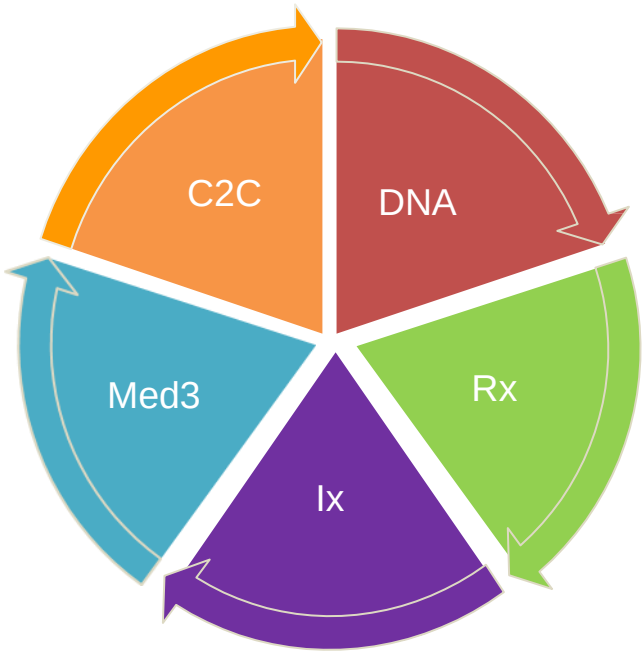
Better care together
Leicester, Leicestershire & Rutland health and social care



Transferring Care Safely Guidelines

Version 2
March 2020

Contents

Context:

This guidebook is intended as a guide to help clinicians across LLR to work more cooperatively when transferring care between organisations with the aim of improving efficiency and safety in our systems and the patient experience.

Table of Contents

Context

This guidebook is intended as a guide to help clinicians across LLR to work more cooperatively when transferring care between organisations, with the aim of improving efficiency and safety in our systems and the patient experience.

Each section aims to give brief clarification on agreed policy, explains the issues, gives example of best practice and provides reference to more detailed policy.

When issues arise they can be reported through the PRISM reporting tool and sent by secure email. UHL has an urgent operational issues phone-line to help facilitate when patients may be at risk in care transfer processes.

If issues raise cause for concern the PRISM tool also allows reports to be sent to the quality monitoring team.

Chapter 1: Medication

Full detailed guidance can be found in the Leicester Medicines Strategy Group (LMSG) on-line tools. The traffic light system classifies drugs as:

Green	*no restriction*
Green (conditional)	*can be started in primary care but with specific conditions*
Amber (simple)	*consultant should recommend but then started in primary care (no SCA)*
Amber (full SCA)	*shared care agreements needed*
Red	*hospital prescribed only*
Black	*should not be prescribed at all*

https://www.lmsg.nhs.uk/traffic-lights/#classifications

SCA drugs

The Shared Care Agreement (SCA) scheme is designed to improve safe prescribing and monitoring of particular drugs. The regulations around these drugs are reviewed by the LMSG and full details of primary and secondary care responsibilities are documented on the LMSG website.
Shared care requires the agreement of all parties, including the patient.

Issues

The General Medical Council advises that SCAs should be based on patients' best interests, rather than the convenience of the prescriber, or the cost of the medicine.
However there may be good reasons, in the interests of patient safety, as to why a GP may decline to accept an SCA.
For example: lack of familiarity or experience with the medicine involved, or insufficient information provided to permit the safe management of the patient's condition.
Therefore care should only be transferred when the SCA has been accepted by the GP, and they are satisfied that they can manage the patient safely.

Traffic light designations may differ between out of county providers and those of LLR.
Use of a SCA in this situation needs to be undertaken on an individual basis, but the traffic light assigned by the secondary care provider's area prescribing committee (APC) should first be confirmed by accessing the websites as listed below.

Risks

Relationship problems can occur when the expectations of patients are raised before the SCA has been agreed. The patient needs clear instruction about how they will obtain medicines and how they will be monitored.

Examples of best practice

The request documentation for a SCA and the responsibilities for both sides are all detailed on the LMSGwebsite.
LLR has an ambition for phasing out of faxing patient information, SCAs can be sent securely to practice generic email boxes.

LMSG on line tools:
http://www.lmsg.nhs.uk/traffic-lights/

Working to the Leicestershire Formulary

If responsibility for prescriptions is to be transferred it is important to have awareness of the traffic light formulary, ensure there is continuity for prescriptions during the handover period and not to raise expectation in patients about borderline areas.

Risks

The patient may be left confused and at risk until agreement is reached about prescribing responsibility.

Examples of best practice

The LMSG website has a traffic light system for GP prescribing. The Leicestershire Formulary has detailed information to help with prescribing decisions, including links to local and national guidance.

References

LMSG traffic lights:
https://www.lmsg.nhs.uk

Leicestershire Formulary: http://leicestershire.formulary.co.uk

TTOs and outpatient prescribing

There is agreement across LLR that when patients are discharged from the ward they will be supplied with the first 14 days of medication.

There are caveats to this agreement for certain medicines, where a short course of treatment is required and where the inpatient stay is less than 48 hours.

Transfer letters should be completed on ICE 24hrs prior to discharge. This is designed to enable communication to take place, and changes to repeat medication to be processed.

For outpatient prescribing, if new medication is started or changed, the patient should be given 28 days supply, or a clear recommendation for the GP to consider (allowing time for the patient to make routine contact with the practice). If the new medication needs to be done before 28 days, it is likely to make the patient experience less complicated by issuing 28 days

GPs should continue the medication after this (unless there are amber red or black traffic light issues).

Issues

Problems can arise if prescribing changes are not clear. Having some clarity in communications can help avoid confusion. For example, “Please can you start the patient on Citalopram 20mg and review them 1m after starting, and a plan to consider stopping 3m after improvement. I have asked the patient to contact the surgery about the prescription in 2 weeks”. Is much better than, “Patient to start Citalopram”.

Problems arise when patients do not go home with medication, for whatever reason, and then ask for urgent action by the practice to prescribe the new items. This can happen because in-patients have not waited for their take home medicines, or out-patients have decided not to wait at the

hospital pharmacy for items to be dispensed.

Although the policy only requires TTOs for inpatient stays over 48hrs, this implies the patient will have been given back their own medication to take home with them.

It is good practice to highlight medication changes in the communication as this helps synchronise the medication lists. The fact that something has been stopped is as important as the new current list. It is also important for planned duration to be clear.

It is important to inform out-patients where they should take their prescription following their appointment (and thereafter if prolonged treatment is required). In most cases this will be the hospital pharmacy, but may vary in different outpatient clinic settings. In some settings FP10(HP)s can be issued, or the medicine may be delivered to the patients home (by a Home care company, or pharmacy).

Risks

Patients are at risk if medication plans are not clear to the GP and the patient.

Anticoagulants

Transfer of patients taking anticoagulants has specific considerations. Primary care anticoagulation services are commissioned by the 3 CCGs through a Community Based Service mode. Federations and practices should provide this service in line with their CBS contract terms.

Patient being discharged from hospital should have an anticoagulation discharge letter (in addition to their main hospital discharge letter). This should include details of the indication for anticoagulation, duration, drug and dose prescribed.

For warfarin, it should also include the target INR, previous INR readings and warfarin doses during the hospital stay. Warfarin patients should normally be dosed for at least four working days after hospital discharge, but less is acceptable for clinical reasons. If action is required by the practice within two working days of discharge, UHL are expected to ring the GP practice to arrange handover of care.

If there are concerns regarding discharge communication from hospital at UHL, these should be addressed using the anticoagulation helpline 07960 779941 (not the PRISM reporting tool)

For patients whose anticoagulation is initiated in outpatients, the hospital clinic letter should give details of the indication for treatment, duration, anticoagulant dose and for warfarin target INR

For patients who require perioperative bridging with their anticoagulation, UHL and the GP practice should follow the LLR bridging plan arrangements as detailed in the LMSG anticoagulation guidelines.

Practices who sign up to do coagulation work should accept requests if they are in line with the enhanced service terms, but they still have the raise concern around requests for example for clinical reasons via the anticoagulation helpline.

It is important that patients are not put at risk.
Particular problems occur with weekend discharges with unstable INRs, the general expectation should be that GPs need at least four working days notice to safely set up coagulation arrangements.
Requests for injectable heparin products must include reassurance that arrangements have been made for the injection to be done (community nurse or patient/carer trained)
All anticoagulation requests must include the diagnosis and planned duration of treatment.

Examples of best practice

The expectations around quantities that should be prescribed are outlined in the LLR Standards for Prescribing and Medicines Management across the interface.

It should not be assumed GPs will do out-patient prescribing.

1. LPT and UHL share the same prescribing policies for both in and outpatients.
2. SCAs are also the same.
3. The GMC is clear that the clinician who prescribes a drug bears responsibility for safe follow up including investigations, so it is important to use the SCA systems to transfer patients safely.
4. Prescribing in non-main site settings can cause problems. But clinicians should not assume GP will consent to do urgent script requests. If scripts are needed urgently FP10(HP) or other arrangements should be made. Routine scripts would be defined as note required for at least three weeks and patient instruction needs to be clear.

LPT and UHL do not currently have access to Electronic Prescribing Services.

References

GMC Good Practice: http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp
UHL Discharge planning guideline (May 2016)
Leicestershire medicines code CH2 prescribing
(Jan 2016)

LMSG guidelines (primary and secondary care) https://www.lmsg.nhs.uk/guidelines/

Chapter 2: Fit Notes (formerly sick notes)

A patient who is off work for less than 7 days should fill in a self-certification form and does not need to be issued with a fit note. (7 days including days they don't normally work such as weekends and bank holidays

The clinician may choose a "may be fit for work" option including:

- returning to work gradually – for example, by starting part-time
- temporarily working different hours
- performing different duties or tasks
- having other support – for example, avoiding heavy lifting

If fit notes are required, patients should be issued with a note to cover the full duration of their in-patient stay and the period at home until they would be expected to return to work, if this is clear and predicted.
(An example might be for a planned operative procedure).

For a GP to issue a note they need to take up an appointment to reassess the patient, or have enough information from hospital communication to understand why patient is not capable of work. This includes start date, duration and diagnosis. It is therefore important this is included in the discharge letter.

Issues

Patients do not need fit notes if they are off work for up to 7 days and can cover this with self-certification forms.
Poor communication can take up GP appointments, and lead to unnecessary urgent requests. It is no more effort to do a note for the full duration at discharge.

Examples of best practice

Setting expectations realistically with patients can avoid problems, and wasted appointments.

It is expected that patients should be given fit notes by the hospital if needed, and not contact their surgery for urgent requests.

References

National Guidance: https://www.gov.uk/government/collections/fit-note
UHL discharge planning good practice guideline (May 2016)

Chapter 3: Consultant to Consultant referral

This policy was set up with the aim of getting best value from the overall NHS resource.

It gives guidance on when it is expected for prompt internal referral to take place, at the same time recognising that GPs may be able to manage many problems that are picked up during hospital treatment, especially when these are coincidental to the original reason the patient being seen.

Issues

If there is a clear case for consultant to consultant referral this should be progressed and the patient informed. If patients are to be referred back to their GP for either treatment in practice or onward referral this should be done with enough notice to make the patient journey less complicated and allow the practice chance to see the patient routinely.
Assume the 21-day window for the transfer to be picked up and make it clear what the patient is expected to do.

Risks

Think about raising unnecessary expectations. The practice may be able to treat the patient without referral but this is more difficult if the patient is expecting to see another consultant.

Examples of best practice

The general guide is that anything that needs urgent referral or that is relevant to the original referral will be much more efficiently dealt with by internal referral.

If not the patient should be re-directed to the surgery with a clear instruction about what they need to do.

For example, “The patient was noted to have eczema and we suggest dermatology referral.” Is not as helpful as, “The patient was noted to have eczema, they have been advised to contact the surgery routinely for advice”.

There are special policies for acute sector UHL departments, such as ED and GPAU, where the nature of work makes referral arrangements particularly difficult. These are updated in the new policy and reflected in easy reference flow charts.

Suitable C2C referrals are:

- Cancer
- Urgent where delays in referral could effect the patient’s health
- Further investigation or treatment needed (eg cardiology opinion before surgery)
- MDTs
- Referrals within the same speciality (when the GP may have sent to the wrong department)
- Referral to the wrong speciality or least appropriate department (eg dermatology to plastics, cardiology to respiratory)

References

The guidelines for this were revised in Jan 2020.
The detailed guide is included as an appendix along with an easy reference flow chart for UHL clinicians.

There is clear GMC guidance around what is expected in the standard hospital contract.

Chapter 4: DNAs, Rescheduling, Offering Admissions, Cancellations.

There are detailed policy regulations around patients not attending appointments, cancelling, or changing their appointments. These are summarised below.

In some cases patients can be discharged back to the GP, and they would then need re-referral if appropriate. It is important that this is done without patient risk.

When the circumstances are unclear, or mistakes seem to have been made the matter should be referred to the hospital-booking centre (via a PRISM issues report).

Did Not Attends

None attendance is extremely wasteful of NHS resources. UHL policy is to discharge DNAs.
However it is important this is done safely and the patient notes should be reviewed prior to discharge.

Vulnerable patients should be followed up this
includes: Under 16s
Vulnerable adults
Urgent referrals (Cancer, chest pain, critical illness)

Rescheduling

Patients are given two opportunities to reschedule; they should be informed at the second change that a third change results in discharge apart from exceptional circumstances.

Offering an admission date (TCI date)

The initial offer should give patients the opportunity for flexibility and contain comprehensive information about what they need to do.
If dates are posted without consultation they should include flexibility, for example two separate dates with at least three weeks notice.
Patients must confirm within two weeks, if not they are considered to have declined treatment and can be discharged, but their notes should be clinically reviewed and a full explanation sent to them and the GP.

Patient cancelling TCI date
Patients are given one chance to change a previously agreed date.

2 week wait cancellations

These must be given special treatment, and an attempt made to re-negotiate with the patient. So that they can be urgently rebooked.
If the patient cancels twice they can be considered for discharge, but this decision should involve the lead clinician, GP and patient.

2 week wait DNAs

The first DNA is dealt with by contacting the patient and they should ideally given a second chance

verbally. The second DNA is referred back to the GP, and the lead clinician informed.

Issues

Patients approach the GP feeling they have been unfairly dealt with, for example that they claim not to have received notice about appointments.

Clarification and re-referral is wasteful of practice time.
Including contact numbers for the relevant hospital booking office is good practice.

Risks

Vulnerable patients must be considered as special cases and should not be put at risk.
Extra allowances must be made for patients with a potential cancer diagnosis.

References

UHL access policy for elective care Sept 2015

Chapter 5: Responsibility for investigations

GPs should try to be helpful in helping with patient transfers, often friction arises, not because of the request but the language used in correspondence, for example “GP to chase….”.

Issues

An understanding of this baseline is important because requests for investigation to be done in primary care should not be assumed, but may well be acceptable.

Risks

Unclear instructions to the patient.
Primary care may not have capacity to deliver what is being asked.

Examples of best practice

The GMC makes clear that the clinician requesting an investigation is responsible for the result, interpretation of the result, and management of the patient thereafter. Writing instructions in a letter cannot be assumed to pass legal responsibility for patient management. The national guidelines are for work that is continuous with the episode of care to be continued and followed through by the secondary care team.

Urgent requests (less than 3 weeks)

These should be organised directly by the discharge team, or an explicit agreement made with the practice. There are a range of phlebotomy clinics that can accept requests for bloods, without using the limited capacity in practices.

Unclear guidance on what to do with the result

GPs may not be fully skilled in the interpretation of a result.

It is good practice to include a management plan in correspondence, so both the patient and the GP understand what is expected.

For example giving clear advice about outcomes that would mean the patient needs to be referred back, if a result is above a certain level.

GPs will have significant numbers of letters to process every day.
A clear management plan can make a lot of difference to working efficiently.
If it is not clear what the patient has been asked to do, the surgery may have to contact a patient (often by letter), to explain they need a test, and the patient has to contact the surgery arrange it.
It is much more efficient for all concerned if for example the letter says, “I have asked the patient to contact the surgery to book a test, as a routine appointment in 1 month”.

Test that are complicated for GPs to arrange

GPs do not have automatic access to many radiography tests. They will need enough detail in letters to be able to request them. If not radiography will reject their requests. MRI scans are a typical example.

Requests for housebound patients are also not simple to arrange. GPs will have to order the test arrange transport or request a community nurse to visit, order blood tests and think about follow up of the results.

It may be simpler to request investigations directly on ICE. Or make direct requests for community nurse support as part of the discharge process.

Pathway work is being done to try and make many of these processes more efficient, taking advantage of ICE ordering and booking investigations through diagnostic hubs. Use of software to manage ordering and recall.

References

GMC advice on good practice for ordering and acting on results

Chapter 6: Reporting mechanisms

Issues and concerns can be raised through a single reporting function in PRISM.

PRISM enables a convenient structured message to be created, this should then be emailed to both the relevant provider's operational office and the GP concerns team. There are four options for raising an issue:

Option 1 24 hr call back

For issues where the patient is potentially at risk (either harm or delayed journey) if not resolved quickly. The GP will leave contact details to be called back within 24hrs by someone in a position to resolve the problem. Suitable examples might be where urgent medication is needed; an investigation with a possible cancer diagnosis, or urgent referral is needed.

Option 2 24hr email

For issues which can be resolved without a telephone conversation but are still quite urgent, the expectation is that the practice will be emailed back with a message to confirm the issue has been resolved or that action is being taken to do so. Suitable issues may overlap with option 1 in some cases but might be resolved by a clinician instructing his admin team to organise an urgent consultant-to-consultant referral, or that the patient is being contacted to make arrangements for UHL led investigation.

Option 3 72 hr email returned task

These are for issues where there is minimal or no risk to the patient and low urgency. The GP has noticed that action has been requested, but it is outside the good practice guidelines and they want the task to be redirected back to the requesting team. The expectation is that an email will come back acknowledging the task has been noted as not taken (but not that it has been completed, it will be looked at as a routine issue). Suitable issues might be a request for the GP to do some routine investigation that is part of the ongoing episode of care for the patient or an investigation that is complex and not easily interpreted by GPs, or medication requests for medication outside the LMSG guide but that do not need starting urgently.

Option 4 No action requested

These are issues where the practice has dealt with an issue despite it being outside of the guide. They want to flag the issue, but no action is needed and the patient is not at risk because the action has been resolved. The expectation is that the issue will be part of the theme discussion by the transferring care liaison group or even that it may be picked up as a near miss by the GP concerns team, but no action is needed. The email will receive automatic acknowledgement as being received, the transferring care group will feed back to practices about changes that result from future themes.

Because there is potential for overlap with reports about quality issues, (GP concerns and incident reporting) the PRISM section now also includes reporting on these issues as well.

(All issues must have a structured report sent as well, the phone-line is an additional service for urgent patient risks, but you still need to send an email report.)

All reports should receive a reply confirming receipt and timely feedback about the outcome.

The outcome should include clarity about how the patient will be informed about their management plan.

The pathway will ensure that the issue is automatically considered appropriately within the reporting and quality monitoring systems.

All issues will also be passed to the TCS liaison group for discussion. This group includes GPs Community LPT and UHL clinicians with the aim of trying to improve the safety and efficiency of care transfer issues. Your reports are an important part of this process. They should shape future policies and lead to the creation of new themes in the guidebook.

The pathway for the reporting structure is illustrated below: