# Primary and Secondary Care Interface Principles Sandwell & West Birmingham

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# Foreword

Delivering safe, timely and person-centred care for the people of Sandwell and West Birmingham depends on strong, trusting relationships between primary and secondary care. At a time of sustained pressure across our services, the way we work together at the interface matters more than ever — for patients, for clinicians, and for the sustainability of our local health system.

This document has been jointly developed by clinical leaders from general practice and Sandwell and West Birmingham NHS Trust, reflecting a shared commitment to collaboration, mutual respect, and collective responsibility for the care we provide. It brings together national good practice with local insight to set out clear, practical principles that support safe transfer of care, reduce avoidable friction between services, and help ensure patients receive the right care, in the right place, at the right time.

These principles align with national expectations from NHS England and the Getting It Right First Time (GIRFT) programme, while being grounded in the realities of how care is delivered across Sandwell and West Birmingham. They are intended to provide a common understanding of roles, responsibilities, and expectations at the primary–secondary care interface, recognising the pressures faced in all parts of the system.

The principles are not designed to be prescriptive or punitive. Rather, they reflect our shared ambition to work in partnership, reduce unnecessary hand-offs, duplication, and administrative burden, and support clinicians to focus on what matters most - providing high-quality, safe care for our population.

Importantly, this is a living document. We are committed to continuing the open, constructive dialogue that underpins it, using shared learning, audit, and feedback from clinicians and patients to refine and improve how we work together over time.

We would like to thank colleagues across general practice, secondary care, community pharmacy, and wider system partners who have contributed to the development of these principles. Their input reflects the strength of collaboration across Sandwell and West Birmingham and our collective determination to deliver joined-up, patient-centred care.

We commend this document to all clinicians and teams and encourage its use as a shared reference point to support respectful, effective partnership working across our local health system.

Please forward any comments you may have about this document to: swbh.practicesupport@nhs.net


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# Executive Summary

This document sets out the core principles for effective communication and collaboration between primary care, secondary care, and patients within Sandwell and West Birmingham. By adopting and continuously refining these principles, we aim to deliver tangible benefits for patients and reduce unnecessary burdens on healthcare professionals.

Monitoring and accountability will be via the Sandwell and West Birmingham Interface Steering Committee which has membership of both primary and secondary care leadership, chaired by the Sandwell and West Birmingham NHS Trust Deputy Chief Medical Officer (Integration & Pathways).

The principles outlined here provide a shared framework for improving relationships, clarifying responsibilities, and streamlining processes across the system. They are designed to support safe, efficient, and patient-centred care, while recognising that clinical judgment and flexibility remain essential. Furthermore, they are intended to support consistent, safe decision-making at the interface and reduce avoidable friction, duplication, and patient harm.

# Introduction

Clear and consistent communication between primary and secondary care is fundamental to delivering high-quality, patient-centred services. This document presents agreed principles, developed with input from clinical leaders across both sectors, to guide interactions and responsibilities at the interface of patient care.

These principles are not rigid rules or contractual requirements; they are intended to support good professional practice, allow for professional discretion and adaptation to individual patient circumstances. Their purpose is to:

1) Strengthen collaboration between colleagues.
2) Reduce administrative inefficiencies.
3) Ensure patients remain at the centre of care.
4) Promote timely, accurate information sharing.

This document should serve as a starting point for reflection and dialogue across Primary and Secondary Care in Sandwell and West Birmingham. Implementation will require ongoing engagement at both locality and system levels to embed these principles into everyday practice.

# Principles for All

- **Treat all colleagues and patients with respect.**
- **Patients should be at the centre of all we do.**
- **Clinicians should seek to undertake actions themselves wherever possible, involving other teams or services where this adds value or is clinically necessary.**
- **Where clinically appropriate and feasible, clinicians are encouraged to speak directly with colleagues to support timely decision-making.**
- **Avoid committing other individuals or teams to specific actions or timescales without prior agreement.**
- **The clinician or service requesting a test retains responsibility for:**
    - Chasing and reviewing results.
    - Determining and documenting the management plan.
    - Communicating results and next steps to the patient.
    - Robust systems should be in place to support this process.
- **For incidental findings, responsibility for informing the patient and managing follow-up normally sits with the requesting clinician or service, unless explicitly agreed otherwise. Where urgent action is required, this should not be deferred or transferred without direct communication.**
- **Ensure patients are kept fully informed regarding their care and what is going to happen next.**
    - Once seen within a service, there should be clear advice about how patients should raise concerns about clinical deterioration that avoid directing them to other services unless clinically necessary (Patient Initiated Follow Up (PIFU)). This should be referenced within the discharge summary or clinic letter with clear contact details or explained to the patient at the point of referral into secondary care.
    - If patients are in a secondary care service, there should be clear signposting to patients about how to get clinical advice between appointments.
- **Any clinician who wishes to prescribe medication should undertake appropriate pre-treatment assessment to support continuity and reduce treatment delays across care settings.**
    - They are responsible for communicating the rationale for treatment, including benefits, risks and alternatives, arranging any follow-up requirements that might be necessary, and documenting all of this in any related correspondence.
    - To support safe and consistent prescribing as patients move from acute to community care, clinicians are strongly encouraged to use the ICB prescribing formulary, acknowledging the differing prescribing responsibilities and constraints

across care settings.

- **Diagnostics should be only requested that follow national guidance including GIRFT, NICE and Royal College and is indicated as per Clinical Decision System.**
- **Any request for diagnostics are discussed with the patients about importance of attending and following any preparation that maybe required.**
- **Community Pharmacy should be used to support safe, timely transfer of care following hospital discharge, particularly in relation to medicines reconciliation, adherence, and patient understanding**.
    - Where medicines support is likely to add value, such as following medication changes, polypharmacy, or adherence concerns, patients should be referred to the Discharge Medicines Service (DMS), in line with national guidance.
    - The clinician or service initiating or changing medication retains responsibility for prescribing decisions, clinical oversight, and communication of discharge medicines, unless explicitly agreed otherwise.
    - Community pharmacy supports medicines optimisation and adherence and should not replace clinical assessment or review where this is required.
    - Appropriate use of community pharmacy services should help to avoid unnecessary transfer of workload to general practice, including avoidable GP appointments for post-discharge medicines queries.
    - Referrals to community pharmacy must include accurate, timely medicines information, including details of any changes made at discharge.
    - Where medicines-related concerns are identified that require clinical review, clear routes must be in place for escalation to the appropriate clinical team or primary care.

# Principles for Primary Care

- **Follow the principles of a good referral including:**
    - A clear reason for request, alongside relevant background information.
    - An up-to-date medication list.
    - Recent investigation relating to the problem, attaching any imaging test results performed outside of the local provider.
    - Highlighting key anomalies in investigations in the body of your referral/request.
    - Indicating within the referral any reasonable adjustments the patient may require or whether this patient is suitable for a virtual appointment.
    - Populate primary care agreed referral proformas/templates as appropriate.
    - For urgent suspected cancer referrals, ensure patients understand the urgency and the importance for attending appointments.
    - UEC patients to be reviewed ahead of referral and discussed with specialist support to ensure the most appropriate transfer (appropriate points of contacts to be provided by secondary care).
    - In e-RS advice and guidance always consider selecting *"conversion to refer"*.

- **Consider using advice and guidance as an alternative to referral for the following indications:**
    - Diagnostic uncertainty which may affect the safety and effective management of the patient.
    - Uncertainty around clinical management or as a pathway to referral if unsure about the need and there is no Clinical Referral Guideline recommended pathway.
    - Support to interpret primary care diagnostics (e.g., ECG) that will affect management.

- **Expediting referrals.**
    - When communicating with secondary care about a patient who is already under a service, contact the consultant or other healthcare provider directly rather than through the e-RS advice and guidance, unless a service has specifically requested otherwise.
    - To support appropriate prioritisation, including the impact on the patient (employment, mobility, mental health, caring obligations) is clear, along with relevant frailty assessment.

- **When referring to secondary care, clearly communicate to the patient who you are referring them to, what for and what to expect (if known).**

- Patients should be advised that waits may be prolonged. Waiting times can be located at the following link: Sandwell and West Birmingham Hospitals NHS Trust – My Planned Care NHS.
- Advise the patient that the first contact by secondary care may be a remote consultation by video or phone.
- If deemed appropriate, patients could contact the patient access team (0121 507 4151) to ascertain when their appointment is in secondary care. If the General Practice deems that the patient's condition has deteriorated since the referral, appropriate action should be taken to expedite the appointment. Patients may be signposted to appropriate patient advice and liaison services where concerns persist. Telephone: 0121 507 5836, email: swbh.patient-experience@nhs.net.

- **Consider the process of *'waiting well'* for patients referred to secondary care.**
  - Set patient expectations around possible wait times and encourage patients to optimise their own health in the waiting period, including long-term medical conditions e.g. weight, hypertension, diabetic control and smoking. A clear explanation should be communicated to patients that this can avoid delays, cancellations and lead to better outcomes. NHS advice can be found at the following link: Getting ready for your surgery – My Planned Care NHS.
  - Where patients are referred to elective surgical pathways, Primary Care should support the optimisation of:
    - Blood pressure
    - BMI
    - Diabetes control
  - All patients with known diabetes or hypertension who are referred by primary care into an elective surgical service should be prompted to have an up-to-date HbA1C measurement or BP check (including use of community pharmacy where appropriate).
  - All eligible patients over the age of 40 who are referred by primary care into an elective surgical service should be offered an NHS health check. . NHS advice can be found at the following link: Getting ready for your surgery – My Planned Care NHS.

- **Advice & guidance.**
  - **Purpose of A&G.**
    - Advice & Guidance should be used by primary care to:
      - Seek timely specialist input where it will support patient management.

- Clarify the next steps**,** including investigation, management, or referral.
- Avoid unnecessary outpatient referrals where safe and clinically appropriate.

- A&G should not replace referral where specialist assessment is clinically indicated, nor be used to delay access to specialist care where referral criteria are met.

- **Quality of A&G requests.**
  - To support efficient, high quality responses and avoids unnecessary delays, Primary care A&G requests should include sufficient clinical information to allow meaningful specialist advice, including where relevant:
    - Presenting problem and duration.
    - Relevant history and examination findings (include any recent ED attendance information/ investigation results).
    - Key results already available.
    - Current management and specific clinical question.

- **Use of investigations prior to A&G.**
  - Primary care should undertake investigations within usual scope of practice where these are:
    - Recommended in local or national guidance.
    - Likely to materially inform specialist advice.
  - Primary care should not be expected to undertake investigations outside scope, nor delay A&G or referral where this would risk patient safety.

- **Acting on Advice & Guidance.**
  - Where Advice & Guidance recommends:
    - **Primary care management**: this should be actioned where appropriate.
    - **Further investigations:** primary care will arrange these where within scope, with clarity on result handling and escalation.
    - **Referral**: primary care will submit this in line with the advice provided.
  - Advice & Guidance responses should be treated as clinical advice, not administrative instructions, and should result in a clear documented

outcome.

- **Escalation and re-contact.**
  - Primary care may re-contact the specialty via A&G where:
    - The patient's condition changes.
    - The results are abnormal.
    - Advice is unclear or insufficient.
  - A&G should support ongoing clinical dialogue, not a single one-off transaction.

- **Fit notes and medication following A&G.**
  - Primary care should solely as a result of specialist advice, where the patient has not been assessed or stabilised.
    - Issue fit notes and prescriptions **where responsibility for ongoing care appropriately sits in primary care.**
  - Primary care should not be expected to:
    - Issue fit notes.
    - Start new specialist-initiated medications.
    - Arrange urgent prescriptions.

- **Appropriate referral following A&G.**
  - Where specialist advice indicates referral is required:
    - Primary care will arrange this promptly.
    - Referral urgency should reflect the advice provided.
  - Advice & Guidance should not be used to deflect, delay, or inappropriately manage demand access to specialist care where referral criteria are met.

- **Patient communication and safety-netting.**
  - Primary care remains responsible for:
    - Communicating outcomes of A&G to the patient.
    - Providing safety-netting advice appropriate to the agreed plan.
  - Where responsibility for follow-up or action sits with secondary care, this should be explicitly documented and communicated to the patient.

- These principles align with national Advice & Guidance best practice, including **NHS England** interface guidance, 2024/25 ICB direction, and **GIRFT** principles. They are intended to support safe, timely access to specialist input while avoiding unnecessary referrals, inappropriate deflection, and an administrative burden.

# Principles for Secondary Care: Onward Referrals

If a patient has been referred to SWBT and they need another referral for an immediate or a related need, the named/lead clinician should normally make this referral directly, rather than redirecting the patient back to General Practice where the onward referral is already clinically indicated.

- **Onward Referrals by Specialists.**
    - Where it is evident that a specialist is confident about which specialty should take over a patient's care for an i.mmediate or related need, they should arrange the onward referral directly rather than sending them back to General Practice (This includes onward referrals for two week wait (2WW) appointments).
    - This would then be communicated with the patient, their General Practice team and the clinicians for whom the onward referral was addressed too.
    - This should be done in a timely manner to ensure minimal delays.

- **Specialist-requested Investigations.**
    - When a specialist orders investigations to aid their clinical management of a patient, they should be responsible for arranging, reviewing and following up on the results. This ensures continuity of patient care and avoids unnecessary delays in patient management.

- **Incidental Findings.**
    - If the finding is clinically significant, the specialist should take responsibility for communicating with the patient and deciding on appropriate follow-up or onward referral.
    - If the finding is not immediately actionable but requires future monitoring, this should be clearly communicated to General Practice with appropriate guidance. This should be clearly written in the letter to the patient and a copy sent to General Practice.

- **Suspected Cancer Referrals.**
    - All suspected cancer referrals must be actioned promptly by the specialist without avoidable delay or inappropriate requests to General Practice. Tracking responsibility will sit with the relevant cancer pathway or MDT coordination function.
    - Patients to be tracked by cancer MDT coordinator until the possibility of cancer is ruled out or until first treatment is received.

# Principles for Secondary Care: Call & Recall (including Patient-Initiated Follow-Up (PIFU))

- Where there is potential for ongoing secondary care input, Patient-Initiated Follow-Up (PIFU) should be offered where clinically appropriate, in line with national outpatient transformation guidance.

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- **Core principles.**
  - Follow up remains the responsibility of the secondary care specialty during the Trust's agreed PIFU period.
  - Patients should not be required to contact general practice to facilitate follow-up while on an active PIFU pathway.
  - PIFU should be time-limited, with a clearly documented duration and end point.

- **Patient information and access.**
  - Patients must be provided with:
    - Clear information on when and how to initiate follow-up.
    - A direct contact route to the specialty (e.g. dedicated phone line, monitored email, or e-RS route).
  - Contact details should be clearly documented in clinic letters and patient correspondence.

- **Clinical clarity and safety.**
  - The PIFU plan must include:
    - The scope of issues appropriate for PIFU contact.
    - Red-flag symptoms and instructions for urgent care where needed.
    - What will happen if the patient does not make contact within the agreed timeframe.
- **End of PIFU.**
  - At the end of the agreed PIFU period:
    - Care should either be formally discharged to primary care with clear advice and safety-netting, or
    - Converted to a planned follow-up where clinically indicated.

# Principles for Secondary Care: Did Not Attend (DNAs)

- **Clinical responsibility following a DNA.**
    - A Did Not Attend (DNA) does not automatically end specialist responsibility. Each DNA should trigger a clinical review to assess risk and determine appropriate next steps.

- **Re-offering appointments.**
    - Where clinically appropriate, patients should normally be offered a further appointment following a first DNA, particularly where there is:
        - Ongoing clinical risk.
        - Suspected cancer, long-term conditions, or safeguarding concerns.
        - Evidence of access barriers or health inequalities.

- **Discharge following DNAs.**
    - Discharge following repeated DNAs should only occur after documented clinical review, with:
        - Clear assessment of risk.
        - Consideration of alternative follow-up methods.
        - Clear safety-netting advice.
    - Patients should **not** be discharged to primary care solely to request re-referral following a DNA.

- **Communication with primary care.**
    - Where a patient is discharged following DNAs, the specialty must provide:
        - Clear rationale for discharge.
        - Summary of clinical risk assessment.
        - Advice on when re-referral is appropriate.
        - Clear safety-netting information.

- **Health inequalities and access.**
    - DNA processes should take account of health inequalities, including language barriers, digital exclusion, mental health needs, and deprivation, and offer reasonable adjustments where required.

- **Suspected cancer and urgent pathways.**
    - Patients on urgent or suspected cancer pathways should not be discharged after a DNA without senior clinical review, in line with national cancer standards.

# Principles for Secondary Care: Complete Care - Fit Notes

- Fit notes to be completed following admission, surgery, outpatient clinic ED attendance (if deemed necessary) (paper copy if electronic not available).

- Ensure fit notes are for an appropriate and full period assessed and required at the time of discharge (i.e., if three months is required off work, complete the fit note for the whole duration). Extensions beyond that period may be the responsibility of Primary Care following reassessment, where appropriate.

- SWBT should ensure fit notes are available for colleagues in inpatient and outpatient settings.

- All clinic or discharge letters to General Practice to make clear where fit notes have been issued by the provider, the reasons given, and the exact dates covered.

# Principles for Secondary Care: Complete Care - Discharge Summaries & Clinic Letters

- Prior to discharge, ensure the patient understands their diagnosis and treatment plan. Use of patient advice leaflets for common conditions is strongly recommended.

- Patients should not be routinely advised to see their General Practice following discharge unless there is a clear clinical reason. If it is necessary for a patient to see their General Practice after discharge, ensure that the reason for this is documented in the discharge letter and that there is a reasonable expectation the General Practice will be able to address their patient's clinical problem.

- Letters should include clear accountability of actions for secondary care, the General Practice and the patient. Investigations initiated should be reviewed and actioned by secondary care clinicians including surveillance and follow-up tests.

- In general, General Practices should not be asked to chase up the results of investigations requested by SWBT clinicians.

- Any urgent (within 2 weeks) testing required following a hospital or emergency department discharge should be arranged by the discharging team.

- Direct referrals (after discharge from the ED for example) to specialists should be used for patients with a firm diagnosis that will clearly require urgent assessment or where there is significant concern of an urgent nature e.g., suspicion of cancer (2 week wait).

- The discharge letter is a key element in ensuring safe continuity of patient care, it is essential to ensure that it is accurate and has all the appropriate information for General Practice to continue to provide care for their patients. It should be sent in a timely manner, preferably electronically.

- Provision of a Statement of Fitness for Work should be issued by SWBT clinicians to those patients who are clearly not going to be fit for work after the 7-day self-certification' period.

- For patients who are not registered with a GP, information regarding how to register with a General Practice should be readily and easily available in the ED.

- IT Systems should be in place to allow ED to easily view the patient's General Practice electronic health record.

- Discharge summaries must be sent to the General Practice within 24 hours after every

discharge from inpatient, day case or emergency department care.

- Discharge communications should clearly state who retains clinical responsibility and how patients should seek urgent advice if symptoms worsen.

- Clinic letters: to be sent to patients within 5 working days (copying in General Practice) including clear accountability of actions for secondary care, General Practice and patients to ensure patient safety.

- Clinic letters should be sent electronically using standardised clinical headings which include phone number and email contact details of the department in case of queries.

# Principles for Secondary Care: Clear Point of Contact

- **Accessibility.**
    - Provide a single route for general practice and secondary care teams to communicate rapidly e.g. the Primary Care Liaison Officer who can be easily reached for information, updates, or concerns (swbh.practicesupport@nhs.net)
    - Facilitates smooth transitions between departments, multidisciplinary teams, and between secondary and primary care.

- **Communication and Information Sharing.**
    - Appropriate communication channels and contact lists to be maintained and optimised to ensure direct contact between primary and secondary care teams.
    - Promote timely, accurate exchange of information between secondary care, primary care, and the patient, reducing errors and duplication.
    - All out-patient departments to have a single generic email address and this should be added to all clinical letters along with the departmental / medical secretary telephone number for ease of contact for the patient, primary care colleagues and other services for issues such as chasing results and/or appointments.

- **Efficiency and Responsiveness.**
    - Reduces delays in responding to clinical queries, arranging follow-ups, and resolving issues.

# Principles for Secondary Care: Other

- **Advice & guidance.**
    - Advice & Guidance is a two-way clinician-to-clinician dialogue via e-RS**,** supporting care to be managed in the most appropriate setting.
    - Responses must include the name and role of the responding clinician (or accountable clinical team/service) and a route for follow-up where required.
    - Advice & Guidance responses should normally be provided electronically within local agreed timeframes (the Trust is working on its A&G timeline with an aspiration to deliver A&G within 2 working days (to be confirmed)).
    - Responses must provide an individualised, stepwise management plan, including thresholds for re-contact and criteria for future referral/escalation.
    - Where tests are recommended in primary care, these should be within usual scope of practice, with clear guidance on interpretation, actions for abnormal results, and when/how to seek further specialist input.
    - Where a referral is triaged, the specialty must assess suitability and upgrade to urgent / suspected cancer where clinically indicated, documenting rationale and next steps.
    - Where straight-to-test is used, the specialty must provide a clinical interpretation in context and a clear management plan, not solely the test result; normal results should not automatically result in discharge where symptoms/risk indicate further action is required.
    - Advice & Guidance must not be used to inappropriately delay or deflect clinically indicated referrals. Where referral is not required, the response must provide a clear alternative pathway, safety-netting, and documented next steps.
    - Each A&G response must record a clear outcome (e.g., advice only / tests / straight-to-test / refer / no further action) and the accountable party for next steps.
    - Where investigations are requested/initiated as part of specialist advice, responsibility for arranging, reviewing, acting on results, and communicating outcomes must be clearly stated.
    - Where the clinical scenario is urgent or deteriorating, A&G should not be used as a substitute for urgent pathways**;** appropriate urgent referral/escalation routes should be advised.

- **Avoid asking general practice to organise specialist tests or examinations.**
    - In Sandwell & West Birmingham, this includes ordering blood tests via **Unity** and directing patients to contact Community Phlebotomy Services via the Single Point of Access (x6104)/ sandwell.phlebotomy@nhs.net to arrange testing. Results will return to the ordering clinician, who remains responsible for review, action, and communication of outcomes.
    - If the first contact is a virtual review but the patient needs an examination, this should happen in secondary care, unless there are exceptional circumstances

agreed (or this would have been an expectation prior to referral). This includes minor invasive procedures such as rectal examinations.
    - If a clinician wishes the patient to have further tests prior to next review, these should be undertaken within secondary care, unless a shared care agreement is in place.
- **Ensure clear and timely communication to the referrer in primary care.**
    - This applies to all patient contacts including outpatients, discharge from admission and ED.
    - Discharge summaries and summaries relating to ED attendance should be received by primary care within 24 hours. Letters relating to outpatient appointments should be issued within 5 working days, in line with nationally recognised good practice, unless a shorter timeframe is clinically required.

- **Ensure correct timely medication.**
    - Issue prescriptions for 28 days (as detailed in GIRFT/ Red Tape Challenge) in outpatients unless clinically inappropriate via FP10s if e-prescribing is not available, and with provision for virtual clinics.
    - When patients are discharged from hospital, they should receive a minimum of 7 day supply (as detailed in GIRFT/ Red Tape Challenge).
    - When there is a shared care agreement in place this should be shared with primary care and any queries addressed.
    - Where variance from the Black Country formulary or the Birmingham and Solihull formulary is in the best interests of the patient, this should be discussed in advance of recommendation with the primary care team.
    - Utilise the enhanced Discharge Medication Service (DMS).

# Scope, Status and Review

These Interface Principles apply to clinicians working across primary and secondary care within Sandwell and West Birmingham. They are intended to provide shared professional guidance to support safe, effective, and respectful working at the interface between services, rather than to operate as contractual or performance-management requirements.

The principles have been developed collaboratively and are designed to support consistent clinical practice, improve patient experience, and reduce avoidable friction and administrative burden across the system.

The principles will be reviewed periodically in collaboration with clinical leaders from both primary and secondary care to ensure they remain relevant, practical, and responsive to evolving national guidance, local system pressures, and learning from implementation, audit, and feedback. The governance for this sits with the Primary and Secondary Care Interface Steering Group.