South East London Integrated Care System

NHS South East London

South east London Primary and Secondary Interface Consensus

Ensuring the best experience of care for our patients

May 2026

NHS Guy's and St Thomas' NHS Foundation Trust

NHS Lewisham and Greenwich NHS Trust

NHS King's College Hospital NHS Foundation Trust

NHS Oxleas NHS Foundation Trust

NHS South London and Maudsley NHS Foundation Trust

Introduction

In south east London, we are committed to ensuring the best possible patient experience of care. The interface between primary and secondary is one of the key channels through which patients and their care flow. It needs to be patient focussed whilst ensuring that there is efficient use of resources.

However, frustrations are common, with all stakeholders having to contend with multiple touch points, at times inadequate communication, failure to make use of all the expertise in the system at the right time and poor use of patients' and clinicians' time. These challenges can lead to poor experience for all stakeholders, particularly patients, and inefficient use of resources which can result in poor patient experience, fragmentation of care, and potentially worse outcomes.

This consensus document presents a set of principles which have been co-designed with stakeholders across our system. They are intended to represent a clear and concise set of principles which will help us work more effectively together in the best interests of our patients. We do not pretend that they are comprehensive, nor are they intended to be over prescriptive. What they do represent is broad agreement as to what good interface working looks like and, where there is uncertainty, something that we can all refer to which provides guidance as to agreed best practice.

It is important that these principles represent the needs of patients. Whilst patient representatives were involved in their co-design, we will continue to work with patients and their carers to ensure they reflect their feedback. Although our initial focus was on the relationship between GP services and acute provider services, we have also consulted mental health and community services. We believe that these principles are broadly applicable elsewhere and we will continue to iterate on them as we work with colleagues across south east London. To this end, we will periodically update the document and our website.

I would like to thank everyone who was involved in their development, and we are always grateful for further ideas and feedback.

Toby Garrood
Medical Director
NHS South East London

South East London Primary and Secondary Care Interface Consensus

General Principles

1. Keep the patient at the centre of all we do. All interactions with patients should add value.

2. Treat all colleagues with respect.

3. Clinicians should seek to undertake any required clinically appropriate actions themselves, within the limits of their professional competency.

4. Ensure patients are kept fully informed of their care and next steps in their pathway. Patients should know who is responsible for the next stage of their care, when their next appointment is, and who to contact in the event of delays.

5. Where possible, speak to colleagues directly if in doubt. A clinical conversation / communication could enable a real-time solution for patients which may avoid onward referral.

6. Take appropriate responsibility for tests or actions that may need to be done in the future.

7. There should be a shared health promotion agenda across the primary and secondary care interface.

Specific domains

1. Onward referral

1.1. Consultants or senior clinical decision-makers will arrange onward referral without referring back to the GP, where appropriate. This may apply to ongoing management of the same condition, an unresolved diagnostic pathway, or a need for urgent advice (such as cancer).

2. Communication (Discharge summaries, clinic letters and fit notes)

2.1. All clinical and patient communications will comply with agreed standards and service-specific guidelines (for example mental health service discharge summary guidance).

2.2. All services will issue fit notes when needed, covering the period of any episode of care. Extensions will be issued by the patient's own GP team.

2.3. For patients who self-discharge or leave a clinical pathway against advice, secondary care will produce clinical communication to conclude that episode of care.

2.4. If a patient does not attend an outpatient appointment, the clinician will attempt to reach them by telephone before recording as DNA.

2.5. All services will ensure clear and timely communication to the GP following each relevant patient contact, using the most appropriate method (such as updating the patient record or sending a formal letter where required.)

2.6. All services should send discharge summaries at point of discharge, with a maximum timeframe of 24 hours,

2.7. All services should send outpatient clinic letters within 10 days of the episode of care.

2.8. Additional consideration and acknowledgement may be required for fluctuating engagement, complex needs (for example mental capacity) and multi-agency involvement (for example, a non-attendance or self-discharge may trigger a multi-agency risk review).

3. Call and recall (arranging follow-up tests and appointments)

3.1. Clinicians who organise tests are clinically accountable for acting on the results and for communication of results and next steps to patients. Local variation in practice may require a coordinated approach across care settings but the steps and reasons for them should be made clear in correspondence. coordination with the GP).

3.2. Where patients are under shared care, any existing guidance should be followed with regards to surveillance such as blood monitoring. Where there is lack of clarity, guidelines should be developed or adapted.

3.3. In the case of home visits for monitoring, community teams need explicit agreements regarding responsibility for recall, when GPs must take over and when escalation to acute care is necessary.

4. Points of contact (in both directions)

4.1 All services will provide a simple, clear and equitable point of contact for queries from patients and carers, hospitals, primary care and other services.

5. Principles of referral (including rejection and advice and guidance)

5.1. GPs will make the intended outcomes clear, including patient expectations, when referring patients to any other service.

5.2. Primary care assessments should be completed when referring to any other service.

5.3. Patients must have consented to, and be clear on, the reasons for referral.

5.4. When patients are referred for surgical intervention, GPs will continue to optimise long-term conditions management.

5.5. Up to date, simple and easy to navigate directories of services and management guidelines will be available across the system.

5.6. Referrals from community care may come from non-medical staff; in these cases the referral should go via the GP for review and onward referral.

5.7. Before making a referral from primary care, GPs will consider whether existing clinical guidelines, written advice and guidance, or a telephone call could avoid a referral.

5.8. Secondary care will always provide clear guidance on their reasons for declining a referral and advise on an alternative clinical pathway.

6. Supporting patient expectations whilst waiting

6.1. For patients referred to any service, an approach of ‘Waiting Well’ will be taken.

6.2. On receipt of a referral, all services will send the patient an appointment as quickly as possible, agreeing a time or letting the patient know about the waiting time.

6.3. Whilst waiting for a first appointment, it will be clear to patients who they should contact for general information and in the case of any deterioration.

6.4. Provider services will have publicly accessible data regarding waiting times.

6.5. Patients will be offered a simple way to make changes to appointments taking into account reasonable adjustments and without delaying access to care.

6.6. Further sources of useful information should also be made available, for example voluntary, community and social enterprise sector resources.

7. Prescribing and discharge medicines

7.1. The clinician who wishes to prescribe a new medication for the patient, will undertake appropriate pre-treatment assessment and counselling with the patient and outline the need for ongoing prescription and review to the GP.

7.2. Medications that are required immediately will be prescribed during that clinical consultation.

7.3. New medications prescribed during a clinic consultation, or discharge medications after hospital admission, will cover an initial period of at least 14 days, or longer as locally agreed.

7.4. Primary care, secondary care and mental health teams will use the SEL Interface prescribing policy, SEL formulary, and Discharge Medicines Service to support efficient prescribing of medications.

7.5. When recommending ongoing prescribing from the GP, secondary care and mental health services will first check locally agreed prescribing formulary and reference relevant shared care agreements.

Considerations for Mental Health Services

7.6. Mental Health services must retain prescribing responsibility for medications they have initiated, especially for patients at risk of disengagement due to fluctuating mental state. If it is clinically appropriate for the GP to take over prescribing this must be explicitly agreed with the GP and clearly communicated with the GP and patient.