.

### The Outcome

This intervention has been piloted with positive feedback noted from participating clinicians. Importantly, follow up interview three-month post intervention revealed ongoing impact and meaningful changes in practice.

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## Interactive e-learning module on the interface

North Lincolnshire

### The challenge

Teams in North Lincolnshire were reporting confusion between clinicians as to who is responsible for what and, sometimes, inappropriate transfer of workload between general practice and secondary care.



### The solution

Medical Director of North Lincolnshire CCG secured funding from NHS England to develop an interactive e-learning module to improve everyone's understanding and knowledge of the interface. He approached a local web development company and used the funding to pay for the creation of the tool and 2,000 user licenses. The tool was then shared with all health professionals in the North Lincolnshire system, initially as an optional module which would contribute towards CPD accreditation.



### The outcome

Teams in both settings reported an anecdotal reduction in inappropriate workload transfer after the tool was shared. The tool may be included as a compulsory module for local medical trainees during their induction programmes.

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# Interface teaching for medical students

Oxford

## The challenge

Medical students' education can often be strongly secondary care orientated. This can result in junior doctors lacking a holistic understanding of how general practice works and sometimes a poor understanding of interface issues when they start their foundation training.

## The solution

A GP based in Oxfordshire who also works at Oxford University Medical School developed a short online module for medical students to improve their understanding of general practice. The topics covered include what makes general practice different to secondary care, the different methods of communication between GPs and secondary care, and the challenges faced by patients at the interface.

## The outcome

The educational module is currently under evaluation, with the author reporting that the work is likely to be written up as a poster at a national conference. It is hoped that early education about the interface will help future doctors have a better understanding of its challenges and how to overcome them.

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# Development of Consensus Document on Primary and Secondary Care Interface

## Cheshire and Merseyside

### The challenge

There was a lack of principles to guide the ways of working between primary and secondary care outside of those detailed in contractual obligations. This was contributing to siloed working and a lack of partnership at the interface.

### The solution

Cheshire and Merseyside Integrated Care Board developed a consensus document which provides a set of clinically led principles which all staff should consider when interacting with colleagues. The document covers a range of situations including but not limited to prescribing, fit notes, and diagnostics. This document was created in collaboration with local organisations including the System Pressures Task and Finish Group, Trust Medical Directors, Primary Care Providers Forum, and Local Medical Committees. It was also endorsed by the RCGP Mersey Faculty.

### The outcome

The [consensus document](#) gives teams within Cheshire and Merseyside a set of shared values that facilitate working across the interface, including setting out key underlying principles, such as, clinicians should seek to undertake any required actions themselves without asking other teams or services to do actions on their behalf. This has helped reduce ambiguity regarding clinical responsibility and provides a platform for partnership working moving forward. The principles have also been adopted by other systems, such as Derbyshire, in recognition that the process of collaboration is greatly facilitated by having a set of shared principles and provides a useful stepping stone to eliminating issues at the interface.

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# Writing Fitness to work certificates (Med3) 'fit notes' in the hospital

Mid and South Essex

## The challenge

Thousands of GP appointments are used each year to issue fitness to work certificates (Med3), often colloquially referred to as 'fit notes'. Many of these appointments are not necessary, as a range of healthcare professionals in both general practice and secondary care are legally able to issue these certificates.

## The solution

In Mid and South Essex guidance was developed and disseminated to its hospital trusts that provides clear instructions for healthcare professionals on how to issue Med3s. The guidance document also outlines the expected minimum period of time that a patient should be signed off, depending on the procedure that has been undertaken.

## The outcome

The guidance has raised awareness among healthcare professionals working in hospital trusts of their eligibility to provide Med3 documentation. It has also provided greater clarity over the estimated time periods that patients should be signed off for. There is anecdotal understanding locally that this has also reduced the number of patients presenting to GPs to request fit notes.

It is worth noting that a new [standard for implementing electronic Med3 documentation](#) has been recently published. It allows for a recommendation by secondary care providers supporting a Statement of Fitness for Work to be issued electronically (eMED3) in a hospital setting.

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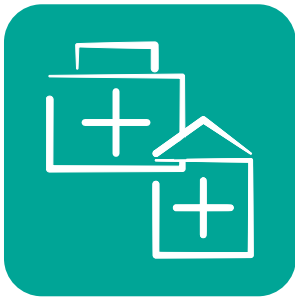


## Paediatricians in general practice

Somerset

### The challenge

Paediatricians in Bristol and the South-West felt they were receiving too many inappropriate referrals which could be more effectively managed in general practice. They began working with GP colleagues to tackle the problem and discovered a commonplace tendency to err on the side of caution. While not unreasonable, this did lead to an excessive burden on the secondary care specialist system.



### The solution

Hospital paediatricians worked with GPs to set up community clinics at GP surgeries where babies and children could be seen. This was followed up by a lunchtime meeting and informal learning process for GPs as well as a case-management procedure.



### The outcome

With specialist advice the teams found that:

- 40% of patients could be treated with a written management plan
- 40% could be treated entirely in general practice
- 20% needed a hospital appointment for investigation or referral to a sub-specialty.



A similar initiative is being undertaken in North-West London [page 43].



## Complex Care Team

Somerset

### The challenge

It can often be challenging to provide care in the community to adult patients who have complex care needs. Patients typically will have a combination of physiological, psychological and social needs that require input from many services including general practice secondary and community care, as well as social and voluntary care services. From the GP's perspective, patients with complex needs can be challenging to manage as they require more intensive input, such as ongoing comprehensive reviews and home visits. They are also at higher risk of using emergency and urgent health care services, which increase the risk of fragmented care for the patient. These patients can also be challenging for secondary care colleagues to manage, who may lack the community context.



### The solution

The Complex Care Team (CCT) in South Somerset was established in 2016, pre-dating Primary Care Networks (PCNs). The CCT consists of an experienced GP, a senior nurse and a support 'key worker' and covers up to six local GP surgeries. Three CCTs, each aligned to a PCN, provide comprehensive assessments of complex patients who are often frail and elderly, coordination and information sharing with GPs, community teams, and secondary care hospital teams.



Shared knowledge between all community teams enables proactive management of patients' social, health, mental health and general support needs. This results in advanced care

planning which lowers the risk of crises that require urgent care, ensuring best chances of care at home when unavoidable deteriorations occur.

The CCTs attend weekly 'huddles' (MDTs) in GP surgeries, incorporating the whole GP team and health coaches. The meeting participants discuss hospital admissions and discharges for complex patients, those on the CCT caseload, and any of concern to the practices, community or hospital teams. CCT members advise on complex management, service coordination, care planning and the ability to contact and visit patients and carers when appropriate.

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A weekly community MDT, involving community health, social and mental health teams, as well as voluntary sector and hospital discharge teams, provides a forum to share knowledge, and enable visit/work-plans to be made without duplication; ensuring the most appropriate team engages with the patient, linking and supporting other services. This has evolved organically to become a coherent neighbourhood team, encompassing all community-based teams and many hospital outreach teams.

The CCT has a liaison role communicating between general practice and the community MDT. There are also regular MDTs with a 'Parkinson's team' and hospital care of the elderly Consultants, for advice and to ensure sound communication regarding patients under shared care.

The CCT also has active involvement with acute hospital attendances of complex patients, by providing detailed knowledge to enable safer care planning, particularly when there are safeguarding and carer-strain concerns.

## The outcome

Multidisciplinary community team working enables the right person to look after the patient at the right time. The combined complex care, huddle and health coach system has been linked with a 14% reduction in hospital admissions, as part of system-wide intervention within general practice and secondary care.

The CCT coordinates the response from appropriate agencies to emergency needs, supporting the patient in the correct place for them, with prior knowledge of the patient's health, wishes and support. The urgent need may be identified by visiting professionals including community staff, GPs and members of the CCT themselves, or any other route.

A pivotal role of the CCT is relationship building, peer support and communication. This is key in building the successful neighbourhood team, leading to mutual trust and respect, with a shared understanding of each other's skills and roles. A key motivator for this is when professionals realise that they have knowledge of the same patients, but were treating them in isolation. Also supporting this is the CCT's access to all services' IT systems. This provides invaluable information that reduces time spent searching for duplicating patient information.

There are also large benefits for the staff involved within the CCT. For example, Foundation Year 2 doctors undertake a four-month shared Complex Care and GP Surgery placement, enabling better understanding for the next generation of GPs and secondary care doctors. This service also offers placement for Frailty Trainee Advanced Care Practitioners, enabling relevant learning and building on a holistic approach to patients with complex care and often, frailty needs.

## Co-creation

Co-creation underpins many of the successful interventions we have heard about. As one respondent put things 'it is difficult to walk in another's shoes when you don't remember what it feels like wearing them!' An open conversation between clinicians about how solutions can work for both general practice and secondary care is key as a good ideas in one place may have unforeseen effects elsewhere. Ultimately, success has been achieved where teams with broad representation from across care boundaries have placed patients at the centre, asked what is needed to deliver quality care, and then moulded the interface to fit.



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# Communication



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# Introduction

Good communication across the general practice and secondary care interface is important for ensuring good patient experience, protecting patient safety, and optimising the use of limited resources and clinician time. The landscape has dramatically changed since the advent of the NHS, long gone are the days where 'dear doctor' letters sent by post form the only communication route. Nowadays, clinicians have a cornucopia of options including phone, letter, email, mobile apps, and virtual meetings.

The benefit of strong communication extends well beyond individual clinical issues. In this project, we have heard on numerous occasions how direct contact between clinicians can build trust and a mutual understanding of the challenges faced in different healthcare settings. Open lines of communication can provide a route for education and building specialism. Furthermore, relationships built through regular personal contact can provide a platform to 'think about things differently' and move the care boundaries set by a traditionalist view of the interface.

The breadth of communication methods we have heard about in this project has provided a unique opportunity to understand what works across the interface and what doesn't. A key theme that has emerged time and time again is the value clinicians place on communicating with an 'individual' rather than a faceless 'system', and the need for dialogue rather than communication in one direction. To be successful, clinicians have emphasised that interventions need to connect the 'right' individuals who have the agency and experience to make decisions. Complex triage processes that require information to be repeated, cause frustration and ultimately add to workload.

When designing communication solutions these must closely consider clinician workflow to avoid 'phones ringing off' and 'emails going unanswered' — a perennial bugbear. Digital innovation has revolutionised the way people practice, and there are now good app-based solutions for things such as advice and guidance. While these bring benefits, many have told us how a phone call, with its directness and simplicity, still has an important place.

Clinical governance was a key theme in our conversations, especially in view of widening patient access to health records, and the best interventions used efficient strategies to record pertinent information in the healthcare record that did not add to clinician workload.

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Thinking about how we communicate *with* patients and not simply about patients is a key component of effective interface working. Too often patients fall ‘in the cracks’ between services and need to fight to get basic information about their care. One part of addressing this involves widening patient access to healthcare records, but it is also important that clinicians share information with patients in a way that can be understood. Addressing clinic letters directly to patients is one example of good practice here, but we heard of several others, including using an app-based platform to involve patients in advice and guidance discussions.

Fundamentally, with the demands on the NHS higher than at any other time in its history, effective communication is more important than ever in ensuring patients receive quality care as they move across the interface between secondary care and general practice.



## Adult psychiatry – GP communication link

Cambridgeshire/Hertfordshire

### The challenge



It can be difficult for GPs to communicate directly with hospital mental health teams. Usually there are systems in place for patients in crisis and a single pathway for all other referrals. However, often GPs also want to discuss a patient with a colleague in the mental health team to determine if a referral is needed or if there are other options to support them in the community. As waiting times for secondary mental health care can be very long, it's also important for GPs to be able to easily talk with mental health colleagues to prevent a patient's condition from worsening while they wait to be seen by a specialist.



### The solution

After hearing about the benefits of setting up a weekly lunchtime Neurology MDT, a local mental health consultant decided to set up a similar system to link up mental health professionals with their GP colleagues.

To facilitate two-way communication, the consultant worked with a local PCN to enable access to their Electronic Patient Record (EPR) system. The consultant can now view patients' records, letters and investigations and GPs in the PCN can send an EPR task directly to the consultant.

In addition to this, the consultant is invited to the PCN to lead mental health MDTs and lunch and learn sessions.

### The outcome

In its current form there are some limitations to this new approach. With the consultant usually responding within a week, the system is not live and can't be used for emergencies. It is also currently only for adult mental health issues. Likewise, the time required to answer queries or attend MDTs is not funded as part of work plans, so the success and longevity of this new process relies for now on clinicians stepping up to do the work in their own time.

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However, the initiative has built strong networks and connections between the PCN and mental health teams and it is easily scalable to other teams and specialties. It has also reduced unnecessary referrals as well as wait times for patient plans.

With the whole process being carried out via the EPR there is no need for secretariat support or letters, meaning little administrative burden. It also provides a full audit trail in patients' clinical record. This means that in the GP's absence, records can be seen by other members of the PCN if necessary. Because the consultant can see the patient's complete record, they are able to give full, rounded, and holistic advice. Cases can also be brought to the MDT if more discussion is needed.

This system allows the consultant to review the type of problems presenting in general practice which means that the lunch and learns can be targeted to local need, closing the learning loop, and improving GP's knowledge and provision of mental health care. The system has also identified those mental health patients in the community that don't meet the criteria for referral to secondary care but are beyond general practice. This allows the mental health team to evaluate local need and adapt services accordingly – in this case planning for PCN mental health clinics led by the mental health team.

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There are many examples of mental health teams providing outreach services across the interface like this. In particular, Surrey Heartlands ICB has introduced the GP integrated mental health service (GPimhs), which provides patient sessions with secondary care mental health teams through their GP surgery.

Other places have also made similar use of shared EPR systems. In East London, for example, the team at Barts Health NHS Trust worked with local partners to establish a virtual community renal clinic. This was enabled by the renal team adopting the same EPR system as their local general practice teams, who could then use it to quickly ask consultants questions. Patients were also given access to weekly virtual renal clinics, which were supported by hospital specialists having access to their full GP clinical record via the EPR system. Now, only 10% of patients referred to the virtual clinic go on to require a face-to-face virtual appointment, and the introduction of the clinic has seen average waiting times for specialist advice reduced from 64 days to between five and 10 days.

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# Integrating emails and care records

## Yorkshire

### The challenge

Communicating with hospital teams from general practice is often challenging and time consuming. GPs often say, phones can go unanswered due to operational pressures and relevant email addresses are difficult to find. Even if the relevant individual is contacted, communications are rarely stored reliably in the care record.

### The solution

GP surgeries in Doncaster now use commercial software that allow emails to be sent directly to hospital teams and exchanges uploaded directly to the patient's GP record. Doncaster GPs are using this to good effect to chase scans with the radiology secretarial team and for acute referrals to ambulatory care. The hope is to expand this to A&E referrals.

### The outcome

Local GPs say this simple technological solution reduces workload and allows greater transparency by storing conversations directly in the care record. It also allows for quick and easy communication with hospital teams.

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# 'Backdoor' GP numbers in secondary care

## Gloucestershire

### The challenge

Communicating with general practice from secondary care can be time-consuming if hospital clinicians use publicly available practice phone numbers, which can sometimes take a long time to be answered. Operational pressures in secondary care can mean this interaction is not always possible and it can negatively impact patient care, especially for complex discharges.

### The solution

The Gloucester ICB Primary Care Network clinical directors have provided the 'backdoor' numbers for all their practices to the hospital switchboards of the acute providers.

### The outcome

Hospital clinicians can now communicate with the GP team in a timely way, reducing valuable 'hanging-on time' and increasing direct communication across the interface. Local users say this improves the quality of care and patient safety and significantly reduces doctors' workload.

Some of our respondents underlined that critical contact information of this kind is held centrally on the online NHS Service Finder and clearly, given the impact of local changes of this kind, greater publicity around this resource will bring further benefit.

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# The use of teledermatology to improve the quality of referrals to secondary care

Gloucester

## The challenge

Triaging dermatology referrals appropriately is difficult when images are not attached to the referral. All GP surgeries were provided with a digital camera for this purpose, but for several reasons including the camera not being accessible at the time of the patient's appointment or difficulties with uploading images safely and securely, images were often not sent.

## The solution

A well-known App-based solution was introduced which allows GPs to capture images of patients skin conditions using their own devices and send these to secondary care in a quick and secure way. GPs received a referral response often in hours, rather than days, as had been the case previously.

## The outcome

An increase in the number of two-week referrals with an attached image from 10% to near 100%. This led to a reduction in the need for face-to-face clinics by about 70%.

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# Standardisation of outpatient clinic letters and discharge summaries; including successful uptake of the Transfer of Care (ToC) initiative using Fast Healthcare Interoperability Resources (FHIR)

Leeds

## The challenge

Quickly and easily accessing important information from an outpatient clinic letter and/or discharge summaries, such as a new diagnosis or whether any actions need to be taken by the GP team, can be a time-consuming task when critical information is written in free text without clear headings, and without a consistent layout. Both typically take a couple of weeks to be processed, which can be a common source of frustration for patients who will contact their GP to action a request which has not yet been communicated to them from secondary care. This also presents a potential safety issue for patients who need actions undertaken urgently.

## The solution

The ophthalmology department at Leeds Teaching Hospital has introduced an electronic outpatient records system which ensures that clinic letters are provided to back to the GP team in a standard format including headings for 'diagnosis', 'treatment given' and 'GP actions'. The 'GP actions' heading is compulsory for clinicians to complete. As a further benefit, outpatient prescriptions can also be issued via this same platform. There are plans to extend this standardisation of clinic letters across the organisation.

Leeds Teaching Hospital has additionally begun the rollout of its Inpatient (Acute) Discharge FHIR message solution, which enables them to send patient discharge summaries directly into the GP surgery IT systems, and allows GP surgeries to respond if necessary.

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## The outcome

The standardisation of clinic letters has been popular with local GP surgeries, who have fed back that it is much quicker for their teams to determine whether there are any actions relevant for the GP team to undertake, as well as enabling them to input any relevant diagnosis/management updates into the patient record. It should however, be noted that within the context of ophthalmology, it is important that a patient's optical practice is also included in any communication cycle, as most eye care referrals originate from primary care optical practice.

The rollout of the Transfers of Care initiative for inpatient discharge summaries has further benefitted the trust and local GP teams by automating the receipt of secondary care information and allowing automatic uploading into the GP patient records.

It is worth noting there is now a published [national standard](#) that standardises the content and electronic delivery of inpatient acute discharge clinical information. In practice, this removes the need for hospitals to send email attachments or paper letters requiring manual processing by GP surgeries.

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## Connecting care for children

### North-West London



#### The challenge

Children in North-West London experience significant health inequalities. Before the Connecting Care for Children was first piloted in 2014, A&E admissions and hospital attendances for 0–16-year-olds were also increasing. Local services were not properly joined up and opportunities for early intervention and cross boundary working were being missed.



#### The solution

General practice and secondary care paediatric services in North-West London came together with patients and their families to establish Connecting Care for Children (CC4C), a new care model which aims to deliver high quality community-based services and patient-centred care for children.



This model consists of three main innovations:

- Removing the barriers of communication between general practice and secondary care paediatric services, by creating a dedicated phone line and email inbox for GP surgeries in the area to get advice from paediatric services at St Mary's Hospital in Paddington
- Establishing Child Health GP Hubs, operating at Primary Care Network (PCN) level and comprising specialist outreach clinics in GP surgery and regular multidisciplinary meetings with GPs to manage clinical cases and share learning. Child Health GP Hubs enable vertical integration between general practice and secondary care paediatric services, along with horizontal integration across multiple local agencies, including health visitors, school nurses, dieticians, social care, children's centres, CAMHS and the voluntary sector
- Working with local champions to improve the health of children by, for example, encouraging preventative interventions. The team were able to use these networks to contact parents directly via an encrypted message service to share infographic FAQs about the benefits of routine childhood vaccinations, which is thought to have contributed to a corresponding rise in immunisation levels among children.

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## The outcome

The implementation of this new model of care has been met with praise by clinicians working in both settings, along with patients and their families. For example, 88% of parents now report feeling more comfortable about taking their child to see their GP. GP trainees, foundation year doctors and ST1-3 trainees in paediatrics are now able to gain experience in these GP hubs, with many describing it as a highlight of their professional and clinical development.

There have also been observed reductions in hospital activity from GP surgeries participating in these hubs. This includes a 39% reduction in outpatient appointments, with a further 42% of appointments taking place in general practice rather than hospital. In addition, there has been a 22% reduction in emergency attendances and 17% reduction in emergency admissions.

The Connecting Care for Children model has now spread to other parts of London and the UK. Multi-site evaluation has shown similar responses from patients and families and comparable reductions in activity for both general practice and secondary care.

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# Primary Care Access Line (PCAL)

## Leeds

### The challenge

GPs in Leeds reported difficulties in accessing clear and comprehensive advice from a specialist secondary care doctor over the telephone. This could be particularly problematic when patients required urgent care.

### The solution

The hospital created a dedicated phone line, the Primary Care Access Line (PCAL), which is open from 08:30 until 17:00 on weekdays specifically to support GPs by providing advice and triage. The phone is always answered by an administrator who then directs the caller to the most appropriate specialist clinician within the Trust. A rota system in the hospital ensures a specialist doctor is always available to field calls. The administrator also stays on the call and provides support if tests or treatments need to be organised.

### The outcome

Although the system requires allocated rota time, and initially it was difficult to persuade busy consultants to be included, it has been extremely successful and has now been rolled out across all specialties in the Trust, having initially begun as a service for geriatrics.

Out of the cases discussed through the paediatric PCAL line, 30-40% were able to be managed in the community with advice alone. GPs now say they are better informed and are less likely to refer. They also report being more confident in redirecting patients to other services such as hot clinics or urgent outpatient services.

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# Single Electronic Health Record (EHR) in all ICB GP surgeries (including secondary care access)

Leicestershire

## The challenge

Clinicians need to access patient information from interactions with other healthcare providers to provide good care. This is often prevented by the fact that different providers use different EHRs which are not integrated and cannot talk to each other. This can cause issues when a patient moves between GP surgeries or between hospital and general practice.

## The solution

Leicester, Leicestershire, and Rutland worked to move all 130 GP surgeries in the region onto a single Electronic Health Record (EHR) system. The ICB has also installed a module that provides all acute providers in the region access to the EHR, so secondary care doctors are always able to access the GP record for patients presenting as an emergency.

## The outcome

The A&E terminals have transformed the care of patients presenting as an emergency to hospital, improving safety and reducing the risk of medication errors. Using a single EHR in primary care has also helped drive improvements. For example, when the electronic forms used by GPs to refer into hospital were modified, these were instantly accessible to all practices through the shared EHR.

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# Waiting list letter

## Leicestershire

### The challenge

Following the COVID-19 pandemic, the waiting list for treatment in secondary care is at a record high. However, many patients, may no longer wish to see a hospital specialist as their condition has either resolved on its own, without the need of a medical intervention, or the patient may have sought treatment from the independent sector. For others, the need for specialist input has become more pressing. GP surgeries were managing a large volume of waiting list enquiries and spending a significant amount of time writing 'expedite' letters to encourage secondary care colleagues to see the patient sooner.

### The solution

GPs in Leicester worked together with secondary care doctors and administrative teams to develop a 'waiting list' letter. This was sent to all patients on the waiting list and included details of whom they were waiting to see and what they needed to do if they no longer required an appointment, or needed to be seen more urgently. This was made possible due to existing relationships between the two groups of doctors.

### The outcome

A significant number of patients contacted no longer needed to be seen in secondary care and there was strong anecdotal evidence that the number of waiting list enquiries received by general practice dropped dramatically. The success of the project relied on existing well-established links between hospital and general practice.

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# Outpatients helpline for hospital appointments

## Morecambe Bay

### The challenge

During the height of the pandemic, many patients in the Morecambe Bay area near Blackpool were unsure of the status of their outpatient and elective surgery appointments. Roughly one quarter of all patients visiting their GP were simply inquiring about their appointments or seeking quicker help from hospital. This put GP surgeries in a difficult position, as GPs could not provide answers or speed up hospital appointments for patients.

### The solution

Morecambe Bay NHS Trust established an outpatients' helpline which patients can call directly without involving their GP surgery. The helpline is publicised on social media, the Trust's website, and in local GP surgeries. At the point of referral, patients are also given a postcard or sent a text by the referring clinician with the helpline number.

For patients whose symptoms have deteriorated and need an appointment sooner, the helpline call handlers liaise with the hospital specialist team to help them get the right care at the right time. Patients can also call the number if they no longer need their appointment.

Furthermore, if concerned patients do call their GP surgery, they are provided with a phone number for the hospital where their appointment is scheduled to take place. This means that more patients can access accurate information about their appointments, saving wasted appointments in general practice and allowing more people to get the right help.

The helpline was established using a team at the Trust's Patient Contact Centre, which had a similar process in place before the pandemic for patients being referred on a two-week cancer pathway. Although the helpline was initially established for patients being investigated for cancer, it was expanded to support all outpatient pathways.

### The outcome

The intervention has made a significant difference, with in-person queries at GP surgeries about appointments now minimal. The changes initially required some extra staffing: there was a peak of 400 patient phone queries per week for the first month after they expanded the helpline to all outpatients. However, this soon settled, and existing staff levels were found to be sufficient.



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# Email addresses and a shared inbox for all outpatient department secretariats

Mid and South Essex

## The challenge

It can be very difficult for GP teams to contact secondary care teams about queries, referrals or waiting times, with a lot of communication nationally still occurring via the post. This means that communication between GP teams and hospitals can be very slow and unreliable.

## The solution

An initiative has been rolled out in Mid and South Essex for all hospital secretariats to have direct email addresses, with communications to be managed by outpatient department secretaries via a shared mailbox. This eliminates the need for any referrals via post and allows the GP team to communicate more easily with secondary care outpatient departments about queries, such as waiting times and whether a patient's appointment can be changed.

## The outcome

This initiative is expected to improve the reliability and pace of communications between general practice and secondary care.

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# Consultant Connect

## South London

### The challenge

The mental health team wanted to break down the rigid distinction between GPs and secondary care, in particular, the different mental health teams. They also wanted to improve patient care, reduce rejected referrals, reduce administrative burden, and improve communication and learning between general practice and mental health.

### The solution

Telephone advice and guidance that enables GPs to speak to the right specialist when timely advice is needed, often removing the need for a formal referral. The initiative was set up by a consultant in her spare time, initially with some paid admin support. It started at the beginning of the COVID-19 pandemic and used 'Consultant Connect' as they had familiarity with the system. [Consultant Connect is widely used in over 90 healthcare areas covering over 33 million patients].

It allows GPs to call mental health consultants and get real-time advice about a patient or book them into clinic etc. It is also possible to have three-way involvement between the GP, consultant and patient together. The decision and plan is recorded in the patient records and the calls are recorded so transcripts can be obtained if needed.

### The outcome

Overall the new system needs less administrative support and is less time consuming than the previous referral system, resulting in improved patient care. However, South London and Maudsley (SLAM) acknowledge that limited staffing makes it hard to spread its use into other departments and services, and getting others to see it as a workload benefit rather than a time burden is challenging.

Despite these kinds of issues, the initiative has connected clinicians and GPs resulting in meaningful and rewarding two-way conversations. The calls are on average 5-10 minutes, and it is easier to triage than by paper, which means decisions can be made more quickly. As a result of the advice, more often than not, further speciality involvement is not needed. The team reviewed the outcome of the calls they received. In 40% of cases a referral was avoided and for 21% advice helped GP teams to continue care in the community.

In a survey of mental health consultants on the Consultant Connect rota, more than 50% felt it was sustainable, 75% said it was a good use of time and 73% said it was beneficial

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to patient care. Consultants commented that they had initial concerns that they wouldn't have capacity to answer the calls, but the reality was that it was manageable with the knowledge that other consultants are on the rota if they couldn't answer. In general they have been free and the calls have been a welcome addition to the usual working day.

*"I really enjoy talking to local GPs as they know their patients well and have direct experience of the patient. Having conversations is also so much richer than text and often so much quicker to sort out complex issues".*

Mental Health Consultant

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# Encrypted messaging platform for GPs – contraception advice and questions

Sheffield

## The challenge

GP teams in Sheffield found it difficult to contact sexual health consultants to ask for advice about contraception. With a routine referral in Sheffield to secondary care sexual health services being up to 10 weeks, this made it difficult for timely advice to be provided to more complex patients.

## The solution

Building on 20 years' experience of teaching, providing support to general practice and networking in the area, the sexual health consultant team in Sheffield set about bridging this gap by creating an encrypted message group for GPs to act as a forum for these questions to be asked.

It is recognised that, as a low risk and high-volume clinical area, contraception advice is well suited to being obtained through an encrypted online messaging service compared with others. The group's chat history is saved to enable GPs to search through previous discussions, and an audit has been performed to ensure that all advice provided follows clinical guidelines.

## The outcome

GPs report finding the group to be a helpful resource which enables advice to be provided to complex patients who may otherwise have to wait a long time for a routine referral. The group is currently used by 150 GPs, with informal reviews suggesting that 10 queries a month are fielded on the group which could have resulted in a referral to secondary care had the group not been available.

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# Clinical process



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# Introduction

The processes for transferring care between general practice and secondary care have been shaped by myriad factors. Institutional culture has inevitably been important but the communication methods available, the distribution of expertise and resources, and diagnostic advances have all played a part. In reality, these factors have often created inflexible care processes that follow a stereotyped pattern of refer-manage-discharge, with information transfer occurring by discharge/outpatient letters. Unfortunately, the accepted 'norms' in these processes — a free text referral letter from a General Practitioner to a secondary care specialist, or a discharge letter from hospital — can sometimes serve to entrench unhelpful binary perceptions of how care is delivered and who is clinically responsible for a patient.

The challenge is that as technology has advanced, system pressures have increased and patients have become more complex, the traditional process of refer-manage-discharge no longer always reflects what is needed to deliver high quality patient care. This has consistently surfaced throughout the research for this report. It is the development of novel clinical processes that can change how demand is managed, how patients flow through the system and radically enhance the patient experience.

In some cases, this has been as simple as introducing a proforma co-designed by general practice and secondary care that details the referral criteria that a patient should meet, and the specific tests that should be conducted prior to a patient being seen in secondary care. This typically is most successful for more protocol-led pathways that you might expect to see in specialties such as ear, nose and throat (ENT). In other cases, teams have reimaged the traditional one-way, directive referral letter into a referral assessment service, which facilitates a conversation between general practice and secondary care, and may even allow a patient to be managed in the community instead of in hospital. In another example, patients with complex needs are managed by a complex care team which spans general practice, secondary and community care. This has so effectively overcome the interface that the typical 'referral' no longer exists; any work is conducted as one 'team' with a culture firmly rooted in patient-centredness. Other regions have worked to standardise processes where there were unclear lines of responsibility and inconsistent pathways across general practice and secondary care.

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Another common feature of successful changes to clinical process has been co-design. Change cannot be unilateral and must have the buy-in of both sides. This is evident even where changes might be perceived to be minor, such as the issuing of 'fit notes' from secondary care.

For those considering adopting or adapting any of these local solutions, there is a word of caution: there are few, if any, one-size-fits-all solutions. Protocol-led referrals may work for some specialties but may not allow for nuance in more complex referrals. Referral assessment services may allow patients to avoid secondary care outpatient appointments, but must be done in a way that shares workload and responsibility fairly. In line with the new NHS England operating framework we encourage systems to develop and implement local solutions to local problems, with co-design at its core.

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# Ambulatory Care Experience (ACE)

Bradford

## The challenge

Only a minority (10%) of urgent hospital assessments in children translate into an overnight admission. There is a consensus that many of these patients could be managed in the community with adequate specialist support.

## The solution

The team at Bradford developed a robust 'step-up' service where unwell children are referred to a specialist community paediatric nurse team, who conduct assessments and provide treatments to children in their homes. Referral pathways are organised around specific clinical presentations such as asthma or bronchiolitis with clear inclusion/exclusion criteria. GPs in Bradford are increasingly referring to the ACE team, particularly from practices in deprived areas with high levels of acuity. The service saved over 300 bed days last year and continues to receive fantastic feedback from referrers and parents alike. Its success has led to the development of a complimentary 'step down' programme, improving the care of children discharged from hospital and allowing them to be discharged sooner.

## The outcome

From the outset, a focus on replicability was carefully considered in the design of the service. For example, the team have created a bespoke training course for upskilling paediatric nurses (Enhanced Paediatric Nursing Skills for Surge), which is approved by HEE and freely available for use by other systems wanting to set up a similar service.



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Other key features that have been central to the success of the project are:

- A 'why not' attitude among the senior management team at the Bradford Royal Infirmary with a hunger to 'try new solutions for the benefit of patient care'
  - A focus on education, which as well as assuring the clinical aspects of the project, have made participating healthcare practitioners feel valued and improved engagement
  - Robust clinical assurance in the form of consultant paediatrician buy-in with these being willing to shoulder significant clinical risk at the start of the project
  - 'No pushback' policy which means that once GPs have referred, the nurse specialist team are responsible for onward referral if this is appropriate. As such, referring to ACE does not add to GP workload
  - Clear tangible and positive outcomes for patients and their families, which has helped solidify buy-in from local GPs.
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# ASSIST (formerly GP Assist)

Bradford

## The challenge

Information about services and pathways is often shared between general practice and hospital in many different ways and can change frequently, meaning keeping it consistent and up to date can be difficult.

## The solution

A local GP created a 'one stop' tool embedded within the GP Electronic Patient Record (EPR) system, which enables clinicians during consultations to easily access information needed to help patients and professionals. This includes current clinical pathways, patient information, formulary and guidance for referrals. It has been developed, built and is maintained locally, meaning it can be tailored to local requirements. All pathways are co-developed between general practice and secondary care. Pathways can include links to requesting diagnostics/tests, Advice and Guidance, and referral forms.

ASSIST standardises referrals using templates which merge data into the referral letter so the referral goes to the correct service, first time, complete with all the necessary patient and consultation information to allow efficient triage.

## The outcome

The system currently has around 275 pathways and live pages, and records as many as 30,000 hits per month. The collated and up-to-date information reduces time wasted and ensures the right patient is referred to the right place at the right time, thereby improving clinical care.

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# Reducing ophthalmology outpatient demand and improving the quality of referrals from non-specialists

Bristol

## The challenge

In recent years, eye casualty clinics have seen significant increases in patient numbers with reduced capacity, in part exacerbated by the COVID-19 pandemic. A high proportion of ophthalmology referrals from both GPs and emergency departments are considered by ophthalmologists to be avoidable as they can be managed without specialist input.

## The solution

A pilot study recruited 54 patients to evaluate the potential benefit of a smartphone-based lens attachment to improve the referral pathway for anterior segment related complaints to eye casualty from A&E. A questionnaire was completed with each patient to simulate the history from the point of referral, and photos were captured using the smartphone lens attachment.

The A&E clinician reviewing the patients was then asked to document the actual diagnosis and the appropriate timeframe within which they felt the patient could safely have been seen within. The images and questionnaires were then reviewed by a consultant ophthalmologist, who made a diagnosis and management plan based upon the questionnaire [History], and the questionnaire with the photo [History with Image].

## The outcome

Diagnostic accuracy of the reviewing ophthalmologist was 98.2% when the image was combined with a patient's history, compared to a diagnostic accuracy of 48.2% when just a history was provided. This pilot provides evidence of the potential benefit of a smartphone-based lens attachment to improve the referral pathway for anterior segment related complaints. The smartphone lens has also been trialled with a small number of local GPs, with plans for a larger pilot in due course. The ophthalmology clinicians involved in the new pathway are confident that the pilot provides initial validation of telemedicine and that it could be rolled out for use with GPs. However, further work is needed to fully evaluate

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the referral pathway, including the development of systems that allow for secure image transmission. It is also noted that consideration should be given to providing extended clinical services in primary care optical practice via an optometry first approach. The provision of such services will enable a patient to have a full assessment in primary care, close to home in a timely manner, and in many cases have the issue treated without the need for further referral to hospital care.

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## Join the dots

### Cambridgeshire/Hertfordshire

#### The challenge

Elderly patients are sometimes admitted to hospital inappropriately, or experience unnecessarily prolonged hospital admissions due to lack of connectedness of care service. These patients are well-known by their GP and community teams, and would benefit from support to stay well, safe, and independent in the community.

#### The solution

Join the Dots was a six-month pilot project designed by a local Primary Care Network (PCN) to improve care for the local elderly population by embedding the voluntary sector's help-to-home service into the network. Their aim was twofold. First, for clinicians, coordinators and social navigators to identify and refer to the Join the Dots team any patient 75 years and over who was at risk of a hospital admission or readmission, particularly for a non-clinical reason. These patients — and/or their carers — were then contacted to have a person-centred, holistic conversation to build trust, understand what matters to them, and what would help them remain safe, well, and independent in their own homes. This was an opportunity to draw in local support, reablement, short-term care packages, and technology-enabled care, with the aim of preventing avoidable hospital admissions. Notes were added to the GP electronic patient record (EPR) to keep all those involved updated and informed. The team had frequent reviews to see if patients were admitted and why. The team would also discuss what could be changed to support patients better.

Second, the PCN aimed to work with the hospital discharge planning team to help support timely, safe discharges, preventing delays in transfers of care. This team also sped up discharges as they are part of the community care team, which means:

- Patients did not need to wait for the hospital pharmacy, as the PCN pharmacists could sort and issue medications
- If patients required transport, the PCN could utilise the local community transport service
- If temporary care was needed to help get patients home to recuperate, this could be found locally, helping prevent bed blocking

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- If the patient was simply waiting for minor checks/bloods, etc, the PCN team could book and organise these in the community to ensure patients could be discharged and that they are continued to improve
  - The team could set up a plan of action if things went wrong and a patient deteriorated or needed extra support.

## The outcome

The project received initial funding for six months, during which time the team found that admissions and readmissions were reduced, length of stay was reduced, and discharge was quicker. Moreover, patients involved in the pilot were positive that it helped them feel more supported, cared for, listened to, connected to support and services, self-reliant and confident.

The project was successful because it was solution-focussed and the multidisciplinary team [general practice, secondary care, voluntary and community support] was integrated and shared the same goal of improving patient care. This removed barriers and silo thinking to allow for engagement and all-round patient care.

*"It feels so good having someone listen to me and not judge"*

*"I've been so worried about everything! I had no idea our surgery could offer such help"*

*"Although I am not sure what went wrong, I am grateful you were in contact and able to help me sort it out."*

Patient comments on the initiative

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## Neuro MDT

Cambridgeshire/Hertfordshire

### The challenge

Patients with neurological presentations require a flexible referral service as symptoms can often be subtle and fluctuate. Prior to this intervention, the existing referral service was unsatisfactory in that it was designed to seek binary solutions at one 'sitting' and did not allow for nuance or tests to be performed at different times to match with symptoms. Neurology is nuanced — much is based on the history and therefore it can be difficult to explain concerns via a written referral or advice system.



As well as being potentially unsatisfactory for the patient, the conventional referral process can be administratively challenging for clinicians. It segregates doctors into 'those that generate the work' [the referrers] and 'those that do the work' [secondary care doctors] with complex needs sometimes being difficult to fully articulate on paper.



### The solution

A weekly lunch-time face-to-face MDT has been created between GPs and neurology consultants, where patients are discussed. Registrars are also invited to attend and bring cases for discussion. A virtual option for the MDT also runs so the process continues if the regular attending consultant is unavailable.



### The outcome

Local GPs and neurology consultants both say the initiative has led to reduced administrative burden, better networks and improved quality of care — with a 60% reduction in referrals.

Compared to other Primary Care Networks, calls for advice and guidance are reduced by 60-75% and referral rates are down by 15%. It should be noted that ensuring buy-in from both GPs and neurologists has not been without its challenges as this process requires an increased time investment initially to stave off work further down the line.

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# MDT follow-up for all patients who have been ventilated for >3 days on the intensive care unit (ICU)

Cardiff

## The challenge

Patients who have been admitted to ICU have been critically unwell and can have complex needs after discharge from hospital. Those who have been ventilated for multiple days are at particular risk of having complications and ongoing symptoms after discharge. GPs are often the first point of contact for these patients even though they do not always have the resources to manage them, and the experience can be worrying for patients who do not know who to turn to for help.

## The solution

Recognising that many ICU patients will have ongoing care needs after discharge from hospital, the University Hospital of Wales in Cardiff developed a 6-week MDT follow-up pathway for all patients who have been ventilated on ICU for more than three days. Patients attending the follow-up have access to a range of specialists including ICU and respiratory consultants, as well as psychologists and physiotherapists. The MDT will review the patient's clinical status, as well as conduct a drug review and organise any further necessary investigations and management.

## The outcome

This pathway provides clarity for patients who may have ongoing concerns about their health following a recent admission to intensive care. It has been very successful in providing patients with the necessary help they need after discharge and provides them with a clear point of access to expertise. The provision of a follow-up provides patients with a fast-tracked mechanism for seeking the help they require, rather than needing to go via their GP for advice for complex symptoms that are likely related to their ICU admission.

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# Medicines Management Hub

Cheshire and Merseyside

## The challenge

Medication errors and unintentional medication discrepancies complicate as many as half of all discharges from secondary care. Some of these will result in adverse events, and even where this is avoided, create significant work for GPs and pharmacies as well as impacting the quality of patient care.

## The solution

The Sefton Medicines Management Team employed by Cheshire and Merseyside ICB [covering a population of 270,000] have created a medicines management hub, staffed by pharmacists and pharmacy technicians, which reviews and reconciles the medications of all patients being discharged from hospital. The staff liaise directly with secondary care, working in the GP clinical system to ensure the summary care record is accurate, and work with community pharmacies to ensure patients receive accurate and timely prescriptions.

## The outcome

In the last six months, the team has reviewed the discharge summaries of over 6,600 patients, reconciling their medication within the GP clinical systems. To do this they made 350 phone calls to secondary care colleagues to discuss individual patients and performed over 450 telephone consultations with patients. The work has helped identify common 'problem areas' and has fed directly into a teaching programme for medical students at Liverpool University aimed at improving medications management at discharge.

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## Getting patients ready for discharge

Throughout this review, it became clear that some of the main frustrations for clinicians in both hospital and general practice centre on the hospital discharge process. Time and time again, evidence emerged of a lack of clarity relating to, in particular, the issuing of fit notes, the prescribing of medications, and the ordering of diagnostic tests after discharge. Some clinicians reported uncertainty about who exactly was responsible for what in certain circumstances. Others highlighted how poor communication from one part of the care system to another in relation to a discharge can be confusing for patients and doctors, sometimes resulting in suboptimal care.

Some of the key case studies highlighted in this review have successfully fixed these issues. In Leeds (page 41), for example, standardised discharge summaries have been created to highlight clearly what actions need to be taken by the GP team, improving care for patients while reducing administrative burden. Steps have also been taken to clear up doubts as to who can issue a fit note, and how long for, removing the need for patients to book unnecessary appointments with their GP (page 28). Likewise, in Leicestershire (page 80) the team have reached a consensus between general practice and hospital teams as to when exactly it is the duty of secondary care to manage a patient's anticoagulation.

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# Paediatric referral decision support tool/Expert Advisory Forum

Chesterfield

## The challenge

Many children seen in paediatric clinics could be managed in general practice without referral. As the waiting list has grown post-pandemic, the importance of reducing unnecessary referrals has only increased. Common 'offender' conditions are well known and include cow's milk protein allergy and tics. Even if a referral is likely for some conditions, it is important that relevant investigations have been performed and simple management strategies have been tried where appropriate. Conversely, it is important that GPs know when an urgent review by a specialist may be required and how to refer efficiently so children get the best care.

## The solution

The paediatric team in Chesterfield have collaborated with local GPs to improve the paediatric referral process.

A key intervention has been the development of an electronic decision support tool for GPs to help with referrals. This is organised by clinical discipline and sets out in detail the expectations prior to referral, the features that should warrant urgent discussion and whether a condition can be best managed in general practice or secondary care. This was disseminated to GP surgeries through practice managers and, more recently, has been made available on a digital GP platform called 'pathfinder'.

Another important workstream has been the creation of a local 'expert advisory forum' made up of local paediatricians from across different providers alongside specialist GPs, commissioners and allied health professionals. This group meet regularly online to discuss specific problems. For example, they have overhauled the tic referral pathway, co-created clinical guidance and developed a new patient leaflet.

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## The outcome

The decision support tool has received positive feedback from local GPs, with widespread reports that it makes the referral process clearer. Similarly, the expert advisory forum has made real gains, reducing the referrals for tics.

The project has helped identify key themes necessary for success. Progress has relied on strong and enthusiastic clinical leadership, as well as involvement of stakeholders within providers/ICBs who have the power to make strategic/budgetary decisions. Risks remain however, with continued success requiring clinicians to have ringfenced 'service improvement' time as well as improved access to administrative and analytical support.

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# Patient Integrated Teams (PIT) Project

Enfield

## The challenge

As is the case across the country, patients in the Enfield Care Network experience lengthy waiting times for elective NHS care. The waiting times are particularly long for urology patients who are not on a two-week wait pathway.

## The solution

As part of the Elective Recovery Programme, Evergreen Primary Care Centre established the Patient Integrated Teams (PIT) project, a working group across general practice and secondary care with support from the North Central London (NCL) Integrated Care System (ICS). The aim was to create a sustainable and effective method for reviewing patients who are waiting for an elective appointment at their local district general hospital, and to review and optimise the care of patients on the non-admitted waiting-list.

Using a bespoke digital health and care information platform, a GP and A&E consultant extracted a waiting list dashboard to identify relevant patient cases. The GP then conducted a desktop review of patient care records to determine whether each patient, based on their clinical situation, needed a multidisciplinary team (MDT) discussion with a urologist or not. The purpose of the review was to obtain an up-to-date overview of the patients accepted under this specialty prior to their appointments being made in secondary care. The PIT team then arranged a virtual MDT between the reviewing GP and a urology consultant to determine whether each referral still required an appointment or if the patient could be managed by their GP with specialist advice.

## The outcome

The initial findings from two Plan, Do, Study, Act (PSDA) cycles suggest that up to 25% of patients on the elective waiting list for a urology appointment could be safely and effectively managed in by their GP with specialist advice. The team are now working to expand this methodology to other patient and specialty groups within the NCL ICS.

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# Blood test discharge guidance

## Mid and South Essex

### The challenge

Patients often require follow-up investigations such as blood tests after being discharged from hospital, either as part of their ongoing recovery or due to medication changes that may have occurred during their inpatient admission. Secondary care teams are understandably keen to avoid keeping patients in hospital unnecessarily and may sometimes ask the GP team for help in undertaking these tests.

There is, however, often a lack of clarity over what is reasonable to ask the GP team to undertake and what a reasonable time frame might be for requesting tests. The result is that patients often leave hospital with the expectation that their GP team will contact them to arrange a blood test even if no time has been allocated for the GP team to process the request.

Conversely, patients might contact their GP to arrange a blood test when the GP team may not have oversight regarding why the test has been requested, or what test they need to conduct, because they have not yet received any correspondence from the hospital.

### The solution

An agreement was reached between hospital trusts and local GP surgeries which specifies the circumstances in which the GP team or the secondary care team should be expected to order diagnostics. Guidance was disseminated to inpatient wards and outpatients clinics within the hospital, as well as to GP surgeries.

### The outcome

Guidance regarding who is responsible for ordering diagnostics has improved the relationship between GPs and secondary care colleagues. This intervention has also improved the patient experience by providing clarity over which team is responsible for follow-up tests, and improved the safety of discharge from hospital.

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## Advice and Guidance

Advice and Guidance (A&G) sometimes known as Specialist Advice, is defined as non-face-to-face activity delivered by consultant-led services which is either: **synchronous** [such as a telephone call] or **asynchronous** [such as an electronic request sent via the NHS e-Referral Service, or via an agreed IT platform/app]. A&G allows a clinician [often a GP] to seek advice from another [usually a specialist] prior to or instead of referral.

While A&G services have helped change the way referrals are managed, there have been multiple challenges with the service format including [but not limited to] unclear clinical responsibility for the patient, potential shifting of workload onto GPs, and risk-averse decision-making which increases overall workload. Some areas have had great success with A&G, but successful models are typically based on a pathway that has been carefully co-designed and in which strong relationships and a partnership model have been built between general practice and secondary care.

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# Referral Assessment Service (RAS)

## Mid and South Essex

### The challenge

Clinically inappropriate patients were too often being booked into specialist clinics when patients may have been better treated in other settings, often without needing to be seen in secondary care. Not only was this a poor use of GP time, but it meant patients were tended to 'yo-yo' between the two domains without a quick and effective treatment which could have been offered in the first instance.

### The solution

A specialist Referral Assessment Service (RAS) was created which effectively allowed specialty consultants to make a judgement on the best course of treatment for a patient as soon as referrals are received by a Trust.

Specialty consultants have four options at the triage stage:

- Book an outpatient review (phone/face to face)
- Order pre-review diagnostics
- Suggest an alternative or further management by the patient's GP
- Suggest a community-based alternative.

### The outcome

For GPs, the benefits have been significant. They can:

- Refer patients directly into RAS without having to book an appointment
- Help to build an education resource for future patient management
- Create a much-improved record of communication for patient care, service evaluation and audit
- Enjoy a faster and less bureaucratic referral process.



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For hospitals and secondary care doctors the proven benefits are:

- The system ensures only clinically appropriate patients are booked into a clinic
- The system provides an opportunity to request diagnostic tests or treatments prior to an appointment booking
- Greater flexibility of service delivery which reduces pressure on clinic space and administration
- A reduced risk of redirected hospital referrals and unnecessary hospital appointments
- More patients being managed in a community setting.

For patients, the system:

- Helps ensure they are seen and treated in the right place, at the right time, first time, and allows many to be treated in the community which may be preferable to them
- Provides them with quicker access to consultant advice
- Ensures the appropriate services are offered earlier in the treatment pathway
- Reduces confusion because the booking is done directly with the hospital.

A similar initiative is being undertaken in Leicestershire (page 81).

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# Joint online MSK/GP clinic

Lincolnshire

## The challenge

Frail or elderly patients can find it difficult to attend orthopaedic outpatient appointments in hospital and they may not always be necessary. GPs, however, may refer these patients due to clinical uncertainty or need for a specialist opinion.

## The solution

Patients with musculo-skeletal (MSK) problems are invited to an extended GP session which is joined remotely (via online video meeting) by an orthopaedic specialist who can talk directly to the patient. They will often ask the GP to oversee the patient moving and help to make a diagnosis. The patient can then receive appropriate management at the GP surgery, such as an exercise course or a device to help their symptoms. If the specialist does feel the patient needs further assessment, relevant investigations can be requested before the patient is seen in the secondary care clinic.

## The outcome

A much-improved patient experience with significantly shorter wait times to see a specialist. It also reduces the burden on orthopaedic outpatient appointments and gives the GP a sense of ownership of their patient's condition and treatment. This can lead to faster recovery and a reduced burden on both GP and secondary care resources.

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# Neurology outreach into general practice

## North Central London

### The challenge

Before the establishment of ICBs, the average CCG in England was responsible for over 75,000 patients with a neurological diagnosis. The prevalence of neurological conditions also continues to grow. The traditional model for the delivery of neurology care is in a hospital setting and accessing the appropriate service for the patient often involves complex referral pathways and long waiting times.

### The solution

The team in North Central London came together to understand existing neurology services and explore ways to harmonise care, engaging with emergency departments, community teams and general practice, and established a new model that would provide equitable access to specialist support, regardless of borough.

New pathways have been developed to support management of patients with common neurological conditions in the community. A consultant neurologist, community neuro physiotherapist, community neuro occupational therapist and complex care nurse support community services and general practice through virtual multidisciplinary team meetings for patients with a neurological condition and join patient consultations with community clinicians. This ensures secondary care expertise supports the patient pathway where needed.

### The outcome

This model integrates neurology care across the interface. It ensures referrals to secondary care are appropriate, and harnesses multidisciplinary collaboration where suitable from the start of the patient's journey. It also provides professional support and has supported the well-being of colleagues in community services and general practice which have traditionally worked in isolation caring for patients with complex needs.

This model works alongside the University College London Hospital's Same Day Emergency Care (SDEC) Neurology service which provides urgent assessment and investigation for patients to prevent avoidable hospital admissions. This collaborative work has uniquely

developed the care interface in North Central London for patients with a neurological condition, enabling these services to work together for the benefit of the patient and has positive implications for cross-sector working across the new NCL ICS.

*"The care and assessment this patient needed was delivered faster through discussion at this MDT. Onward referrals were made with ease through the MDT. Therapists had been trying to refer for weeks without success."*

Referring Clinician

*"The knowledge I have gained will support me to support the service user in the appropriate way."*

Attendee at the functional neurological disorder MDT

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# Primary Care Liaison Officer

North Hampshire

## The challenge

Errors or inconsistencies in discharge summaries are common, pose a significant patient safety risk and create significant work for the GP team. A reliable mechanism to feed back issues often doesn't exist meaning the same old errors go on occurring.

## The solution

Hampshire Hospitals Foundation Trust has employed a full-time Primary Care Liaison Officer to act as a single point of contact for GPs and GP surgeries in the region. The post was originally set up to build better team working and facilitate closer collaboration. However, during the COVID-19 pandemic the role became more hands on by acting as a go-between across the general practice and secondary care divide, and for the most part ironing out errors and uncertainties in discharge summaries.

It is worth noting, there are many reasons why discharge summaries might need correcting or clarifying — many perfectly understandable. A pharmacist may legitimately want to question a prescription, a patient may be discharged to a care home in a new location with their current GP unaware that this has happened. There may be inconsistencies in the summary because it has been filled out by multiple clinicians possible in multiple locations. Occasionally an inaccurate diagnosis might be listed.

Key to success is that GPs have ready access to the liaison officer by phone or email with the majority of queries being dealt with within 24 hours. The liaison officer also works with a local GP to teach trainee doctors how to fill out discharge summaries. The teaching sessions are always well-received and have an immediate impact in reducing errors.

## The outcome

In November 2022, 146 queries were dealt with of which 67 related specifically to discharge medication. Ninety-six related to discharge summaries more generally. A quarterly report is produced to track errors and highlight trends.

Summaries that need correcting are sent back (electronically) to the doctor who is asked to amend and resubmit. This is designed to reduce repeated errors. However, most mistakes are down to miscommunication and misconception.

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With a wide variation in the time taken to research and fix an issue across the interface, it is not possible to calculate the time saved with any degree of accuracy. However, with more than 60 queries relating to medication each month alone the impact on patient safety and consequential cost to the NHS cannot be over-estimated.

The liaison officer has also co-hosted 'show and tell' sessions with a GP colleague for trainees at the local trusts to explain how to fill out discharge summaries effectively so that can be quickly and easily understood. These sessions are always well received and there is some anecdotal evidence that they too reduce errors and save time.

*"I think it helps that I have worked in one of the local hospitals and I know most of the people I deal with. I do need to be quite diplomatic at times, but it's not about blame it's about getting the right information most of the time and everyone knows that's important."*

Jackie Gunner – Primary Care Liaison Officer, Hampshire Hospitals Foundation Trust

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# Transferring Care Safely (TCS)

Leicestershire

## The challenge

Good working at the interface requires a clear understanding of who is responsible for different clinical and administrative tasks. Changes to the standard contract aimed to codify this more clearly, providing guidance on things such as onward referrals and 'fit' notes. Despite these changes, deviation from this guidance remained commonplace in Leicester, Leicestershire and Rutland.

## The solution

The team created a programme known as the 'Transferring Care Safely' (TCS) initiative which was used to identify areas of poor practice at the interface requiring closer attention. Practically, GPs flagged problems by filling out an online TCS e-form. These were sent to a central administrative team who were responsible for actioning responses and identifying trends. Trends were reviewed in a TCS working group made up of local GPs, CCG representatives and secondary care doctors and actions formulated.

## The outcome

The TCS initiative has had some success. For example, it helped identify unsafe variations in anticoagulation management between hospital and general practice, which led to pathway redesign. Conversely, delays in providing feedback to TCS submissions has hampered buy in from clinicians, as have difficulties disseminating learning more widely. The TCS team are currently looking at ways that accountability can be improved, and how the TCS could work better in both directions.

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# Standardisation of anticoagulation practices as a result of the Transferring Care Safely initiative

Leicester

## The challenge

In Leicester there was not a consistent pathway for managing patients who were taking anticoagulant medication, with some managed in general practice and others in secondary care. The difference in management was often the result of happenstance, with entry onto a given pathway dependent on where the patient was diagnosed with the condition that necessitated anticoagulation. This led to the creation of multiple different pathways for patients receiving anticoagulation, with inconsistent lines of responsibility for who was managing the patient when they required care elsewhere.

## The solution

The issue was raised as part of the Transferring Care Safely initiative, and the entire anticoagulation pathway was harmonised, with monitoring occurring primarily within general practice. To ensure that monitoring was not overly burdensome, additional agreements were made which outlined the circumstances in which secondary care must take responsibility for managing a patient's anticoagulation. This includes, for example, the responsibility of secondary care to adjust and monitor anticoagulation peri-operatively.

## The outcome

A consistent pathway has provided much greater clarity to patients about who should be monitoring them, and also created the foundations for better collaboration between general practice and secondary care.

A similar initiative is also being undertaken at Chesterfield (page 67).

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# Chronic Obstructive Pulmonary Disease (COPD) referral triage

Leicestershire

## The challenge

Local GPs were facing challenges managing their complex COPD patients due to the long waiting times to be seen in COPD clinic and no alternative for obtaining expedient specialist advice about management. Patients who did have secondary care appointments were often advised they needed further investigations before being seen in clinic, or were started on treatment that could have been instigated by the GP following discussion and advice from a specialist.

## The solution

The concerns of both local GPs and COPD consultants were shared with the local integrated COPD team, which comprises members from both community and secondary care. A pilot clinical pathway was developed, with IT and administrative support provided by a community interest company. In the new COPD referral pathway, referrals are sent via SystemOne, using a dedicated COPD referral proforma which has mandatory requirements for information such as FEV1, smoking status and most recent spirometry results.

If spirometry has not been undertaken within five years, this will be organised by the COPD triage team to confirm the diagnosis before the patient is then clinically triaged. Triage will either be done by a GP with special interest in respiratory, a respiratory consultant or a clinical nurse specialist. Patients are then directed into the most appropriate clinical service, e.g. complex COPD clinic, community COPD clinic, advice and guidance, or to an alternative clinic that would better suit their needs. The triage team can also communicate back to the referring GPs via the patient's notes as a data-sharing agreement has been reached which provides the hospital-based respiratory team with access to SystemOne.

## The outcome

This is an ongoing pilot due to end in May 2023. The service will continue if it proves to be effective in reducing the waiting time for complex COPD clinic as is anticipated. There are further plans to expand the service to include all respiratory referrals if the pilot is successful.

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## GP-to-hospital referral pathway incorporating Pathway and Referral Implementation System (PRISM)

Leicestershire



### The challenge

GPs often report that staying up to date with the intricacies of referral pathways is difficult. Changes are frequent and communicating these to every local GP is challenging. This can mean referrals are made outside of the agreed guidelines or to the wrong clinic or speciality.



### The solution

Clinicians in Leicester, Leicestershire and Rutland (LLR) ICB have developed a novel multi-staged referral management process to remedy some of these issues. The first stage was developed in collaboration with the Leicester Healthcare Informatics System (LHIS) and incorporates a decision support tool within an electronic referral form. The electronic forms, known as PRISM letters, require the user to answer a series of questions according to a referral algorithm agreed with secondary care.

The form then advises if further tests are required, if another pathway may be more appropriate, or takes the answers to the questions and uses these to populate a letter which can be sent on. There are also free text boxes that provide GPs with the latitude to communicate subtleties about a particular case.

Once completed, PRISM forms are sent to GPs with a relevant specialty interest, who are paid by a provider company to triage the referrals. These individuals have built personal relationships with relevant secondary care clinicians and have a good knowledge of the local services available and the practical challenges facing GPs.

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## The outcome

Local GPs insight has allowed patients who would have previously been seen in hospital to be directed to community-based services where appropriate. For example, in Leicester, 25% of ENT referrals are seen in GP-led clinics and of these, only 5% subsequently require secondary care input. The new triage process has cemented close collaborative relationships between GPs and secondary care. As an example, in dermatology, one consultant now provides clinical supervision for six GPs with a specialist interest in skin disease.

The key to the success of this referral process has been:

- Building individual relationships between specialised GPs and secondary care consultants
- Consistency across a particular geographical area with all GP surgeries in LLR using PRISM letters on the same electronic health record
- Strong clinical leadership within the ICB with the confidence to explore different care models such as GP-led specialist community clinics.

Steps for the future include:

- Formalising the mentorship between secondary care consultants and GPs through regular ringfenced CPD interactions
  - Implementing a 'straight-to-test' pathway following triage to minimise unnecessary care interactions and increase the number of patients suitable for GP team management.
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## Long COVID Multidisciplinary Team (MDT)

Leicestershire

### The challenge



Long COVID is a new and challenging condition for healthcare professionals to manage. A growing number of patients with complex symptoms following a diagnosis of long COVID are presenting to their GP. Many require specialist input, but GPs also require advice on managing these patients in the community. There is uncertainty on both sides as often specialists are unclear what it may be reasonable to ask of their GP colleagues.



### The solution

A long COVID MDT was created comprising a GP with a special interest in respiratory medicine, a respiratory consultant, a psychiatrist, a neurologist, a diabetologist, a cardiologist, and a physiotherapist with other specialties attending when requested. Patients can be referred to the MDT either from hospital or by the GP, and a specialist nurse will call the patient to undertake a telephone triage within six weeks of the patient being referred.

Depending on the outcome of the triage process, some patients may be referred directly to the rehabilitation team. The MDT is virtual, with the triage nurse typically presenting cases to the MDT.

### The outcome

The long COVID MDT necessarily draws upon a wealth of specialist expertise within the team to find the best possible solutions available for patients suffering from long COVID. Additionally, the MDT unanimously reported the benefits of having a GP in the conversation to understand what can be provided in general practice, and what cannot. The GP within the MDT has also repatriated much specialist knowledge relating to long COVID to her local practice and PCN, thereby upskilling the local GP workforce on this complex condition.

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## Pre-transfer clinical discussion and assessment (PTCDA) pilot

Leicestershire

### The challenge



For many years in Leicester, Leicestershire and Rutland (LLR) there had been a growing feeling among clinicians with an interest in the care of older people that the model of care was not adequately meeting the needs of this complex population. Historically, there had been an overemphasis on hospital admission, with a limited appreciation of patient wishes, the value community care could add, and the perils of admission for elderly people. This was underscored by the emergence of the COVID-19 pandemic in early 2020.



### The solution

As the scale of the pandemic started to become clear, clinicians from LLR, from across general practice and secondary care, worked together to co-create an alternative model, known as pre-transfer clinical discussion and assessment (PTCDA). This targets frail older adults at the point of ambulance call-out using a two-pronged approach to try to prevent admission and improve overall care. First, ambulance staff discuss the case with an experienced geriatrician by phone, with this preventing up to 50% of conveyances. If a decision cannot be made virtually then the geriatrician can activate a 'roving' GP team who review the patient in their own home. GPs can perform a thorough assessment, institute treatment and communicate with the patient's named GP, documenting plans on SystemOne. Of patients visited at home by the GP team, half are deemed suitable for management in the community. The strategy is no 'quick fix', with more than 90% of patients who are managed at home avoiding hospital admission over the subsequent 30 days.

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## The outcome

GPs can develop their specialist interest through formal training with geriatricians, with these interactions helping build trust in both directions. The 'roving' GPs have enjoyed the variety this provides in their working week and the team is expanding at pace.

The feedback from local GP surgeries has been positive. The PTCDA GPs know what is practical to do in general practice, so if they need to pass work back to the patient's named GP after they have finished their review, the requests are realistic. For secondary care, the positive impact is huge, with over 1,900 bed days saved in as little as three months.

The benefits don't stop there, with great feedback from local paramedics who feel that their interactions with specialist GPs on the scene has improved their approach to frail older adults.

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## Same Day Emergency Care advice line linked to hospital@home

Oxfordshire

### The challenge

GPs routinely review complex, acutely unwell patients in the community, where access to specialist, timely advice from secondary care clinicians and diagnosis is not available. GPs are often left with little choice but to send these patients to hospital for further assessment and treatment.



### The solution

Oxford University Hospital have developed and expanded a timely acute medicine advice service for GPs in Oxfordshire. GPs contact the team via a dedicated line, which connects to five separate phones held by acute physicians, geriatricians and specialty consultants working in Same Day Emergency Care (SDEC) — an algorithm 'hunts' between the phones until one is answered to ensure a timely response. As well as providing advice, the SDEC consultants can also refer directly to the local 'hospital@home' team, who perform investigations and administer treatments in the community. Patients referred to this team are the clinical responsibility of the hospital and managing patients in this way means general practice is protected from any additional workload and clinical risk.



### The outcome

The project has been real triumph and has been expanded to cover referrals from paramedics (via a triage nurse) and to include other specialties. It benefitted from leadership by a 'champion' who committed early to change through their own actions.

*"The success of this programme relied on co-creation with clinicians who had skin in the game"*

Senior Consultant



## Clinical Assessment, Support and Education Service (CASES)

Sheffield

### The challenge



The number of referrals from GPs to secondary care continues to increase year on year. Of these referrals, a proportion are made to the wrong specialty or clinic, and some lack pertinent investigations that may help in determining urgency. Furthermore, secondary care pathways may lack an understanding of what is feasible in general practice.

### The solution



GP teams in Sheffield set out to develop a novel pathway that would enhance referral quality, ensuring patients were seen by the right specialty at the right time with all the necessary information to hand — out of this was born the Clinical Assessment, Support and Education Service or CASES. This service involves directing specialty referrals to a group of GP reviewers with a relevant specialty interest who have been upskilled by secondary care clinicians. The reviewers, who review all cases within 72 hours, can redirect referrals to a more appropriate clinic and/or communicate directly with referrers via email to request further investigations or advise on temporising management. Crucially, advice is provided by GPs who have first-hand knowledge of what is realistic in general practice.



### The outcome

Reviewers meet regularly with secondary care mentors to discuss difficult cases, referral trends and pathway changes. However, the mentorship undoubtedly goes both ways, with hospital doctors gaining a unique insight into the practical reality of general practice, improving future communication across the interface.

Building on this peer-to-peer mentorship the CASES team have organised engaging talks at city-wide 'practice learning events', which are ring-fenced afternoons for GP education.



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These events, which have a focus on 'what a GP needs to know' draw heavily on the themes identified by reviewers to maximise practical utility.

The insight provided by this model of working has led to host of other benefits. For example, findings from the dermatology workstream led to a successful proposal to procure dermatoscopes for all GP surgeries, greatly enhancing the ability of secondary care to prioritise referrals (as all were accompanied by photos). In urology, feedback about difficulties navigating the myriad of different clinics available led to pathway redesign by the hospital urology team.

The CASES initiative has been a great success with 67 out of 72 practices in Sheffield now using this regularly when making secondary care referrals for 10 high volume specialties. The positive effect on referral number and quality is easy to measure, however, both GPs and secondary care doctors agree it is the less tangible benefits on the relationships across the interface that really mark this initiative out.

Similar initiatives are also being undertaken in Leicestershire [pages 81 and 84].

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# Developing a community service for people with long term pain

Somerset

## The challenge

A pain management clinic based in secondary care which provided injections for people with persistent pain had a consistently long waiting list, which never seemed to reduce. At the same time patients not attending that clinic but being seen in general practice sometimes struggled to get effective treatment.

## The solution

In a radical move, the decision was made in 2010 to transfer all services into the community over a three year period. The injection service in the secondary care trust with long waits was curtailed and all patients were offered alternative, evidence based management strategies.

Other programmes were put in place to support patients. These included:

- An online resource for patients and clinicians
- A patient education programme — explaining the causes of pain and non-medical ways of treating or managing it
- Community based peer support groups
- An education programme for local GPs about supporting patients who suffer from pain.

## The outcome

Apart from the obvious cost-saving, patients reported improved quality of life (in part often due to reduced use of medication such as strong opioids). Specialist pain clinicians (nurses, physiotherapists and doctors) were redeployed in the system to provide locality based support for patients and clinical teams.

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# Shared Referral Pathway (ShaRP)

Yorkshire

## The challenge

Local GPs and secondary care colleagues identified a number of problems with the referral process. First, referring patients into secondary care was like a handover; the patient was either in general practice or handed over to the hospital when patients then waited weeks and sometimes months for a specialist opinion. Second, when eConsultations (Advice & Guidance [A&G]) or pre-referral diagnostics were completed, they were not accessible in one place and were rarely integrated into the referral process. Therefore, at each stage the information from previous stages in the referral process was not readily available. As a result, decisions about patient care were made solely on each individual encounter. This system resulted in patients being referred into the hospital with limited information and little opportunity for interaction and shared care of patients. The administrative process was also complicated, burdensome and could take weeks.

## The solution

The Shared Referral Pathway (ShaRP) was jointly created by GP and secondary care teams to provide better outcomes for patients by improving the referral process and fostering collaboration when caring for patients who need specialist input.

It allows GPs to seek advice and guidance, but it also shares the GP electronic patient record (EPR) system with the hospital so that hospital clinicians can see the patient record and better determine whether a patient needs an appointment, a diagnostic test or can be managed in general practice.

## The outcome

The collaborative approach has resulted in a new shared culture and attitude towards patient care. It removes the traditional handover, which can leave a patient in limbo while they wait for specialist treatment.

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There were nearly 20,000 eConsultations in the five specialties using the SPR approach which resulted in 2,500 fewer patients needing a specialty referral. This is demonstrated in clinic by around 2,100 fewer patients having just one appointment and then being discharged without treatment compared to 2019/20. On top of this, by integrating diagnostics into this pathway for one specialty there have been around 1,600 fewer investigations requested for patients. Those patients who go through SRP and still require a referral, go to the right clinic first time and are fully optimised to allow for the maximum benefit from their initial outpatient appointment. With the reduction in referrals patient care is improved due to shorter waiting times for first appointment and the whole pathway. There is also significant saving in administrative burden.

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## Key findings and next steps

This report unveils a wealth of local initiatives that transform the way staff in hospital and general practice are working together for the benefit of patients and for each other. It is inevitably tempting to want to hold these initiatives up to the light with the hope of extracting the magic formula which can then be spread across the entire health and care system. While it is true that many initiatives, especially those relying on administrative improvements do lend themselves to this 'cookie-cutter' approach, the Academy counsels caution on taking a wholesale 'lift and shift' approach to all the examples outlined here.

There are two reasons for this. First, locally grown initiatives have not evolved in a vacuum but are intimately related to the local environment in which they developed. Second, success will almost always depend on intangible factors such as strength of leadership, local cultures, customs and practices. Even the personalities of those managers and clinicians involved in attempting to bring about beneficial changes may have an impact on whether they are successful.

With this in mind, our intention in this section is twofold. In Table 1 below, we list 10 administrative changes that we believe depend less on local context, are relatively simple and inexpensive to enact, and will likely result in near-term benefit. Crucially, while these changes will surely be welcomed across the system as a 'quick fix', sustainable reform at the interface will rely on longer-term change, including initiatives that are more complex.

The second table addresses this, by setting out a smörgåsbord of possible 'change-enabling factors' based on the initiatives submitted to the Academy. We hope that these will allow system leaders to think about how they could adapt their local environments to nurture bottom-up improvement, where creativity is encouraged, and projects are allowed to start quickly and fail fast.

Table 1. Potential quick wins

Immediate actions that could be taken to ease pressure at the interface	Relevant examples
Provide easy access to general GP team for secondary care clinicians via non-public phone numbers and shared email mailboxes	'Backdoor' GP numbers in secondary care – Gloucestershire
Provide easy access to individual hospital departments via non-public phone numbers/shared mailboxes to help in the resolution of administrative queries (ideally any correspondence should link directly with the electronic health record)	Email addresses and a shared inbox for all outpatient department secretariats – Mid and South Essex Integrating emails and care records – Yorkshire
GPs giving trainee doctors regular 'show and tell' sessions on how to fill out discharge summaries in the most informative and accessible way	Primary Care Liaison Officer – North Hampshire
Establish outpatient helplines where administrative queries about hospital appointments can be directed	Outpatients helpline for hospital appointments – Morecambe Bay
Make 'fit note' more accessible on inpatient wards and in outpatient clinics and produce guidance for secondary care clinicians on their use	Writing Fitness to work certificates – Mid and South Essex
Consider establishing regular 'interface groups' which include balanced representation from general practice and secondary care. The precise specifications should be locally determined (please see the relevant examples for varied configurations)	Integration meetings – North Central London Clinical Interface group (CIG) – North London Joint working – Scotland Medical Council – Gloucestershire Local delivery system – North Hampshire
Provide clinicians with read-only access to health record systems across the interface	SystemOne access – Leicestershire
Employ a Primary Care Liaison Officer to help in the resolution of queries between secondary care and general practice	Primary Care Liaison Officer – North Hampshire
Provide patients with a written update on where they are on the waiting list, asking if they still require or want treatment	Waiting list letter – Leicestershire
Standardise outpatient clinical letters where possible (placing particular emphasis on concise GP recommendations)	Standardisation of outpatient clinic letters and discharge summaries – Leeds

Table 2. Drivers for success

Lens	Success factors
System	<p>Successful initiatives tended to be in systems where:</p> <ul style="list-style-type: none"> <li>— local healthcare leaders were open to change and prepared to fail</li> <li>— local clinicians did not have fixed ideas of 'GP work' and 'hospital work'</li> <li>— strong relationships already existed between clinicians in general practice and secondary care and could be built upon.</li> </ul>
Team	<p>Successful project teams tended to:</p> <ul style="list-style-type: none"> <li>— be initiated/driven by an enthusiastic 'champion'</li> <li>— be clinically led</li> <li>— have balanced representation from general practice and secondary care</li> <li>— be well supported by their local system (in terms of administrative, IT and financial support).</li> </ul>
Initiative	<p>Initiatives were more likely to succeed where they:</p> <ul style="list-style-type: none"> <li>— addressed a specific local need (rather than responding to a central diktat)</li> <li>— were predicated on facilitating dialogue between clinicians</li> <li>— focussed on removing administrative steps which did not add value</li> <li>— included an educational component, either formalised or through peer-to-peer interaction</li> <li>— carefully considered the impact on clinician workload (on both sides of the interface) and how new ways of working would tie in with existing workflows</li> <li>— focussed on including patients on discussions about their care</li> <li>— could illustrate value to patients and clinicians at an early stage.</li> </ul>

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## Making change happen

The Academy, which represents the professional interests of the UK and Ireland's 220,000 doctors via its members, the medical royal colleges and faculties, is acutely aware of the pressure patients, staff and the whole NHS estate is under. The reasons why are numerous and well-documented. It is this organisation's view therefore that there has never been a better time to be radical with the way care is delivered. That does not mean taking risks with the quality of care, but it does mean staff being enabled to think and do things differently.

And while the Academy has no levers with which to directly bring about change, it can advocate for a more permissive health and care system. And there is room for optimism: much of the foundation work for a more decentralised, locally led health and care structure has already been laid with the introduction of Integrated Care Systems. Indeed, it is precisely this 'local-solutions-for-local-challenges' mantra illustrated by the examples here that is at the heart of the new NHS structure.

It will be tempting to try to quantify the improvement in hours or money saved and without doubt there are hundreds of thousands of hours and pounds that have been saved thanks to these initiatives. It is worth noting however, that when asked, respondents tended not to point to cost savings as the primary driver for change. In all but a few cases, the key factor was reducing the clinical workload and improving patient safety. It is precisely this win-win which is far more likely to resonate with an overwhelmed clinical workforce than time and money. Although, they are of course, both sides of the same coin.



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# Endword

By any measure the ingenuity and creativity of the dedicated healthcare professionals outlined in this report are extraordinary. It is also encouraging that it frequently felt as if we were only scratching the surface of what is being done across the UK to break down barriers between general practice and secondary care that have existed for too long. We know of other examples of improvements being made in community care and mental health.

It is also true that there are many great developments being rolled out which mean that the local fixes and workarounds should not be so necessary in the future. The growth of electronic prescribing in hospitals and digital fit notes are good examples, as are the moves to streamline discharge summaries which were continually described to us as problematic. But we urge system leaders to note that innovation is often best when it is led from the bottom up. Of course, central diktat and national developments such as digitisation have a place — especially so in a system so vast and complex as the NHS, but this should not stifle individual efforts because often that is where the real successes can be found. They should be championed — as we have set out to do here, and replicated if and where appropriate.

It is our hope that this report then, is very much a first step on a journey that will enable good practice to be shared smoothly and efficiently across the system to support patients, doctors and healthcare managers most importantly drive up quality and standards of care for everyone.

If you have ideas or examples of great practice or initiatives that improve the quality of care and reduce the burden on doctors please do get in touch with us at [psci@aomrc.org.uk](mailto:psci@aomrc.org.uk).

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**Academy of  
Medical Royal  
Colleges**



**Academy of Medical Royal Colleges**

10 Dallington Street

London

EC1V 0DB

United Kingdom

Website: [aomrc.org.uk](http://aomrc.org.uk)

Registered Charity Number: 1056565

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