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Professional behaviours and communication across the

Primary & Secondary Care Interface

interface.amrcw.org.uk

A report from the AMRCW Interface working Group led by Dr Jane Fenton-May FRCGP

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Executive Summary & Recommendations

Many patients cross the primary/ secondary care interface in the course of the management of both acute and chronic conditions. Good communication between clinicians and between clinicians and patients is an essential prerequisite for safe and effective care.

Led through a working group and exploring a narrative of members in primary and secondary care, this report has identified some areas where doctors themselves can make a difference to ease the problem in terms of ensuring appropriate attitudes and behaviours regarding sharing or transferring appropriate information and activity round patient care. It recognises there are significant system and process changes needed to improve efficiency. These are by no means insurmountable but they will need a willingness to recognise that collaboration and good patient care requires cooperation, mutual respect and a need to give and take. Improved IT will undoubtedly help but work patterns may also need to change.

Issues include inadequate information in referral communication, inflexible care pathways designed without input from all relevant stakeholders, delays in patients receiving appointments and long waiting lists. Responsibility for ordering and responding to investigations or providing prescriptions and drug monitoring is not consistently agreed. Letters from secondary care after inpatient or outpatient care are sometimes delayed and incomplete. Patients requiring certificates for insurance or work purposes are unsure who will provide these.

Many clinicians are feeling workload pressures and the need to off load or avoid activity, whilst understandable, may create excess pressures elsewhere in the system. There may be a failure to consider the implications on colleagues across the interface. This harms professional morale and effectiveness of individual and team working.

This paper identifies the issues causing concern and considers to how the behaviour of doctors may contribute to the problem and subsequently sets principles to improve communication and maintain good relationships.

It recognises that many issues are related to system barriers, and the AMRCW recognise that process and system enablers are absolutely essential for some of the key attitudes and behaviours to be put into practice.

Whilst identifying several system barriers throughout consultation, the AMRCW aims to further explore these areas in future work, identifying how they can be overcome and set recommendations.

*Timescales of proposed future work will be updated - www.interface.amrcw.org.uk

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3. Give clear guidance to the patient as to what is the problem, what has been done so far and what it is intended to do. The patient should have an appreciation of what they themselves need to do. Do not commit other teams to any particular action or timescale without checking that is reasonable and practicable.

4. Try not to hand over work to a colleague in another team if you or a member of your team can do it unless you are sure that the task can be done more effectively or efficiently elsewhere. When handing over care, check that all tests and treatment plans have been instigated and plans are in place to forward additional information when available.

5. The individual who orders a test is responsible for reviewing the result and taking appropriate action. If not able to review the result the individual should check another person will take on this responsibility in their team.

6. If one colleague is unsure whether another can take responsibility (eg for ongoing care, prescribing or monitoring), get in touch directly by email or phone.

7. If contacted by a professional colleague, make every effort to respond to them as quickly as possible or pass them onto another individual who can do so.

8. If a doctor makes or is aware of changes in treatment or there is a change in the status of the patient whilst under the continuing care of another colleague , it is important to update all who need to know.

Introduction

Many patients cross the primary/ secondary care interface in the course of the management of both acute and chronic conditions. Good communication between clinicians and between clinicians and patients is an essential prerequisite for good care.

General practitioners are the first port of call for many patients seeking healthcare. Those seeking care may present undifferentiated problems without stigmatisation. GPs provide continuity of holistic care and support patients to manage long term conditions. They may act as patient advocates and signpost them or refer them to other care providers. Patients return to their GP to have their ongoing management after contact with other providers and often seek clarification, explanation and advice regarding the implications of the interaction with specialists.

Secondary care doctors are consultants, staff grade and doctors in training. They may work in hospitals or other settings. They may work as generalists or specialists. These doctors see patients who have been referred by GPs or other colleagues or who have been admitted via the urgent care services. This may involve relatively short term care for a specific condition which may resolve or be ongoing. It may involve support and care for long term conditions with multiple interactions over several years. Secondary care doctors may initiate treatments and handle all specialist decisions or may share care with a GP.

Good information must pass between primary and secondary care (and indeed within primary and secondary care) so all health care providers are fully aware of what is being done for or with the patient. Anecdotal evidence over many years suggests this often does not happen and one or more care givers are frustrated by the lack of current information as to what has been done by other care givers. There is also inconsistency in the perceived responsibility for undertaking review and follow up. Such lack of information or inconsistencies in management pose a risk to the safety of patients who may not receive appropriate treatment or who may receive incorrect treatment. Some of these failures or frustrations in communication across the interface appear to derive from a failure of one party to appreciate the working arrangements , experience or skill of the other party or just a lack of consideration for others.

This paper identifies the issues causing concern and considers to how the behaviour of doctors may contribute to the problem. It recognises that many are related to system issues and these will be looked at by a subsequent working group.

Sections

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Issues

Prescribing Responsibility

Secondary care may not check that the patient is aware that urgent hospital-only medication is collected from hospital pharmacy rather than requested from the GP.

Hospital sometimes requests the patient collects their prescription from general practice but doesn't explain that it won't necessarily be provided straight away. The patient is frustrated by the delay and the GP may be irritated by the disruption.

Specialists sometimes ask GPs to prescribe specialised items outwith the LHB formulary or their expected competency. This often occurs following private consultations.

Patients may deliver notes from clinics asking GPs to alter medication without explicit reasons for change.

GPs may be requested to prescribe medication such as skin cleaners prior to private surgical procedures in private facilities.

There have been requests to prescribe parenteral iron for anemia identified preoperatively as it is less easy to provide that quickly in the hospital setting.

There may be a lack of clarity about prescribing responsibility for patients in the community under the care of the palliative care team.

There is difficulty accessing urgent medication out of hours in the community particularly with respect to palliative care in some areas. It might be easier to obtain some supplies from the hospital pharmacy.

Service Planning

There is little or no secondary care input to Primary Care Clusters.

There is little or no GP input into care pathway design.

Information Technology

There is variation in access to medical records between sectors. This may mean urgent decisions have to be made without reference to important patient data.

Lack of standardisation of NHS systems means different parts cannot share information electronically.

There are concerns re confidentiality when information is shared. On the other hand security rules may prevent people involved in the care of patients not being able to get information quickly enough. There is a risk of emails containing confidential information going astray across the interface.

Completion of certificates and forms

Some doctors do not supply patients with appropriate certificates or forms. This may particularly apply to “Fit notes” for both inpatients and outpatients and leads to inconvenience for patients and extra work for GP staff.

Continuing care

Single condition pathways are often not appropriate for patients with more than one condition.

Super specialists may not understand the implications of their recommendations on other conditions.

Internal referrals or between specialists save time and avoid the need for patient to return to GP.

Internal referrals without reference to the GP may cause duplication of effort.

Patients are requested to follow up with GP before that has been agreed between specialist and GP. There may be failure to provide advice to GP or to indicate under what circumstances the patient should be referred back. Patient is left unsure who they should be contacting.

Some shared service pathways are developed without GP input or without agreed resource for primary care.

Lack of timely communication between health professionals when the patient's condition is changing (eg during cancer treatment) can lead to uncertainties as to what the current treatment should be.

Patients are sometimes discharged home at short notice who have significant continuing care needs. It can lead to disruption to a general practice in ensuring a care package is in place.

There may be a lack of clarity as to who is responsible for ensuring advance care plans are in place for palliative care in the community.

It may be unclear who is responsible to whom for death notification. This may cause distress for carers and staff if inappropriate messages or contacts are made.

Referrals

There is sometimes insufficient background data about the patient from GP to enable secondary care to determine priority.

GP letters are sometimes poorly structured or difficult to read.

Test results may not be included in the referral information which leads to risk of unnecessary duplication.

Failure to include details of treatment past or current may lead to inappropriate treatment recommendations.

Failure of GPs to notify specialists of changes in treatment, possible side effects identified or new investigation results may lead to inappropriate interventions.

Some single condition clinical pathways mandate investigations required by primary care prior to patient acceptance for a secondary care opinion and this may delay referral.

Receiving clinicians may expect that a GP has seen the patient immediately before making an urgent referral even when there has been a recent encounter by another competent health professional or a suitable remote consultation.

There is lack of time put aside in consultant job plans to handle e- referrals. Non face to face interactions with patients are not counted in clinical activity. There is sometimes a lack of audit trail for e-referral triaging and recording information in hospital notes.

Appointment procedures, Waiting list, delays in follow up

Long waiting lists cause patient anxiety and lead to more GP appointments. Time can be wasted trying to determine waiting times. There is pressure on GPs from patients to expedite appointments.

Some referrals are downgraded from urgent without explanation to GP or patient.

Delays occur in cross border referrals (between different health boards or into England whilst it is determined who is financially responsible or whether there is an agreement in place.

Patients are being referred back to the GP as not meeting the criteria for a particular clinic.

Follow up appointments may be postponed leading to further appointments with general practitioner or delayed review of treatment plan.

Patients on hospital only medication have difficulty getting their medication if follow up delayed.

Patient appointments are classified as DNA (did not attend) when they phone up and cancel appointments for legitimate reasons. Patients sometimes have difficulty getting through to appointment clerks so are unable to seek a postponement or subsequently explain a DNA. This may necessitate the GP making a new referral.

Partial booking appointments have confusing letters for those who have reading, visual impairment or language difficulty.

Access to urgent opinions

GPs have difficulty getting hold of specialists for urgent advice which may avoid an admission.

Hospital practitioners have difficulty getting hold of GPs to discuss patients.

Urgent phone calls for advice may go to junior members of staff who are less competent to deal with the problem.

Phone calls are not always added to the patient record.

Urgent admissions routed via A&E may delay a specialist opinion.

Emergencies may be seen quicker if sent direct to A&E.

Ordering and reviewing investigations

Hospital doctors may request a GP to perform investigations which could have been done when the patient attended clinic. This may be to avoid time spent ordering tests, for patient convenience or to avoid costs to the patient when attending a private clinic.

GPs may decline to do investigations at request of hospital doctor. It may be far more convenient to the patient to attend their local practice but is extra demand on the practice.The secondary care doctor may not know that the GP doesn't have direct access to some investigations.

GPs are often asked by patients to find investigation results carried out in secondary care and interpret them and/ or respond to them. At the time they may not have all the relevant details as to why the test was ordered or it may be outwith their expertise.

Results are sent to the GP for action with no additional information as to why they were undertaken or what action should be considered or even whether the patient is aware that the result is available.

GPs are being requested to undertake routine or specific pre - operative investigations and investigations prior to infertility treatment or other surgery.

Discharge and outpatient letters

Delays in sending information to GPs (and poorly written or incomplete discharge information) mean patients may not get correct medication or appropriate monitoring by primary care. Time may be spent by GP staff seeking clarification. Tests may be repeated unnecessarily.

Letters get sent to the wrong doctor (ie not the actual referring doctor). Letters may get sent to the usual doctor rather than a temporary doctor when not discharged to their usual residence.

Letters are not always copied to patients appropriately.

Failure to send letters to other relevant providers or agencies involved in the patient's care means they may need to contact the general practice or hospital clinic.

Diagnostic or intervention coding may not be clear. This may cause delays in updating the GP record. Sometimes secondary and primary care use different coding schemes.

Use of abbreviations or acronyms (particularly the same acronym used for different conditions in different specialties) may need clarification causing delays in actioning recommendations in letters.

Professional Attitudes and Behaviours influencing the interface

Silo working and work pressure

Many GPs and specialists rarely meet colleagues outside their immediate team due to pressure of work. They concentrate on maintaining their own knowledge and expertise. This may lead to failing to appreciate how work and constraints exist for different groups of doctors, both in different specialties and grades. There is little joint training or CPD as much is now done online. Doctors may have little understanding of what other disciplines or specialists can or cannot do.

Workload shift

High workload and financial pressures may lead to less time to spend with individual patients and in planning care. Some doctors will be pushed to meet service or performance targets rather than delivering patient centred care. It may seem easier to shift the work to other practitioners.

Low morale

Some doctors have a perception that managers or others do not value professionals and their skills. Fragmentation of care and not feeling part of a recognised clinical team can lead to a feeling of constantly struggling to work collaboratively. Doctors are often reluctant to ask for help, particularly for emotional support. All these factors can lead to low morale and demotivation. Such feelings can impair efficient working and a loss of consideration for colleagues.

Communication skills

Not all training programmes provide adequate training in effective communication (both verbal and written). Learning to share information with colleagues as well as patients should be a core skill. Many doctors do not give clear guidance to patients about what they should expect or what further action is needed so that patients need to make further contact with other practitioners for explanations. The importance of transferring appropriate and correct information across the interface in a timely manner is not always appreciated

Disrespect

Doctors may make or imply derogatory comments about another doctor or group of doctors to either colleagues or patients. This may arise from ignorance, insecurity or arrogance. This can create uncertainty or lack of confidence amongst patients and other healthcare professionals, undermine the work of others and increase pressure on colleagues.

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Conclusion

The above lists are not exhaustive nor exclusive. There will be overlap in these problems and recommendations which will vary between different disciplines and organisations. There were differences of view between contributors to the workgroup, particularly with regard to attribution of causation between primary and secondary care. All agreed there were significant problems of communication across the primary/ secondary care interface which needed to be addressed and there was a frustration expressed that these problems had been discussed for many years with no sustainable solution in sight. Many good suggestions have been offered over the years but often by “one side or the other”. Shared mutually acceptable solutions are needed.

There was an overarching concern that doctors felt more undervalued by the health service than in the past. Doctors work in relative isolation from colleagues whose roles they felt were unclear. Generally it was felt that current working practices did not allow enough time to communicate across the interface or to get to know colleagues from other disciplines.

This report has identified some areas where doctors themselves can make a difference to ease the problem in terms of ensuring appropriate attitudes and behaviours regarding sharing or transferring appropriate information and activity round patient care. Accordingly, the principles developed throughout consultation identify a synergy with work undertaken by the GMC & Academy of Medical Royal Colleges into professional values and behaviours as outlined in the GMC Generic Professional Capabilities Framework.

The report recognises there are significant system and process changes needed to improve efficiency. These are by no means insurmountable but they will need a willingness to recognise that collaboration and good patient care requires cooperation, mutual respect and a need to give and take. Improved IT will undoubtedly help but work patterns may also need to change. Above all , clinicians and managers need to recognise the potential risks of harm posed by not addressing this important area of healthcare.

The AMRCW is keen to further explore issues across the primary & secondary care Interface with stakeholders and believes the drawing together of principles of improved communication and behaviour set against identified barriers experienced across the interface to be a solid foundation in which to start.

Organisations contributing to discussions

Academy of Medical Royal Colleges in Wales

British Medical Association Wales

Bro Taf Local Medical Committee

Royal College of General Practitioners, Welsh Council and Faculties

Royal College of Anaesthetists

Royal College of Obstetricians & Gynaecologists

Royal College of Physicians Wales

Royal College of Psychiatrists Wales

Local Medical Committees in Wales

Local Negotiating Committees in Wales

Wales Deanery

Gwent LMC

GPC Wales

This report is produced by the Academy of Medical Royal College Wales in consultation with its members, individual doctors as well as doctors within core organisations and Royal Colleges from across Wales. and may not fully represent the views of all contributing organisations.

The Academy of Medical Royal Colleges Wales brings together the voices of its member colleges and Faculties for overarching generic issues around healthcare.

The Academy comprises of representatives of the Medical Royal Colleges and Faculties who meet regularly to agree direction; providing a collective, independent medical voice to promote College and Faculty standards through influence, collaboration and advice in Wales.

Royal College of Surgeons Edinburgh	Royal College of Radiologists	Royal College of Pathologists
Royal College of Anaesthetists	Royal College of Obstetricians & Gynaecologists	Royal College of Ophthalmologists
Royal College of General Practitioners	Royal College of Surgeons England	Wales Deanery
Faculty of Occupational Medicine	Faculty of Public Health	Faculty of Dental Surgery

Academy of Medical Royal Colleges Wales

c/o Academy of Medical Royal Colleges,

10 Dallington Street,

London EC1V 0DB

United Kingdom

Telephone: 07759169268

Website: amrcw.org.uk