October 2007

Improving communication, the exchange of information and patient care

Suggested guidelines for secondary care doctors and GPs

This joint paper produced by the General Practitioners Committee (GPC) and the Central Consultants and Specialists Committee (CCSC) offers a number of suggestions to improve two-way communication between primary and secondary care practitioners, for the benefit of patients. The feasibility of implementing the proposals, if they are not already in place, will depend on local agreements and protocols.

Points for hospital doctors to consider when communicating with GPs

Communication, outpatient letters and discharge information

- Where a hospital unit uses an automated system to generate replies to referral letters, these will be addressed according to the details provided by the patient when registering with the hospital, which should include the name of the referring GP.

- Attempts should be made to avoid using historic GP data rather than the name of the referring GP, as historic data may be out of date.

- News of important results *where appropriate* should be sent directly to the patient with a suitable explanation, and a copy to the referring GP including proposals about future management, monitoring, watchful waiting and further testing. Information provided to patients should include how to contact the hospital for further information. Copies of other letters detailing a patient's condition and treatment could also be sent in this manner.

- When a follow-up test or appointment is to be carried out in the GP practice, endeavour to ensure that the patient understands that they will need to arrange a non-urgent appointment for this. This should also be emphasised in any letter you send to the patient. If you do not know if the GP can arrange this test, it is essential to contact the practice rather than to assume that the GP can perform the test you request.

- Wherever possible, letters should be sent within a week of seeing the patient and within a maximum of 10 working days.

- Letters should be brief and to the point; including any medication changes and details of important investigations undertaken, their results and arrangements for follow up, in order to prevent unnecessary future referrals.

- Whenever correspondence is to be sent directly to the GP practice, provide the patient with a realistic estimate of when the letter is likely to be received. This helps to avoid situations where patients make an appointment, but the GP cannot assess their condition because a letter from the hospital has not yet been received. In some cases, it may be appropriate to send a legible handwritten note of sufficient detail that the patient can give directly to their GP.

- All important information should also be included in the immediate discharge summary, particularly details of follow up arrangements, medication, and important test results. If possible this information should be typed and in a form that can be scanned on to the practice computer system. A template of a model discharge letter from a hospital doctor to a GP can be found in appendix 1.

- Appendix 2 details information required by GPs following a patient's attendance at an out-patient clinic.

- Further suggestions on information that might be useful to include in discharge letters can be found in the Scottish Intercollegiate Guidelines Network (SIGN) Guideline 65 on

the Immediate Discharge Document. These recommendations can be applied across the UK and can be accessed at the following address:

http://www.sign.ac.uk/pdf/sign65.pdf

- If a patient dies in hospital, the GP practice should be informed by telephone as soon as possible. Similarly, GPs should inform the hospital if a patient that has previously been referred dies.

Referrals and prescribing[1]

- Where incidental health problems that are not within the expert area of the receiving consultant are identified and do not relate to the original referral, the patient should be referred back to their GP.

- Onward referrals should only be made where they relate to the existing condition and are clinically appropriate; such referrals should also comply with any relevant local policies and contract restraints. A copy of any onward referral letter should also be sent to the patient's GP. The hospital may wish to wait for an agreement on the course of action from the GP before acting on the referral. However, onward referral to a physiotherapist etc. that is part of the ongoing treatment of the patient is the responsibility of the hospital doctor, and should not be delegated to the GP. [Note that doctors' preferences on arrangements for onward referrals may differ where clinicians are not managing a budget].

- Medication required for hospital procedures (for example, EMLA cream before hospital dialysis) and any immediately necessary medication should be prescribed by the hospital doctor, or if there are shared care arrangements in the local area, by other licensed prescribers, using HP10s or hospital prescriptions pads. The patient can then take the prescription to the hospital or community pharmacy as appropriate.

- If prescribing is being left to the GP, he/she cannot make an informed decision before receiving the full outpatient letter. If the patient requires any medication before the hospital can guarantee that the practice will receive such a letter, it is the responsibility of the hospital to provide the prescription. It is always the responsibility of the hospital to provide medication if it is unavailable in the community, if it is being used off-licence or where a GP feels he/she does not have sufficient experience of the drug to take clinical responsibility for prescribing it.

- If a typed letter cannot be sent in a timely manner, it may be preferable to give a patient a hand written note to take to the GP surgery to give notice of medication changes. This should not be used to give medication that is not available in the hospital formulary.

- Sickness certificates for in-patient stays to cover known absence from work after discharge, or related to an outpatient appointment should be provided by the appropriate member of staff in the hospital for the appropriate period of time.

- It may be necessary on some occasions to remind junior staff that it is the responsibility of the doctor arranging a test to check the result and take appropriate action. Copying the result to the GP does not fulfil this duty of care.

[1] There may be some local variation with regards to the best practice for referrals and prescribing.

Points for GPs to consider when communicating with hospital doctors

Communication and out-patient referral letters

- A good *out-patient* referral letter should be typed, thorough, yet concise and should contain the following:

    - Full patient details, including current telephone number, NHS number and hospital number if known;
    - Reason for referral;
    - Urgency of referral;
    - Information on any past medical conditions particularly if relevant to the current condition;
    - Information on the results of any examinations carried out;
    - Detail of medication(s) being taken by the patient and medication taken in the past;
    - Drug or other allergies;
    - The involvement of other medical and non-medical specialists in the patient's care in the past and present;
    - Any relevant laboratory results already taken;
    - Expectations held by the patient and the GP on the course of action taken to address the condition;
    - Any relevant social or family information including relevant social services involvement for children;
    - Any other information deemed relevant.

Further details of what to include in a model out-patient referral letter can be found on the Scottish Intercollegiate Guidelines Network (SIGN) website:

http://www.sign.ac.uk/guidelines/fulltext/31/section4.html

- As mentioned above, GPs should inform the hospital if a patient that has previously been referred dies, and likewise, if a patient dies in hospital, the GP practice should be informed by telephone as soon as possible.

Prescribing

The GPC has produced specific guidance to help develop the primary and secondary care interface in relation to prescribing. The document puts forward proposals which could further improve the line of communication between hospital doctors and GPs and is particularly aimed at the role of GPs in this process.

The guidance can be accessed at the following link (log-in required):

www.bma.org.uk/ap.nsf/Content/GPprescribingguidance

Appendix 1

Model discharge letter from a hospital doctor to a GP

[Hospital address]

[Referring doctor's name]

[GP Practice address]

[Date]

[Patient reference name/date of birth]

Dear *[insert name of referring doctor]*

Following the referral of the above patient, please find below an outline of action taken which may be relevant for further consideration of the patient's medical condition.

- Full patient details including NHS and hospital numbers;
- Diagnosis of patient's condition;
- Admission and discharge dates;
- Reason for admission;
- Admission type: planned or unplanned. If unplanned please state the route of admission e.g. GP/A&E/999/NHS direct/out of hours/other;
- Name of consultant in charge of case;
- Ward from which patient has been discharged;
- Important procedures that have been carried out e.g. thombolysis, pacemaker insertion, operations etc;
- Important tests that have been carried out - please state results if known;
- Test results not yet known and tests scheduled for the future. Please provide time scale;
- Drugs the patient has started taking – declare whether this should continue - and/or stopped taking. Please declare any reactions or allergies to drugs and reason for medication changes if applicable;
- When will the patient next be seen for review, if at all, and any other follow-up arrangements;
- Information given to the patient;
- Contact details (at hospital or elsewhere) for further information;
- Any other information deemed relevant.

Yours sincerely,

[Name]

[CC to patient if felt appropriate]

Appendix 2

Model letter from a hospital doctor to a GP following attendance at out-patients

[Hospital address]

[Referring doctor's name]

[GP Practice address]

[Date]

[Patient reference name/date of birth]

Dear *[insert name of referring doctor]*

Following the attendance of the above patient at x hospital, please find below an outline of action taken which may be relevant for further consideration of the patient's medical condition.

- Full patient details including NHS and hospital numbers;
- Date of attendance;
- Name of consultant in charge of case;
- Diagnosis of patient's condition, provisional or final;
- Information on the results of any examinations carried out;
- Information on examinations yet to be carried out, and arrangements made for informing the patient of these results;
- Detail of medication(s) prescribed to the patient or information on medication(s) to be taken or discontinued;
- Follow-up arrangements made;
- Information given to the patient;
- Contact details (at hospital or elsewhere) for further information;
- Any other information deemed relevant.

Yours sincerely,

[Name]

[CC to patient if felt appropriate]