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| **PRIMARY & SECONDARY CARE INTERFACE DEVELOPMENT - NATIONAL & LOCAL PRIORITIES 24/25** |
| **NATIONAL & LOCAL INTERFACE PRIORITIES** | **ACTION FOR 24/25** | **DATE** |
| **1. IMPROVE QUALITY & EFFICIENCY OF DISCHARGES (National & Local Priorities)** |
| **IMPROVE DISCHARGE PROTOCOLS (inc. for urgent requests /blood tests discharge & a min acceptable timeframe for urgent request for GPs [National Priority- Level 2]​)** | Explore and agree a **general consensus around discharge protocol timeframes** for follow up requirements in primary care and secondary care e.g. less than x day requirements will be managed by secondary care.​ | Q4​ |
| **​IMPROVE THE QUALITY OF DISCHARGES & OPD CORRESPONDENCE​ INCLUDING – REDUCING DELAYS IN SENDING CORRESPONDENCE [Local Priority]** | Produce and **deliver an ‘induction’ pack /training guide for FHFT clinicians** covering agreements within the FHFT & Primary Care Collaborative working reference guide​ (particularly highlighting: Management of results, onward referrals & other elements etc.) | Q3 |
| **Continue to audit discharges & implement & embed improvements** through the weekly Friday Discharge Improvement meeting​. | Q1-4​ |
| Ensure robust processes are in place to **monitor and manage delays in sending discharges and other correspondence** to primary care​ | Q4 |
| **Ensure a clear “GP to action” section is visible in all discharges (Nat Req.). Agreed locally to have matching clear sections: *“Actions required of General Practice (GP)” and “Actions required of FHFT.” (agreed to pause for ED/UEC areas)*** | Q3​ |
| Explore feasibility of **‘GP to action’ section in OP correspondence** (National Priority) | Q3​ |
| **Focus Speciality:** Ophthalmology & Clinical Correspondence – clearer fields for New vs FU pt, “Clinical Diagnosis” and ‘GP to action’ & changes section​. Reduce use of Acronyms in general (add to reference guide and see if digital support via Epic for all specialties). | Q3 |
| Strengthen FHFT requesting processes for patient care from **virtual clinics** within FHFT embedding an updated SOP​. | Q3​ |
| **2. STRENGTHEN DIGITAL INTERFACES BETWEEN PRIMARY & SECONDARY CARE (Local Priority)** |
| **MORE EFFICIENT REFERRAL STATUS & TRIAGE OUTCOMES IN ERS (Epic/eRS Interface)​** | Share FHFT Waiting time information for key specialities (quarterly)​ | Q1​ |
| Roll out of API to strengthen Digital Interface between Epic and eRS​Install further interface developments on Epic/eRS referrals and A&G interface | Q2​ |
| **IMPROVE VISIBILITY OF A&G RESPONSE TAT BY SPECIALITY** | Share **FHFT A&G turnaround times** by specialty (quarterly)​ | Q2​ |
| **​REDUCE PAPER CORRESPONDENCE RECEIVED BY PRACTICES (often duplication of DOCMAN)​ by 50%** | Initiate task & finish grp – to understand cause of **duplicate correspondence** received in PC | Q3​ |
| Identify & resolve where technically possible **correspondence that remains on paper- Cardiology resolved, Endoscopy reports in progress/testing.**  | Q3​ |
| **SUPPORT INCREASE EPIC CARE LINK UPDATE** | Re-share uptake and **re-promote** sign up opportunities **Epic Care Link (webinar 26th)** | Q3 |
| **ROLL OUT ELECTRONIC EMED3 (Fit notes) [Nat. Priority - Level 2]​** | Roll out **electronic fit notes (eMED3)** (led by another Epic Trust (UCLH), NHSE & DWP)​Also, improve triggers for realistic timeframes. Anticipated roll out early 2025.  |  Q4​ |
| **3. IMPROVE THE QUALITY & CONSISTENCY OF REFERRALS & A&G USE (Local Priority) – DRAFT FOR ICB / PC TO SUPPORT** |
| **​DRAFT - FOR ICB / PC TO SUPPORT & EDITING****IMPROVE THE QUALITY & APPROPRIATENESS OF REFERRALS TO FHFT – ensuring patients are being managed in the most appropriate setting - supporting optimal patient care inc. prioritisation of patients requiring specialist care, and supporting efficient triaging and onward care (including straight to test)​** | **Optimising DXS Work programme:​ 'DXS strategy and assurance.'** If all agree DXS is our agreed strategy / method for providing high quality referrals: 1. Ensureforms/pathways are fit for purpose and work for everyone (PC & SC & Pt)​2. Ensure DXS referral forms are available for all key specialties with agreed minimum data sets (MDS)​3. Ensure forms are adopted throughout Primary Care (working with LMC etc.)4. Increase uptake of DXS with clear performance dashboard (including triangulating referrals, A&G and DXS use etc.) Add metrics e.g. by x%. | TBC (ICB) |
| **Ensure everyone has sight of referral, A&G and waiting time information**​Review returned referral rates and A&G patterns in triangulation with referral rates​ and work with outlier practices and services.  | TBC (ICB) |
| **Ensure robust processes in place for non-medical referrals, A&G and diagnostic requesting** | TBC (ICB) |
| **Ongoing pathway & transformational developments**. Agreed 24/25 Priority – **MSK pathway transformation.** | TBC (ICB) |
| **Improve Quality of diagnostic requests received (inc. US)**1. Prepare for Roll out of I-refer and Universal ICE Programme (for late 25/26)​ (BSPS)2. Consultant education/support sessions arranged in '23 and being repeated in '24. US waits now at 6 wks. PC support TBC.3. ICS review of direct access to diagnostics in response to National GPDA guidelines (+ linked to UICE & I-refer development)4. PC to review diagnostic activity requesting | Q3 |
| n/a |
| Q4 |
| TBC  |
| Effective assessments in PC prior to referral (aligned to ref guide and DXS minimum data sets) - Wording agreed in FHFT / PC Collaborative Working Guide. Further engagement work (above)​. - Virtual SOP for FHFT (see second section) | TBC (ICB) |
| **4. GOLDEN THREAD - STRENGTHEN RELATIONSHIPS & UNDERSTANDING ACROSS PRIMARY AND SECONDARY CARE** |
| **GOLDEN THREAD – CONTINUE TO STRENGTHEN RELATIONSHIPS AND UNDERSTANDING ACROSS PRIMARY AND SECONDARY CARE ​** | Strengthen interface connections with **Education Events** in Primary Care |  Q3 |
| **Clinical Lead Evenings -** Refresh for more FHFT engagement (ideas shared) B |  Q3 |
| Review other ideas and take forward as required e.g. **‘Meet the Team’/ ‘Working Well with our Partners’** workshop, Shadowing/Twinning, Increase F2F meetings e.g. CIC  |  Q3 |
| **Focused relationship support, troubleshooting & understanding with specific specialties or practice teams (teams identified, first step meetings arranged)** |   Q3 |
| Review & **Strengthen management / governance structures** across ICS meetings (inc. CIC, ESG) & strengthen PCN connections and connections with **Provider Collaborative** etc. |   Q4 |