# Principles and practicalities of transfer of care between secondary and primary care in the Southern Health System.

**This framework has been endorsed by the Te Whatu Ora Southern Chief Medical Officer and clinical leads from WellSouth.**

## Summary

This document outlines the principles and practical aspects of transfer of care between secondary and primary care, particularly regarding medical investigations and tests and applies to both inpatients and outpatients:

1. which are required after discharge from secondary care.
2. where results are not available at the time of leaving secondary care.

Lack of clarity regarding transfer of care and with whom primary responsibility lies, represents a clinical risk to patients. The purpose of these principles is to mitigate this risk.

The fundamental principle is that the requesting clinician holds primary responsibility for follow up of the results (as defined in Cole’s Medical Practice and established by key institutions including HDC, MPS and RNZCGP – see references).

Any clinician who is copied into a result has residual responsibility for acting on clinically significant results. This creates duplicate work for clinicians who are copied into results without handover of clinical responsibility or context.

Copying of results is **NOT** a transfer of care and results should **NOT** be routinely copied to any other clinician at the time of request. This ensures that ongoing responsibility lies unambiguously with the requester. If handover of responsibility is requested, this needs to be clearly communicated in writing and with closed loop communications – i.e., currently by phone call or GP/NP direct message on Health Connect South (HCS)

Some GP/NPs consider copied results useful and there may be locally agreed exceptions on a service or geographical basis, e.g., in rural communities

In Te Waipounamu, test results are electronically available for viewing by GP/NPs via Health One. However, when GP/NPs have requested an investigation or test or patient care is being transferred to them, results must be actively communicated to General Practice. **Directing GP/NPs to look in HealthOne is not acceptable**.

## Visibility of information

The discharge summary remains a key communication tool for transfer of care and contains information for patients and whanau, as well as advice and requests for the primary care team.

A patient activity dashboard is available to primary care on HCS and includes details of both admissions and discharges, with a flag if a summary has not been completed.

A hospital clinician dashboard is available, which provides information on the status of discharge summaries (both) to individual practitioners, teams, and the wider institution.

## Access to services

Patients should have access to services according to greatest clinical need and ability to benefit, and not according to which clinician has made the referral. Where both General Practice and hospital referrers can access a particular service, criteria and referral quality should be the same. Exceptions may include where services are required to enable discharge and where there are exceptional patient equity, geographical or social factors.

## Role of the General Practice team

For most patients, their General Practice team is their central point of contact with the health system, and it is essential to communicate clearly between professionals and with patients about who is the key contact person during an episode of care. For example, this may not be the General Practice team for:

* patients undergoing intensive treatment e.g., bone marrow transplantation or cancer therapy, where their specialist team may be their central point of care.
* patients with severe mental health problems, where case workers are their central point of care.
* pregnancy care – provided by lead maternity carers.
* some Marae-based and other Kaupapa Māori services.
* other NGO led services.

General Practice teams need to develop local processes for clinically responsible handover when required (e.g., when hospital medical staff phone to pass on an aspect of handover of care). This recognises the reality that while GP/NPs want to discuss their patients, it is often inappropriate for them to be disturbed during consultations, or they may not be on site full-time.

Patients’ longitudinal care is core General Practice business. There should be direct communication with Primary Care teams, ideally through a Shared Care update, clinic letter or discharge summary. This includes progress notes which should not just be posted on HealthOne. Primary Care teams should be informed about or involved with any care plans, especially shared care plans such as Acute Plans, Personalised Care Plans and Advance Care Plans.

## Requests for investigations and internal referrals for in- and outpatients in Te Whatu Ora Southern hospitals

### The hospital team should make requests:

* When related to the management of the presenting condition or reason for admission e.g.
  + a patient with new malignancy will be referred for radiology, medical oncology, and surgery.
  + a patient admitted with bleeding duodenal ulcer will be referred for follow-up gastroscopy if indicated.
* To General Practice teams, for ongoing care that is required but cannot be provided at the time of consultation in hospital or transfer home from hospital, e.g., monitoring warfarin, assessment of heart failure control.
* When it is sufficiently urgent or other exceptional circumstances make referral by the hospital team a better option for the patient, e.g., high suspicion of cancer, if the General Practice team cannot access the required service e.g., some imaging such as CT, or MRIs for non-ACC conditions.
* When tests will be required prior to future specialist review, e.g., CEA or radiology in a year’s time. It should be noted blood tests can be requested for a specific point in time utilising the SCL online request system.

### The hospital team should **NOT** make requests:

* When a patient has a non-urgent condition unrelated to the primary reason for specialist consultation.

In this situation, General Practice is better placed to discuss all community care and funding options with the patient, including private options. This fulfils patients’ right to informed choice and helps avoid duplicate or incorrect referrals. There may be exceptions to this, e.g., high needs paediatric patients.

There is clearly a tension between patient-centred care and best referral practice in the above principles.

**Example:** *A patient comes into hospital acutely with a bowel obstruction and is found to have cancer. The hospital team should refer to oncology and arrange district nursing services for postoperative home care and removal of sutures. The hospital doctor should arrange this and follow it up. While in hospital, the patient also complains of vertigo and a skin lesion that were both unrelated to the reason for hospital admission.*

*It should be stated in the discharge summary that the patient has been told, and understands, they need to contact their primary care team to discuss management for both conditions, e.g., ‘Mrs Smith had a lesion thought to be a skin cancer on her hand. As discussed on the phone with Practice Nurse Jones today, Nurse Jones has made an appointment for Mrs Smith to see you. Please arrange further management as you see fit.’*

*This is preferable to ‘Mrs Smith has a skin cancer, please refer to Plastic Surgery Outpatients**’, which eliminates options including GP/NP excision or medical management, any doubt about diagnosis, or private options.*

## Responsibility for test results

Hospital doctors are responsible for following up the results of all tests and referrals initiated as part of the reason for specialist consultation, unless an explicit and documented handover has been agreed and occurred. This includes:

* Lab tests arranged in the hospital with no result available before discharge
  + Most results are available within a week with only a few exceptions. Where the action is clear (e.g., prescribe antibiotics) the RMO/hospital team should arrange this.
  + Where the action is not clear or there is a significant finding, there should be a handover to the General Practice team in writing and by phone.
* Radiology post discharge or outpatients
  + If a hospital clinician feels a radiology investigation is indicated, they should request it and follow up the results. If the hospital clinician has moved on by the time the result arrived, (e.g., rotating RMO) results will be followed up at a team or service level.
  + General Practice should not be asked to arrange radiology post discharge or following an outpatient appointment.

## Pre-operative prescribing

* Hospital teams should prescribe pre-operative antibiotics for patients they have seen in outpatients.
* General Practice should, when requested, prescribe pre-operative antibiotics for patients who remain under the care of their general practice team/have not been seen in outpatients, e.g., a patient with an elevated PSA going for prostate biopsy.

## How hospital teams can contact General Practice teams

HealthOne holds the details of a patient’s correct current enrolled General Practitioner (GP), who has responsibility for ongoing patient care.

This can be checked via the tab in HCS and may vary from that recorded in Health Connect

South (HCS), iPM (soon to be PICS) and written notes, all of which are unreliable sources of the enrolled GP. If the GP in HealthOne is different from that recorded elsewhere, the admin staff should be advised so they can update the details in iPM (PICS), which will in turn update Health Connect South.

## Urgent patient discussion about in- or outpatients, including patients being discharged

1. Where complex, frail or rapidly changing patients are transferring out of hospital and require immediate clinical supervision, or where patient care would benefit from discussion or confirmation, contact the [General Practice team](https://info.erms.health.nz/directory.htm?region=Canterbury&funder=Private&referraltype=General%20Practice%20Referral) directly during working hours:
   1. If the problem is urgent but non-complex, speak to the practice nurse.
   2. If best to talk with the GP/NP ask to be put through to them directly, stating the name/NHI of the patient. If the GP/NP is not available and:
      1. You cannot be reliably contacted via a return call – ask to be put through to the practice nurse.
      2. You can be reliably contacted via a return call – leave a clear message with your name, role, reliable contact number (preferably a mobile number so GP/NPs do not have to wait for an RMO to answer a page) and the patient’s name/NHI.

and;

1. Send a discharge summary as usual.

## Non-urgent requests for in- or outpatients

1. If a General Practice team is being asked to arrange an investigation or service, the referrer should check on Community Health Pathways that the service is available to the Primary Care team.
2. Requests should be clear and unambiguous, e.g., under the “Information and Requests to GP” section of the discharge summary, “referral to urology has been made by the inpatient team” is preferable to the ambiguous “referral to urology”.
3. The patient should be advised to make an appointment to see their GP/NP to discuss further management, and a clear statement written in the “Advice to Patient/Whānau” section of the discharge summary. There should also be a clear statement in the "Information and Requests to GP" section of the discharge summary that the Primary Care team is being requested to discuss management with the patient, who has been advised to make a GP/NP appointment.
4. If the patient is assessed as not having capacity to arrange an appointment this needs to be made clear in the “information and requests to GP” section of the letter, to request the General Practice team to determine the most appropriate way to facilitate this.

## References

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