The Wessex Model for workplace exchanges

Learning and next steps from the Consultant GP exchange, Southampton 2018

NHS England and NHS Improvement

Contents

Executive Summary

It has been evident that the barriers building up between primary and secondary care lead to frustrations and, more importantly, a possible impact on patient care and safety. Knowing that relationships drive improved patient outcomes, Southampton City CCG facilitated a GP Consultant liaison. We set out to reduce the barriers, whether relational, reputational, historical or infrastructural. Our ambition was to foster deeper partnerships between our clinicians, an appreciation of the challenges we all face, and to ignite opportunities for innovation and quality improvement.

Dr Pritti Aggarwal, GP Board Member,
NHS Southampton City CCG

We have already begun to see changes, some of which cannot be quantified due to their behavioural and attitudinal nature. The strategic paring has changed working relationships that will affect patient care. Whether this be due to the friendly GP/Consultant they spent time with or by learning about different perspectives of managing conditions, or ideas on making life easier for one another with discharge letters headed 'Information Only' 'GP Action Required". Together, we are making a difference and it has been an absolute pleasure in leading and participating in this project myself. I am enthused to see what more we can all do for our patients, together.

Forward

Dr Mark Kelsey, Clinical Chair
NHS Southampton City CCG

The consultant GP liaison scheme has provided a fantastic opportunity for us to break down the barriers that often exist between primary and secondary care.

I had the opportunity to take part in two exchanges and both really opened my eyes to how our hospital colleagues work and I believe the consultants involved agreed.

Perhaps the most surprising thing was how many of the same issues we are both dealing with. It was clear to me that knowing and understanding the specialists that I refer to has tremendous benefits for the patients we serve and, ultimately, can improve the care they receive.

What is this all about?

1. 59 self volunteered secondary care doctors from UHS were strategically paired with their primary care counterparts

2. Each pair were asked to spend half a day in each others environments from Sep-Dec, to appreciate the challenges they both faced

3. Reflection templates were voluntarily returned, and the information categorised into themes

4. A celebration of the learning and next steps took place in early January 2018 focussing on compassionate leadership

Artwork inspired by the discussions at the celebration event and made by Diana Dagadita

Reflections and next steps Theme: ***time***

What did you expect to see that you didn't see?
(Or see that you weren't expecting?)

- "I was surprised to learn that patient can discuss one issue at an appointment."
- "I was impressed by the time management as a 10 minute appointment is clearly not a one size fits all."
- "I did not expect the clinic to be running on time considering the complexity and variability of the presentations."
- "I expected to see that the consultations take much longer and that there is a massive back log of patients waiting to be seen."
- "I was impressed by the time management as a 10 minute appointment is clearly not a one size fits all."
- "I did not expect the clinic to be running on time considering the complexity and variability of the presentations."
- "I expected to see that the consultations take much longer and that there is a massive back log of patients waiting to be seen."

What will you take back to your own work place or clinical practice as a result of this experience?

- "As a GP I realise I have the advantage of knowing my patients well. This allows me to hold shorter consultation times compared to secondary care doctors."
- "I wish we had more TIME in general practice to be able to do this too - it would be so much more satisfying for patients and for myself "

Did anything surprise/shock you during your visit?

- "Had to quickly move onto the plan during the consultation – only 10 min appointments. Intense working." (referring to Primary Care)
- "The patients I see in clinic often complain that they can't see their GP in a timely fashion; they spend ages on the phone trying to get through and often in the end see a GP who doesn't know them or about their condition. My morning with the on-call GP confirmed this."
- "My visit confirmed that there was no time constraint to the level of what one would see in general practice nor the variety. A consultant could literally spend up to an hour with a patient."

Challenges witnessed

- Flexibility – in primary care see you in days, secondary care see you in months
- Access to GPs- majority part-time
- Time required to manage expectations

Appreciation of Primary Care

- How much is condensed into 10 minute
- consultation
- Competency of GP to do everything in 10
- minutes

Next Steps:

- Encourage the increase utilisation of e-Consult in primary care.

Reflections and next steps Theme: ***MDT working***

What did you expect to see that you didn't see? (Or see that you weren't expecting?)

- "Whilst attending a cancer MDT I witnessed how secondary care consultants despite being specialists have to manage a lot of uncertainty in the diagnosis and management of some of their more complex patients"
- "How much extra the team do to keep up with demand"
- "The amazing camaraderie in a very difficult working environment that provides support for the staff"
- back log of patients waiting to be seen."

What will you take back to your own work place or clinical practice as a result of this experience?

- " I wish we had more TIME in general practice to be able to do this too - it would be so much more satisfying for patients and for myself "
- "Although team work was apparently taking place via a group messenger application on the doctor's desktop, I felt they mostly practiced in isolation during the bulk of their working day. However, I still came away with a sense that the group have a strong vision and they work

Did anything surprise/shock you during your visit?

- "Team working in the practice really was apparent and they appeared very close knit."
- "The luxury state of having an MDT"
- "How much team work there is in secondary care"
- "Surprised that radiotherapy planning for individual patients takes 5 days involving a team of very clever physicists/consultant etc. and really wowed by the 3D technology demonstrating the cancers"
- "Really supportive team from the nurses, but very little juniors around!"

Next Steps:

- Discussions are being had on looking at outreach clinics
- Exploration of virtual clinics to support clinicians

Reflections and next steps Theme: ***complexity***

What did you expect to see that you didn't see?
(Or see that you weren't expecting?)

- "In the main we saw some very complicated diabetic patients, across the hospital. Clearly ward based clinicians have been well trained to manage diabetes without specialist intervention"
- "Whilst attending a cancer MDT I witnessed how secondary care consultants despite being specialists have to manage a lot of uncertainty in the diagnosis and management of some of their more complex patients. This is something we as GP's have to do all the time, but I had never considered that secondary care have to do the same"
- "Less mental health problems and complex co-morbidities than I thought I'd see"
- "I was surprised that the cases I saw weren't more complex it has made me re-evaluate my own practice as I think I manage a more complex caseload than some other colleagues in General Practice"

Did anything surprise/shock you during your visit?

- "GPs are prescribers and highly trained clinicians with extraordinary communication skills."
- "It was interesting to see the case mix that the neurologist saw, and how much of it was not specific to neurology but more general – e.g. chronic fatigue/anxiety etc."
- "The efficiency of GP to navigate through complex case and medications in short time."
- "Given the nature of the role, the caseload was varied and largely unpredictable. There was a lot more mental health and illicit drug related issues than I tend to encounter with inpatient work, which can be challenging."
- "I joined a geriatrics consultant and saw the ongoing pressures on community care from the other side. I perhaps was a little surprised at the level of involvement the geris team still have after discharge that I wasn't previously aware of."
- "I was not surprised but impressed by the competence in dealing with a very wide range of patient types (from a tiny baby to an elderly gentleman). The patients were probably slightly more complex as a whole than might have been expected and several needed further input after the consultation (referral or telephone calls for advice)."
- "That some GP's really go the extra mile with their patients (setting up a support group for women suffering from domestic violence)"

Theme: ***complexity cont.***

What will you take back to your own work place or clinical practice as a result of this experience?

- “GPs need to sell themselves as specialist generalists more!”
- “Listening style – I tend to write whilst listening. It was good to see another clinician’s communication style. My GP was an active listener. We often don’t know the answer to a problem – be confident in your uncertainty”
- “I already had a great respect for my GP colleagues which has been strengthened. I think their job is really difficult “
- “Respect – when GPs call in they are calling on their clinical experience and are more often right than wrong about a diagnosis.“
- “Consider sending every SpR out to primary care for a week before they become a consultant – would be really good for them especially if they have not done primary care”

Reflections and next steps Theme: *IT*

What did you expect to see that you didn't see?
(Or see that you weren't expecting?)

- "Completely paperless system"
- "Paperless/light transition from primary to secondary care – even e-referrals were being printed off to be graded!"
- "I was impressed by the electronic white board, but was hoping to see electronic notes"

Did anything surprise/shock you during your visit?

- "We decided to use e-mail queries more to quickly address clinical issues without necessity for appointments"
- "As the MOP consultants take patients from a certain cluster, we have a named acute secondary care based consultant who we can contact if felt useful. We would need GPs to be alerted of admissions to allow this. Can we set this process up?"
- "Can Hospital and GP system be linked together with further linking with community system- big task but would allow for information to be easily available"

What will you take back to your own work place or clinical practice as a result of this experience?

- "I felt that the computer system was not as easy to navigate, as the systems we have in place in primary care
- "All done (except documentation) with the patient in the room – and it did not feel awkward. The IT system did not look very user friendly at all to me but was felt by the GP to be well designed and was certainly navigated extremely quickly"
- "3-D technology in making customised hips"
- "Seeing how paperwork and IT is Managed GP appears high Technology"

Next Steps:

- The reflections have been passed onto the IT Leads to look at and consider what can be done

Reflections and next steps Theme: ***prescribing***

Did anything surprise/shock you during your visit?

- "I was surprised that the consultant only had a hospital script pad and not able to do NHS script for normal chemist. This meant that patients seen after the pharmacy had closed, or if medication not in stock, the patient would need to travel back to hospital to pick up script and some patients lived far away."
- "Pressures to prescribe"
- "Prescriptions form outpatient appointments in hospitals – incl. workload in primary care

What will you take back to your own work place or clinical practice as a result of this experience?

- "Focus on practicalities revolving around responsibility for prescribing"
- "Include any antibiotics given that worked well, preferably as a summary at the end rather than in the main body of text."
- "Specify what medication you want the patient to have and at what dose."
- "Hospital clinics can adopt template system allowing for letters to be completed and send to GP immediately with important info like drugs filled in with a mandate for drugs (dose, frequency and future plans)-currently variable time frames from hospital to send important information to GP"
- "Changes in antibiotic use: guidelines for hospital infections changing regularly. It would be helpful to know on discharge summaries what antibiotics someone has responded to in case they have a similar infection again and we want to try and avoid a hospital admission in the future. This may need advice from microbiology but would help inform advanced care planning"

Next Steps:

- Prescribing Lead has been approached to look at
- OPD consultant prescribing.
- Southampton City CCG in conversation with UHS regarding discharge summaries.
- Southampton City CCG looking with all providers at OPD letters can be made clearer.

Reflections and next steps Theme: ***training, appraisals & education***

What did you expect to see that you didn't see?
(Or see that you weren't expecting?)

- "I expected GPs to write high-quality referrals in general e.g. PSA level in two week wait urology cancer referrals) however I noted that some were less than comprehensive and the results were not readily available as they had been performed in another laboratory. This meant the patient was subject to further investigations and follow-up by secondary care (more cost/ time) as they did not have the reassurance of previous tests to base their assessment"
- "I witnessed several examples of the everyday frustrations and barriers secondary care clinicians encounter due to poor interfaces between primary and secondary care. I hadn't expected to see as much of this."
- "The latter – it was interesting how keen he was to see the UHS cardiology services from a GP's perspective. It seems a shame that the current commissioning structure doesn't seem to allow this sort of informal, friendly discussion to shape services more."

Did anything surprise/shock you during your visit?

- "Sheer lack of juniors in clinic"
- "I saw a lot of health promotion happening in outpatient clinic and I didn't expect this "
- "I was shocked by the lack of responsibility the patients take for their own health. Obesity, not aware of contraception. The GP does a lot of teaching basic stuff that I forgot was needed."
- "I was really impressed by the efforts the consultant had gone to develop training materials for doctors and patients. Quite inspirational."
- "I also didn't realise how the GP partners were involved in shaping primary care in their area"
- "The amount of risk that has to be managed in General Practice."

Theme: ***training, appraisals & education cont.***

What will you take back to your own work place or clinical practice as a result of this experience?

- “Would be great to go back and re-do clinical attachments again, there is so much to learn. The BMJ last week had an article about how GP was not a sought-after profession by hospital staff - it is a real shame, as I feel that all junior doctors should do some primary care and get a feel of what we can and do manage. There is a huge amount that gets filtered out and never referred in.”
- “Appreciate how hard our consultant colleagues work. I also realised that they don’t have the luxury of having the patients whole medical record or drug history in front of them, hence the importance of giving as much details, in the referral letters we send. I can appreciate why they send the proformas for us to prescribe medications that they recommend.”
- “That I’m a good GP this has been a very positive experience however the consultants are self-selecting and largely know how hard GP work is I hosted two consultants both absolutely lovely and flying the flag for general practice I’d love to see this being compulsory as there are a number of consultants at the trust who feel differently about GP’s and would really benefit and learn from this experience thanks for arranging it I’ve thoroughly enjoyed the experience.”
- “For me one of the key challenges is improving the flow of information between primary and secondary care. This can improve both patient care.”
- ““I will understand referrals from GP better because I have refreshed my experience of how a GP practice is run.”
- “We had a helpful conversation about writing useful care plans for avoiding hospital admissions. I think we need time to plan these properly with patients and family and sharing what we have discussed either in primary care or secondary care is really important”
- “A better sense of how I can support general practitioners with their queries and managing liver patients in the community. I learnt some secondary care consultation letters were more helpful than other. As an example, we perform a test (Fibroscan) which provides a value on how stiff the liver is, when interpreted it allows a diagnosis of liver fibrosis to be made. We have improved our written communication to the GPs to provide an interpretation rather than just the raw value.”

Theme: ***training, appraisals & education cont.***

Good things about the exchange

- Learning
- Career options and revalidation
- Break down stereotypical longstanding views of each other
- Share understanding of the fact we are sharing the same patients

Next Steps:

These reflections have been passed onto Wessex Deanery to consider if there can be anyway of incorporating into current training.

- Wessex Faculty RCGP have been approached to see if they can provide a platform for dissemination of this program of work in primary care.
- TARGET planning will explore how more networking opportunities can be built into the system.
- NHSEI approached to see how this can be implemented at a national level.
- Explore setting up similar to ‘Schwartz rounds’ action set style learning between GPs and consultants

Reflections and next steps Theme: ***actions implemented***

What did you expect to see that you didn't see?
(Or see that you weren't expecting?)

- "GPs will not be reading letters addressed to them and are increasingly going to be read by admin and medicines management team who will implement medicines change."
- "The lack of a meeting space for ward handover meeting-not even enough chairs for all and they were sat in a corridor not a room. This lack of private space also meant that patients were openly being discussed in front of other patients and relatives. I know that is how it is in hospital but the contrast with GP seemed more stark somehow in terms of confidentiality of patient information."
- "Getting patients to come back for an appointment to discuss blood test results (when the results would almost always be normal as assessed during the appointment). Personally I would've thought either a phone call to discuss results or even a well constructed letter to the GP giving them advice on how to deal with the result that the hospital would review and send directly to the GP would have made the system more efficient and financially more affordable (as I suspect secondary care appointment cost a lot more than seeing a GP, as well as inconvenient to the patient)."
- "Eagerness to provide relevant info to secondary care providers – and was interesting how we discussed the role of independent providers for commissioned services (e.g. echo) and how that leads to duplication of work despite clearly the advantages in terms of availability/waiting times etc."
- "Use of sign-postings in consultation: Surprised by how many consultation were signposted to steps to well being. Makes you wonder about support and information availability in community to avoid GP appointments. Also any role of telephonic consultation in this cohort? "
- "The paper trail of getting the patient into having an operation – number of stages from original referral = 26"
- "GPs will not get discharge summaries for 3 days at least therefore if a blood test needs to be done within a week you need to arrange it to be done yourself, for example do an e-quest and arrange the patient to have the test done in outpatients and copy the GP in."

Theme: ***actions implemented cont.***

What will you take back to your own work place or clinical practice as a result of this experience?

- “How we can help secondary care by having a BMI documented in the last 6 months. Ensure that secretaries can talk to secretaries”
- “I think there is a place for having better communication between GPs and the Medicines for Older people team. If GPs were made aware of admissions for their elderly patients and we knew them well ,it may be helpful to have a conversation with the hospital team. This occurred on the ward round I attended, as a patient I knew well was in and myself and the consultant felt that if that prior knowledge had been shared, it may have helped form a clinical picture sooner and possibly reduce the need for certain investigations.”
- “See if the CCG could do some targeted education on referrals”
- “When seeing patients who are dying, they are fast-tracked to a nursing home where appropriate. Is there scope to consider fast-tracking to allow patients to go home to die? GPs are able to do this in the community for our own patients we are not sending in to hospital and if we were asked to do this on a regular basis suddenly by the hospital this could potentially be difficult to organise quickly (we would need to get the district nurses and palliative care support workers in place as well as any equipment and make sure the family are there to support this). However, if we could have a process in place for this, perhaps we could allow people who wanted to go home to die more often. Can we use the fast track system and encourage liaison with GPs to link these systems so that if someone has days to live we can get someone home quickly in appropriate cases?”
- “If a patient goes to a new nursing home (and therefore will have a new GP) the home needs to be contacted and so does the new GP. The old GP will have no way of finding out who the new GP will be and will receive the discharge summary from hospital but not be able to forward it on making handing over of important points about patient’s impossible. This happens frequently and is a source of frustration for the receiving GP and the old GP.”
- “This will help inform how the CCG commissions neurology and in particular some of the frequent referrals that probably don’t need to go to neurology at all if there was another pathway, e.g. headaches.”
- “One frustration for both of us was the need for prescriptions from hospital clinics to have to be done via GP. This seems a waste of time for both patient and GP when hospital doctors could simply do a prescription”

Theme: ***actions implemented cont.***

Did anything surprise/shock you during your visit?

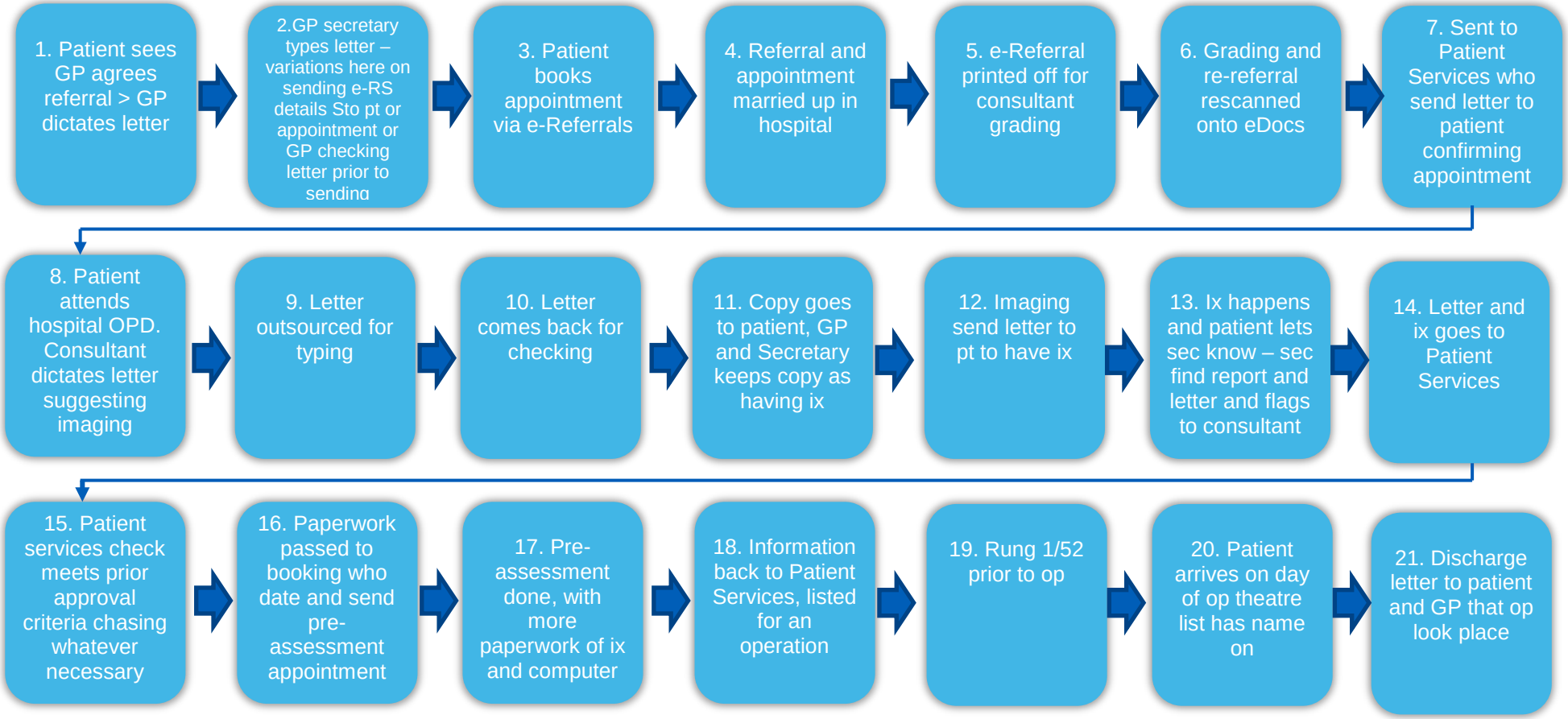
- “Unfortunately there was a lot of time spent searching for folders strewn across the ward.”
- “Hospital records still have the wrong GPs listed!”
- “Secretaries struggling to get through to practices to chase up information on patients”

Next Steps:

- TARGET team to look at holding sessions focused at education on referrals.
- Encouraging early contact with patient’s GP during the admission at the hospital.
- Look into the process for hospital patients who are dying to pass away in their homes instead of hospital.

Patient Pathway

This is an observation of the patient's pathway from seeing a GP to having an operation. Below is the contrast in the behind scenes of the paper pathway for the same patient's journey.



Case Studies

Case Study 1

- Dr G spent a morning in GP. Dr G observed how many templates were being used to code and structure the consultation.
- Dr G reflected on the experience and consequently has piloted a template structure for their OPD letters.
  Benefits:
  - ✓ **Time efficiency as each letter could take up to 30 mins dictating.**
  - ✓ **Training efficiency for juniors to know how to structure their own OPD letters.**

Case Study 2

- Dr A realised that their patients, whilst in secondary care, were unseen and unsupported psychologically by primary care, whilst going through probably the most traumatic experiences of their entire life.
- Dr A discussed their thoughts with Dr H
  Result:
  - ✓ **They are, currently, exploring options on how patients can be better sign posted to primary care psychological support whilst in secondary care.**
  - ✓ **Changes are being made in national guidelines specific to this liaison.**

Case Study 3

- Dr D observed in primary care the direct urgent lines that the community teams had to access General Practice in an urgent situation that didn't require 999
- Dr B observed in secondary care, secretaries struggling to get through to primary care
  Result:
  - ✓ **Dr D & Dr B's reflections have resulted in direct dials for all GP secretaries in SCCCG have been identified and shared with all providers**

Case Study 4

- Dr P spent time in GP and reflected that 90% of the letters were being read by admin team in primary care. They coded letters and only passed on to GPs that required specific thing for GP to action.
- Dr P considered and has begun to change their own practice by heading their letter ‘For Information Only’ ’GP Action required’

  Result:
  - ✓ **Discussions have been had with UHS to see if this could be done across all specialties to save time in primary care.**
  - ✓ **The idea has been shared with all providers and the LMC.**

Case Study 5

- Dr F spent a morning in primary care with Dr H and considered how they could improve communication between primary and secondary care.
- Following the evening celebratory event, an affiliated NHS organisation was present as a sponsor, the pair have set up in another local CCG a virtual secure communities directory within the organisation’s website.

  Benefits:
  - ✓ **Improve verbal communication between primary and secondary care**
  - ✓ **Reduce the paper burden of faxes, emails, and letters to get responses**

Case Stud y 6

- Dr J working in a multi-site practice spent some time with Dr K in secondary care where there is always support or colleagues around to discuss things with. On reflection realised that primary care has a workforce of mainly part-time workers and noted the support for their partners and other GPs within the multi-sites could be improved by setting up a clinical what’s app group

  Result:
  - ✓ **Increased support for all clinicians**
  - ✓ **Increased CPD through learning from others**

Case Study 7

- Dr M observed in secondary care the MDT working and detailed communication. Following the evening celebratory event approached the organiser in suggesting creating Schwartz rounds locally
  Benefits:
  - ✓ **Increasing compassionate care provided**
  - ✓ **CPD for all involved**

Next steps:

Exploring Schwartz Style Rounds in Southampton

A first across primary and secondary care

Are you ready to take part in a challenge and lead collaboration?

Further information on Schwartz rounds
https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/

'Compassionate leadership for compassionate health services'

- ***Attending:*** paying attention to staff – 'listening with fascination'
- ***Understanding:*** finding a shared understanding of the situation they face
- ***Empathising***
- ***Helping:*** taking intelligent action to help

Page content replicated with permission from Prof Michael West from his presentation at the celebratory evening event