HEE Fellowship Report

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My pathway to the HEE Fellowship year

I returned to NHS General Practice in May 2020 having worked overseas for several years. Whilst it's been great to be back in the UK (COVID pandemic and lockdowns notwithstanding!) having been away and experienced different ways of working I now see some aspects of UK life and especially NHS culture through new eyes.

Through 2020 -21 I was particularly struck by how much of a GP's working day is taken up with handling administration: filling in forms, writing referral letters and dealing with correspondence from secondary care (in addition to EPS, pathology reports, emails etc) can take a disproportionate amount of time.

As I typed another letter to the hospital and read through letters from secondary care colleagues, I found myself thinking 'there must be a better way to do this!'. Conversations with GP colleagues led to the suggestion that I pursue possibilities for change through the HEE Fellowship, via the 'Quality Improvement' stream.

I have been very grateful for the opportunity to take time out to think, to explore, and to connect with primary and secondary care colleagues over this year. It's been a valuable learning experience and given precious space for a change of pace and purpose as I re-adjust to the demands of NHS GP life.

Two projects – workload and letters

My initial project ideas focussed on two areas: finding ways to streamline GP workflows so that GPs (and other clinicians) could give a greater proportion of their time to clinical work by passing administrative tasks straight to administrators; and on improving the quality of communication between primary and secondary care by designing new letter templates that gave the key clinical information 'at a glance', to facilitate prompt and efficient action.

I started the year pursuing both tracks, but soon concluded that the second idea (improving two way communication) might be more productive. My Fellowship Project therefore focussed on this area.

Communication: question to address

The question that has driven my letters project is:

'How can we improve two way communication between primary and secondary care?

Good communication is a two way street.

As a GP, I want to help my patients and my secondary care colleagues by making sure my referral letters are clear and concise. Modern IT systems mean that with a few clicks it is very easy to pass on patient data - but an 'information dump' is not the same as communication. To communicate I need to clearly define the reason for referring the patient, with enough background information to give necessary context, without overwhelming the reader in secondary care with unnecessary data. A helpful question to ask as I write is 'If I was receiving this letter, what would I want to know – and what would be unnecessary?'

By the same token, as a GP reading discharge summaries and clinic letters from secondary care, the main question in my mind is 'what do I need to do?'. Am I free to simply file the letter, or is there an action that I need to take – and if so what is it? It's not uncommon for the key action step for primary care to be hidden somewhere on the 3rd or 4th page of a long discharge summary. If the key action points are not made clear, it can take a lot of GP time to hunt for them with the risk of harm to the patient if they are missed and not actioned.

So the focus of my project became: As a GP practice how can we improve our patient referral letters to secondary care? And how can we help secondary care colleagues to improve written communication with General Practice?

Approach

As the focus of my project was improving communication, I wanted to meet secondary care colleagues who had a similar concern. It took a while to make the connections and find the right people to talk to! I decided to start with discharge summaries from the Emergency Department (ED), and arranged a face to face meeting with our local ED consultant Dr ON. He in turn put me in touch with other consultant colleagues and I arranged further meetings with Dr TC and Dr JS, both of whom were interested in improving primary-secondary care communication.

I also met in person and online with HH, Primary Care Partnership Manager for Berkshire NHS Foundation Trust. She was very helpful and arranged meetings and video calls with other key people in the Trust.

Together we agreed to prioritise improvements to the ED discharge summaries; the hospital trust acknowledged that they were untidy and didn't communicate important clinical information well. To this end, with advice and feedback from secondary care colleagues I designed a template for a new, simpler ED discharge summary .

One of the fruits of discussion with secondary care colleagues was advice about what made a good GP referral letter. As a result I was able to work with the practice IT manager to redesign all our 'in house' referral templates. I have also spoken with my GP colleagues and as a practice we now aim for letters that are a maximum of one side of A4, with all the other relevant clinical details communicated in a standard 'Clinical Information Summary'.

Obstacles

My ideas and suggestions about improvements to the discharge summaries were received positively by secondary care colleagues – but so far no actual changes have been made. There seem to be at least two obstacles to change – financial resource and software functionality. In a meeting in September with MM (Information Management and Technology Consultant for the Royal Berkshire Foundation Trust), it was clear that though there was an appetite for changing the discharge template, and my suggestions were largely welcomed, there was currently insufficient financial resource within the trust to finance the considerable change in software function that would be needed to bring the project to fruition.

Reflections

My Fellowship year has proved to be an unexpected opportunity to take time out of the usual routine of general practice clinics, to meet and learn from other GPs in the Thames Valley and Wessex areas and to pursue possibilities for change in an area of daily relevance to my practice. I am disappointed that so far the changes that I had hoped for haven't yet materialised. I am hopeful that ongoing contact with secondary care colleagues may yet yield change when money and software changes bring new openings for improvements.

In terms of driving change in the health service, I have been learning the importance of:

- Deciding on realistic goals at the beginning. Whilst it is good to be ambitious, discerning what may (and what may not) be achievable is a key step in laying the foundations for eventual success
- Building relationships. Any change to the way a team works needs to have the support of other team members who will have their own insights and who will need to feel enthusiastic about the changes being proposed.
- Negotiating. My initial hope was to drive wholesale changes to outpatient letters, inpatient discharge summaries and ED discharge summaries. Initial conversations persuaded me that my aim would need to be more focussed. Negotiation includes thinking through what is 'essential' and what may need to be altered, adjusted or delayed.
- Celebrating success. I had hoped to see new templates for letters and discharge summaries agreed by the local hospital trust as a result of this year. This hasn't happened (yet!), but I have started a dialogue with key decision makers, forged new relationships, learnt about the possibilities and constraints of achieving change in a large organisation, and learnt more about my own strengths and weaknesses too. And the door to the changes I had hoped to see hasn't been closed; real possibilities for change over the next year or two remain – just not yet.

I am enormously grateful to Maggie Woods and Katie Collins for facilitating the Fellowship Year with wisdom and patience; to Dr Natasha Jones for key suggestions and constant encouragement as a mentor in regular zoom calls, and to Health Education England for the opportunity to pursue this project this year.

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