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WELSH HEALTH CIRCULAR

Status: Action

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Title: All Wales General Practice and Health Board Clinical Interface Standards

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Action by:
Chairs and Vice Chairs of Health Boards and NHS Trusts
Chief Executives, Health Boards and NHS Trusts
Chief Operating Officers, Health Boards and NHS Trusts
Directors of Primary Care, Health Boards
General Practitioners
Primary Care Services, NHS Wales Shared Services Partnership
General Practitioner Committee, Wales
Royal College of GPs
Health Education and Improvement Wales

Required by: Health boards and Trusts must put in place arrangements to ensure these standards are fully adopted and include processes to receive, collate and respond to concerns expressed where these standards have not been upheld.

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Enclosures: All Wales General Practice and Health Board Clinical Interface Standards

Mae'r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh

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Dear Colleagues,

A set of standards for clinical behaviours and communication across the primary secondary care interface were developed for adoption throughout Wales in 2018 (WHC/2018/014). The standards were informed by a report by the Academy of Medical Royal Colleges Wales and based on the Communications Standards established by Cwm Taf University Health Board, which were subsequently endorsed by the Welsh Government, Health Board Medical Directors and BMA Wales. The standards aimed to clarify the roles and responsibilities of GPs and Secondary Care doctors in areas which were previously unclear or ambiguous, with the intention of minimising inappropriate transfer of work between sectors and improving patient experience and inter-specialty relationships.

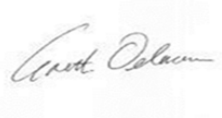
Since the original standards were published, significant changes have occurred in the way the NHS operates and conducts interactions across the primary-secondary care interface. The delivery of health care in primary care and secondary care is increasingly multi-disciplinary in nature. There has been an increase in remote and electronic consulting, with subsequent separation of some tasks from the clinical consultation (e.g. requests to colleagues to carry out blood tests or physical examinations when patients are consulted in a 'virtual' clinic).

To ensure that the standards remain fit for purpose, they have been reviewed to reflect these changes and the experiences of implementing the standards over the past 7 years. The original standards placed an emphasis on the responsibilities and behaviours of individual clinicians. We recognise that the behaviour of individual clinicians is heavily influenced by the environment they work in. As such, the revised standards have been split into individual and organisational standards and expectations.

There is an aspiration to make these standards applicable to all professions and contractors working across the primary and secondary care interface, to reflect the multi-professional nature of the modern NHS in Wales, and the increased provision of multi-disciplinary services outside of the traditional hospital-based model. This release is therefore a staged approach that recognises the importance of implementing initial improvements without delay; while acknowledging that wider work will need to follow.

Yours sincerely,

Professor Isabel Oliver
Chief Medical Officer for Wales



Dr Gareth Oelmann
Chair, GPC Wales

All Wales General Practice and Health Board Clinical Interface Standards

These standards have been designed to improve the safety and quality of patient care in NHS Wales and ensure that our patients have the best possible experience as they navigate their pathways. It is a consensus document that has been co-produced with Primary and Secondary Care Clinicians and endorsed by the All Wales Medical Directors.

They apply to all NHS Wales clinicians communicating clinical information between General Practice and Health board run services. They also apply to clinicians working in the private sector who interface with General Practice.

They replace WHC (2018) WHC/2018/014 - All Wales Communication Standards between Primary and Secondary care

Section 1- Standards for Communication and Delegation

Individual Professional Standards	
1	**Investigations**: Any clinician managing a patient's care who deems an investigation is necessary should: • Request the investigation • Take responsibility for actioning of the result • Communicate the result directly to the patient and help them understand it. Delegating these responsibilities is appropriate if there is agreement to do so (see Standard 5).
2	**Referrals:** Any clinician referring a patient for a consultation should: • Ensure the patient understands the reason for the referral • Ensure the patient knows who is responsible for their care • Ensure the patient knows what should happen next • Ensure the referral contains all information needed to determine the priority of the referral • Make the referral themselves when they have the competence to do so When not making a referral themselves, a clinician should never direct a patient to another clinician to ask for a specific referral or expected timeframe for action. Clinicians should respect colleagues' autonomy and allow them to determine what is best for the patient.
3	**Med3:** The clinician who advises the patient to refrain from work must: • Issue the Med3 • Ensure the duration of the note covers the time period to expected return to work or the next planned review
4	**Prescribing:** A clinician recommending that a patient starts a new medication must: • Issue a prescription if that medication needs to be initiated within the next seven days

	• Issue a prescription for a minimum of two weeks but longer if clinically appropriate • Communicate all necessary counselling of the patient if recommending another clinician starts the medication • Ensure prescribing and prescribing recommendations should be within the scope of practice of the clinician to whom the recommendation is being made • Name the responsible clinician when recommendations are from non-prescribers. • Adhere to shared care prescribing processes by retaining prescribing responsibility until the GP has accepted the request and received the stable handover letter • Take account of guidance provided in the health board's prescribing formulary and the availability of the medicine in primary care, when initiating or recommending a GP initiates medication(s) • Be prepared to retain prescribing responsibility if the medication does not have a UK marketing authorisation (i.e. the medication is unlicensed) • Be prepared to retain prescribing responsibility if the medication has a UK marketing authorisation but it is being prescribed in a way which is outside the terms of its authorisation (i.e. the medication is licensed but prescribed 'off-label'), where such prescribing is not generally accepted clinical practice.

Organisational Standards	
5	**Investigations** • Organisations should have standard operating procedures (SOPs) to mitigate against clinical governance risks and transfer of clinical responsibility when requesting investigations and actioning the results • There should also be SOPs with regards communication of results to patients • These SOPs should support clinicians in adhering to the individual professional standards
6	**Referral and Outpatient Communications**: • Must be compliant with data protection regulations. • Must be made via the nationally or locally agreed electronic method where it exists. • Must be actioned promptly, including requests for further information • Changes to priority must be communicated to the referrer and the patient • Should be addressed to the referrer with copies to the patient and their GP if not the original referrer. • Referrals that are declined, must be clinically justified and require timely communication to the referrer within the timeframe stated in Planned Care guidance (currently 48 hours).
7	**Expedite Requests:** Patients who make contact to expedite appointments should be dealt with accordingly: • Should be based on clinical need; a long waiting time does not alter priority • For patient experience, clinically valid expedite requests should be dealt with by the team who they contact, rather than directed elsewhere • Follow-up appointments for review or treatment should be brought to the attention of the specialist overseeing their care for action.
8	**Did Not Attend:** • Care needs to be taken to ensure reasonable adjustments are made for patients with protected characteristics under the Equality Act. • Where patients do not attend for out-patient appointments without giving notice, in line with WG guidelines for pathway management, they will be discharged.

	• The original referrer, the GP (if not the original referrer) and patient should all be advised of the discharge. • Where the patient has reasonable grounds to challenge the decision, they should be reappointed without a new referral. • In the case of vulnerable adults and children who do not attend refer to the local "was not brought" policy
9	**Patient Discharges:** • Electronic discharge advice letters (eDAL) should be completed at the time of discharge, and a copy sent with the patient • Patients should be discharged with at least two weeks of medication (which may be supplied from the hospital or from medication already in the patient's possession. Where there may be a longer than usual time needed to source a medication in primary care (e.g. where a special formulation or unlicensed preparation is prescribed), consideration should be given to providing at least four weeks of medication at discharge • Discharges out of hours should ensure appropriate handover to Out of Hours providers e.g. End of Life Care. • Similar information should be provided for completion of an ambulatory care assessment.
10	**Pre-operative Assessment Clinics** • **Must have named medical support** • Should first use the named medical support when unexpected findings are identified. Refer internally for optimisation for surgery, or an appropriately commissioned optimisation service

Section 2 - Documents referenced

1) GMC Guidance Delegation and referral - professional standards - GMC
2) Robert Powell enquiry
3) BMA Guidance 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
4) Planned care waiting times guidance: April 2025

GMC

The following applies whether you are delegating or referring:

a You should explain to the patient that you plan to transfer part or all of their care, and explain why
b You must pass on to the healthcare professional involved:
- i) relevant information about the patient's condition and history:
- ii) the purpose of transferring care and/or the investigation, care or treatment the patient needs.

c You should check that the patient understands what information you will pass on and why. If the patient objects to a disclosure of information about them that you consider essential to the safe provision of care, you should explain that you cannot refer them or arrange for their treatment without also disclosing that information.

NHS Guidance

Three important overarching principles guide this work.

The first is that the clinician who orders the test is responsible for reviewing, acting and communicating the result and actions taken to the General Practitioner and patient even if the patient has been discharged.

The second is that every test result received by a GP practice for a patient should be reviewed and where necessary acted on by a responsible clinician even if this clinician did not order the test.

The third is that patient autonomy should be respected, consideration given to reasonable adjustments for people with learning disabilities and mental health problems and, where appropriate, families, carers, care coordinators and key workers should be given the opportunity to participate in the handover process and in all decisions about the patient at discharge. Use of interpreter services should be considered if the patient doesn't speak English.

ROBERT POWELL ENQUIRY

i. General Practitioners need to be adequately informed, in writing, of the material facts and intended course of further investigation when a patient is discharged from hospital.

ii. Correspondence of the type identified above needs to be addressed to the General Practitioner who made the referral. The current evidence is that this does not always occur.

iii. All correspondence from a hospital should be considered by the General Practitioner who made the referral. If it is not addressed to that doctor but another doctor in the practice then the practice administration should ensure that it is brought to the referring doctor's attention or a designated doctor if the referring doctor is away from the practice; on holiday for example.

BMA

Duty of care regarding communication of investigation results.
We are aware that in some areas, some hospital doctors have been instructing GPs to find out the test results which the hospital had ordered.

Both the General Practitioner Committee and the Consultants Committee of the BMA agree this practice is potentially unsafe, and that the ultimate responsibility for ensuring that results are acted upon, rests with the person requesting the test. That responsibility can only be delegated to someone else if they accept by prior agreement.

Handover of responsibility has to be a joint consensual decision between hospital team and GP. If the GP hasn't accepted that role, the person requesting the test must retain responsibility.

This advice is in line with both National Patient Safety Agency guidance and the Ionising Radiation (Medical Exposure) Regulations.