**Clinical work across the Interface**

The NHS is under immense, and some may argue unsustainable, pressure. Both sides of the clinical interface are experiencing unprecedented levels of demand, the causes of which are multifactorial but include higher than ever levels of patient expectation; an extensive clinical backlog that still lingers from the coronavirus pandemic; and current fiscal restrictions. The importance of interface relations, efficiency and communication has never been more vital. This document attempts to capture some key parts of interface working, so ensuring professionals are working effectively (but still within) their competencies. It aims to increase efficiency and avoid duplication, so promoting patient care and safety as paramount.

We are all aware of the growing evidence of burnout amongst GPs and hospital doctors due to excessive workload with the loss of doctors from across the spectrum to careers abroad and outside of the NHS. This is clearly a difficult environment for everyone, and we hope this document will help promote resilience by helping to support effectiveness across the interface.

Following consultation with colleagues across primary and secondary care, we have produced the following guidance to assist doctors to work within their competencies and contract, and support each other by following the guidance recommended in “Good Medical Practice.”

**As advised by the BMA and recommended as Good Medical Practice by the GMC, those who request the test or deem the test necessary, should maintain responsibility over results handling and subsequent management. Duty of care lies with the requesting physician to communicate results to the patient. Secondary care may offer recommendations to primary care for further investigations or monitoring for patients who are currently managed in primary care, following which the responsibility for choosing to do those investigations and results handling resides in primary care.**

[**https://www.bma.org.uk/advice-and-support/gp-practices/communication-with-patients/duty-of-care-when-test-results-and-drugs-are-ordered-by-secondary-care**](https://www.bma.org.uk/advice-and-support/gp-practices/communication-with-patients/duty-of-care-when-test-results-and-drugs-are-ordered-by-secondary-care)

[**https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice**](https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice)

* Phlebotomy required by secondary care for the ongoing management of a patient under speciality care, must remain the responsibility of secondary care (including those that pre-pandemic would have been undertaken in face to face OPD appointments). These should take place either in monitoring clinics or out-patient clinics unless there is an agreed arrangement such as SACT and pre-chemo bloods (see further details below)

(Please refer to the “Blood tests across the interface” document previously issued by the Lothian Interface Group (LIG) <http://intranet.lothian.scot.nhs.uk/Directory/lothianinterfacegroup/Pages/default.aspx> )

General practice must continue to honour agreed phlebotomy work of which there are some 47,000 bloods tests undertaken each year (an increase from 36, 000 in 2019). Those that have been agreed with the GP Subcommittee include pre-chemotherapy or SACT bloods. Other agreements exist including those that are part of the phlebotomy enhanced service and shared care agreements. Whilst we recognise phlebotomy services closer to home will often be the patient’s preference and indeed aligns with many gold standard ideologies including the green agenda, we are all working within resource poor environments where services for the sake of the wider patient population must be protected. Ultimately, we must all strive for greater phlebotomy resourcing and prioritisation given the ever-increasing dependence on this service and the evolving nature of the medications we are prescribing. There is a Lothian vision to create phlebotomy community hubs, but these are far from realised and indeed CTACS remain hampered by a lack of funding and de-prioritisation. Monitoring clinics serving a number of acute specialties continue to run and have capacity.

The following list has been compiled from practice feedback of what GPs are asked to do outwith Lothian agreements and includes both common and very rare work. As outlined above, for patient safety and clinical competency reasons, as well as resource restrictions, the boundaries within which workload and clinical responsibility lies is described here:

**Investigations required prior to referral.**

These should be undertaken by the referring clinician using the guidance on RefHelp. In exceptional circumstances where this is deemed not possible or might lead to patient harm due to delay it is expected that the referring clinician would contact the specialty involved to inform them of the reasons for this.

**Monitoring (including phlebotomy) ONLY undertaken by speciality services**

In these following circumstances general practice may be advised to prescribe on behalf of secondary care. However, the monitoring and clinical decision to prescribe, has been agreed to remain the responsibility of secondary care specialities.

|  |  |
| --- | --- |
| **SPECIALITY** |  |
| Psychiatry | Antipsychotic monitoring (including ECG)  ADHD medication monitoring  Phlebotomy pending CAMHS allocation  Patients referred for Eating Disorders, pending assessment or as part of ongoing assessment |
| Dermatology | Roaccutane monitoring |
| Bariatric surgery | Phlebotomy following bariatric surgery under the NHS is the responsibility of the specialty team. Where the patient has received surgery privately or abroad, patients should be directed to a private provider for suitable follow up. |
| Urology | PSA monitoring post prostatectomy for prostate cancer so that it aligns with Oncology monitoring of PSA in patients treated in other ways for prostate cancer.  Urology have developed a new system for recalling and monitoring PSA blood tests post prostatectomy and acknowledges that clinical responsibility for this lies with the urology department. If the GP checks a PSA on their own accord they have a responsibility to refer accordingly. Also GPs remain responsible for referring patients who have had a prostatectomy outwith Lothian into the urology surveillance programme as appropriate. |
| Colorectal | Phlebotomy prior to colonoscopy following positive bowel screening. When patients require phlebotomy prior to test (about 75% of patients already have blood results in the system). The other 25% are offered phlebotomy in secondary care settings but a small number decline or struggle to access these options so GP will attempt to support these small numbers. |
| Sexual and Reproductive Health/Genito-Urinary medicine | Testosterone monitoring as part of menopause treatment.  Masculinising and feminising hormone therapy with the exception of pre-dose testosterone levels where it has been agreed that the GP practice will undertake these. |
| Cardiology | Bosentan monitoring |
| Endocrinology | TFT monitoring for hyperthyroid or thyroid cancer patients  Other hormonal levels required for investigation or treatment (excluding those prior to fertility service referral or early menopause assessment) |
| Rheumatology | Baseline bloods prior to IV bisphosphonate infusion |
| Pregnancy support service | Serial HCG measurements |

**Monitoring AND prescribing undertaken by speciality services**

**In these circumstances both the monitoring and prescription required remains under the remit of secondary care specialities**

|  |  |
| --- | --- |
| **SPECIALITY** |  |
| Pan-speciality | Biologic prescribing and monitoring |
| Dietetics as part of weight management service | Liraglutide |
| Lipid Clinic | Bempidoic acid prescription and monitoring within 3 months of initiation |
| Cardiology | Mexiletine |
| Uro-oncology | Bisphosphonate counselling and baseline bloods for patient with prostate cancer |
| Endocrinology | Hyperparathyroidism management including calcium and vitamin D monitoring and prescribing |
| Neurology | Fingolimod |

**Waiting list re-triage**

As agreed with LIG, patients should **not** be redirected back to general practice to request a regrading of their referral priority to expedite appointments on waiting lists, unless there is a deterioration in the patient’s symptoms.

GPs should not direct patients to contact secondary care teams if they have clearly been discharged but refer or liaise appropriately if required.

**Vaccination requests**

LIG has also agreed that any vaccination out-with routine schedules should be referred via the appropriate forms by the health professional assessing a vaccination to be necessary and not passed to GPs or secondary care colleagues at the time of referral or via outpatient communication. The forms are accessible to both primary and secondary care clinicians through **RefHelp**:

ADULT: <https://apps.nhslothian.scot/refhelp/vaccinations-and-ctacs/>

PAEDIATRIC: <https://apps.nhslothian.scot/refhelp/vaccination-services/>

It is important to remember that general practice no longer provides any vaccination (excluding emergency tetanus in certain practices signed up to a voluntary minor injury enhanced service and the ad hoc vaccination of drug users against hepatitis as part of a voluntary enhanced service) and does not have access to vaccinations under the Scottish Government’s reorganisation of vaccination services.

**Acute prescription requests**

General practice is often better placed to provide patients with an acute prescription; however, it is considered reasonable that the duty to inform patients a prescription is being recommended rests with the assessing clinician. Furthermore, patients must be advised of a minimum 3 working dayswait for any acute prescription unless a delay is considered to significantly alter patient outcome by delaying a procedure or cause significant harm. In such circumstances, secondary care colleagues are requested to consider hospital pharmacy dispensing, particularly where the patient is already within acute medical sites. However, where appropriate, emailing a practice clinical mailbox is the optimum route of communication if primary care is considered to be more suitable.

**Sick-line requests**

The majority of sick-line requests are undertaken in primary care. However, for patients that have been seen by colleagues in Emergency Dept, outpatients or as inpatients, sick-lines should be issued by the speciality to assist patients and reduce duplication of work.

**Lothian Shared Care Agreements:**

For ease of reference, SCAs are here:

<https://formulary.nhs.scot/east/help-and-support/for-healthcare-professionals/>

For patient and clinician safety, monitoring or prescription requests to primary care must strictly remain within the boundaries outlined within such agreements. **It is important to note, some SCAs are “recommendations” or “agreements in principle”, but there has been no formal acceptance by general practice or transfer of resource to cover workload transfer. This issue has been raised with NHS Lothian. Those that are recommendations or draft agreements are described as such. It is also important to note that some GP practices may choose to opt out of an SCA, in which case full care defaults back to speciality.**

**Referrals**

Any referral proposed by a primary or secondary care health professional should be undertaken by the individual themselves and should not be passed onto colleagues to do on their behalf. For more detail (*including exceptional circumstances*) please refer to the letter previously issued by LIG:

[*http://intranet.lothian.scot.nhs.uk/Directory/lothianinterfacegroup/Pages/default.aspx*](http://intranet.lothian.scot.nhs.uk/Directory/lothianinterfacegroup/Pages/default.aspx)

Furthermore, where a USOC (Urgent Suspicion of Cancer) referral has been re-triaged to a less urgent pathway, it is recommended good practice that the triaging clinician informs the patient as well as the referrer, when it is clear in the original referral letter that the patient was informed of the USOC status. <https://www.gov.scot/publications/urgent-suspicion-cancer-national-regrading-guidance/>

The NHS is a vital resource for our communities. We **must** protect the services we provide, and the health professionals that work within it. Only through working together, respecting colleagues, their roles, and expertise, will we be able to overcome such challenging times.

Many thanks for your cooperation.

***Lothian GP Sub-committee and LIG***

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