Health Education England

# A HEE Quality Improvement Fellowship on Wellbeing and Resilience

By Sanjeev Agrawalla

**Contents:**

# Improving the Culture and Relationship between Primary and Secondary Care

## Introduction

It was a privilege to be asked and to be able to work on the culture and relationship between primary and secondary care.

It was very different to my original plan for the Fellowship; this was big organisational change, not easy and potentially political, and I was not sure if I was the right person for this work being new to Oxford, due to be a salaried GP. Who was I to advise or effect change?

However our relationship with secondary care is very relevant for our wellbeing and resilience, which was the theme for this Fellowship.

My own experience was from being a GP 20 years, and the son of a GP, noting how our culture and relationship has changed over time, and as a GP Appraiser almost 10 years, regularly discussing and learning about individual GPs' work environment, education, and resilience factors each month.

My impression was we have not been meeting like we used to, even before Covid-19, and that disconnect was affecting our understanding and feelings about work shared.

A large part of our interaction had been through professional development.

Was education a route to effect organisational, cultural change?

Would this be relevant in Oxford?

## The Need for change

Health organisations state a need for change in how we work together, whether to minimise errors in care between primary and secondary care,[1] or to reduce bureaucracy, administration and cost.[2,3,4]

> *'interfaces are points of high risk for patients accounting for 50% of all medical errors, with one third of those errors occurring at the primary-secondary care interface' RCGP and BMA Scotland 2020*[1]

Table 1 shows recent government policies to improve the interface.[5]

**Table 1 – Policy Initiatives to Enhance the Primary-Secondary Interface (Since 2012)**

| Year | Report / Strategy |
|---|---|
| 2012 | **Health and Social Care Act**<br>• Consultants represented as clinical member on the governing body of clinical commissioning groups (CCGs)[143] |
| 2014 | **NHS 'Five Year Forward View'**[144]<br>• Advocates increase in out-of-hospital care<br>• New Models of Care Programme established to support 'vanguard' schemes to rapidly develop and implement 'new care models'<br>  • Envisaged Multispecialty community providers (MCP), or extended group practices forming federations, networks or single organisations offering a wide range of care using a broad range of professionals with an aim of shifting the majority of outpatient consultations and ambulatory care out of hospital settings.<br>  • Also establishes Primary and acute care systems (PACS) (single organisations providing list-based GP, hospital, community and mental health services). |
| 2015 | • NHS electronic referral service (or e-RS) introduced with 'advice and guidance' (A&G) feature, allowing GPs to request advice from consultants before or instead of making a referral. |
| 2016 | **GP Forward View**[145]<br>• Includes "new Standard Contract measures for hospitals to stop work shifting at the hospital/general practice interface."<br>• A new NHS England, NHS Improvement, RCGP and GPC Working Group set up to drive action to improve current interface between primary and secondary care. |
| 2019 | **NHS Long Term Plan**[146]<br>• Committed to service redesign to reduce pressure on emergency and out-patient hospital services.<br>• Commits to removing up to 30 million outpatient visits a year through better support for GPs, online booking systems, appointments closer to home, alternatives to traditional appointments and avoiding patients having to travel to unnecessarily. |
| 2021 | NHS England announces £160m initiative to 'develop a blueprint for elective recovery' which includes 'greater access to specialist advice for GPs'.[147] |
| 2022 | **Fuller Stocktake**[148]<br>• Calls to enable secondary care specialists to "wrap-around" 'neighbourhood teams', and for an expansion in the role of community clinics. |
| 2022 | **Health and Care Act**[149]<br>• Placed integrated care systems (ICSs) on a statutory footing, creating the conditions to enable shared budgets across provides. |
| 2023 | **Hewitt Review: an independent review of integrated care systems**[150]<br>• Calls for "close partnerships between many parts of the health and care system - primary care, community health, mental health, acute hospital trusts, local government and social care providers - working together in different ways." (p. 11) |
| 2023 | **Delivery plan for recovering access to primary care**[151]<br>• Requires ICBs to report progress on improving the interface with primary care, especially areas highlighted in an Academy of Medical Royal Colleges report which provides 50 vignettes of improved and effective interface working covering culture, communication and clinical process.[152] |

Integrating care is thought to improve patient experience, quality, efficiency and reduce error.[6,7,8,9,10,11]

The NHS restructure in 2022 to Integrated Care Systems is to increase 'collaboration and innovation at Place', to develop 'shared outcomes', 'common purpose' and 'deliver more efficient and joined up services'.[6] (Place is normally a 250,000-500,000 patient population group.)

However is that link needed at just top management level? Organisational studies including within the NHS indicate wider culture change is needed to deliver patient benefits[9,12,13,14,15,16] changing structure alone is not effective.

WHO (2016) Transitions of Care: 'One of the most important factors in improving transitions of care is the culture of the organization(s)'[9]

## Why the different culture?

General Practice and Secondary Care have different approaches to medicine;

Hospital a more 'neutral', scientific method, while primary care more narrative, patient-centred.[17,18,25]

We manage different levels of risk and uncertainty with different resource and speed to that resource, we see the patient at different timepoints in their health and diagnosis and with a different level of contact and interest in the patient, one more focussed on a particular problem the other more holistic and contextual.

We are funded differently, with different targets and different team structures to meet those objectives.

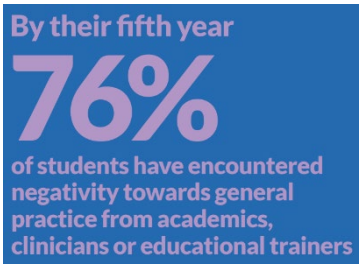
One analogy used is Foxes and Hedgehogs, comparing the depth of specialist knowledge and the breadth of GP knowledge.[19,20,21]

Another of Gatekeepers and Wizards,[22,23] however neither analogy provides a complete picture for the increasing and more complex work done in both primary and secondary care.

Mutual understanding and appreciation of our different roles can reduce the sense of difference, increase shared purpose and teamworking. However over the past 20 years as each system has grown, fragmented, become more pressured how has the line of work between us evolved, for what reason and to what perception?

With pressure, less time and potentially less role models how much investment do we give to more than the immediate process of care, to provide quality for a team we have little personal contact with?

There has been a flood of literature recently on how to improve our teamwork and culture across the interface; within the Fuller Report, from the AOMRC, Policy Exchange, RCGP, Handover, WHO and many others.




Work on views and attitudes led to a push in 2017 for improved GP perception amongst medical students and trainees. [34,35]

However imbalances in our training and a need to improve perceptions across the interface have been discussed since before 2001.

Box 1 sets out the 10 targets from the 2001 European Working Group for Improving the Interface, with targets including education on the interface and teambuilding exercises. [24]

- Develop leadership with a defined responsibility for improving the interface
- Develop a shared care approach for patients treated in both primary and secondary care
- Create consensus on explicit task division and job sharing
- Develop guidelines that describe quality problems at the interface and seek solutions to such problems
- Develop an interface that contains the patient perspective
- Develop systems for appropriate information exchange to and from general practice care
- Reinforce interface improvement through education
- Facilitate team building across the interface
- Establish quality monitoring systems which focus on quality at the interface
- Establish a broad understanding of the need for cost effective use of the interface

Education seems key to develop that shared understanding and team purpose.

The interface research on improving human factors consistently mention education, themed on learning about:

- the whole pathway,
- clinicians' roles within their pathway
- good communication for continuity of care,
- to raise awareness of the other team's perspective
- the impact of care given along their pathway,
- And from the opportunity to meet other clinicians along their pathway

Studies mention shared education has additional benefits of teamworking and sharing best practice at 'horizontal integration', ie between different primary care providers, not just vertical integration, between primary and secondary care.[29]

From discussion with neighbouring counties, setting up protected education time between primary and secondary care is stated to have had an economic as well as quality benefit; reducing referrals, admissions, demand and prescribing costs.

The 2022 Fuller report, acknowledges the role of education for workforce retention and recruitment, advising training hubs 'to *ensure 'the offer' they provide is broad enough to help integrated neighbourhood teams flourish'.*[7]

How has this 'offer' linked in with education to support working across primary and secondary care?

'**Training Hubs. What do they do?...** Broadly they help to deliver the ambition to bring 26,000 additional staff and a further 6,000 GPs into general practice through:

- Conversations around workforce planning
- Embedding new roles into primary care teams
- New ways of working e.g. rotating posts across secondary and primary care
- Increasing the number of innovative and high-quality learning environments for multi-professional trainees/students
- Retention and coordination of staff through preceptorships/fellowships for GPs, nurses, allied health professionals. Mentoring, coaching and CPD support particularly in leadership and educator development programmes. ' [33]

As advised by the WHO in their 2016 Transitions of Care report, interface change needs to be based on local need and incorporate the local team view.[9]

This project set out to explore whether our clinicians felt a change was needed, and what they thought would be effective.

## Method

There were 4 layers of information gathering:

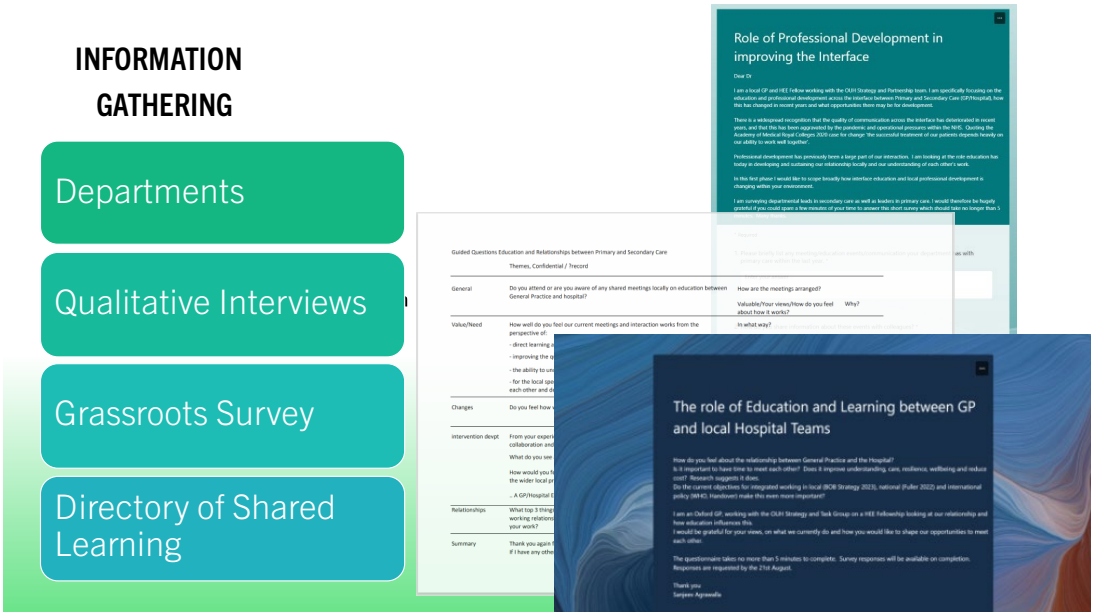



*Figure 1*

1. A Secondary Care Departmental Survey
   Exploring views on current communication and education shared with General Practice.

2. Qualitative Interviews
   Guided Questions were used to provide more depth of opinion from individual primary and secondary care clinicians. This included discussions with representatives and leaders in primary and secondary care.

3. 'Grassroots' Survey
   An online questionnaire to gain a wider range of opinion and more representation of views.

4. Directory of Shared Learning
   Noting the current learning between GP and Hospital available to anyone in General Practice.

The focus in all of them was:

- the different elements of **education** which support integrated care
- views on our r**elationship**
- the **opportunities** to meet
- how we felt the above had **changed over time**, and the
- **potential** for change to improve the primary secondary care culture.

## Results

There were 25 responses from departments, 18 qualitative interviews conducted, more discussions held informally, and 121 responses to the final survey, 72 of these responses were from General Practice, 49 from secondary care.

Results across the information gathering were similar.

Secondary care departments were in addition asked their routes for communication about learning with primary care; the majority felt these were poor as indicated in the pie chart in Figure 3, many stating no communication.

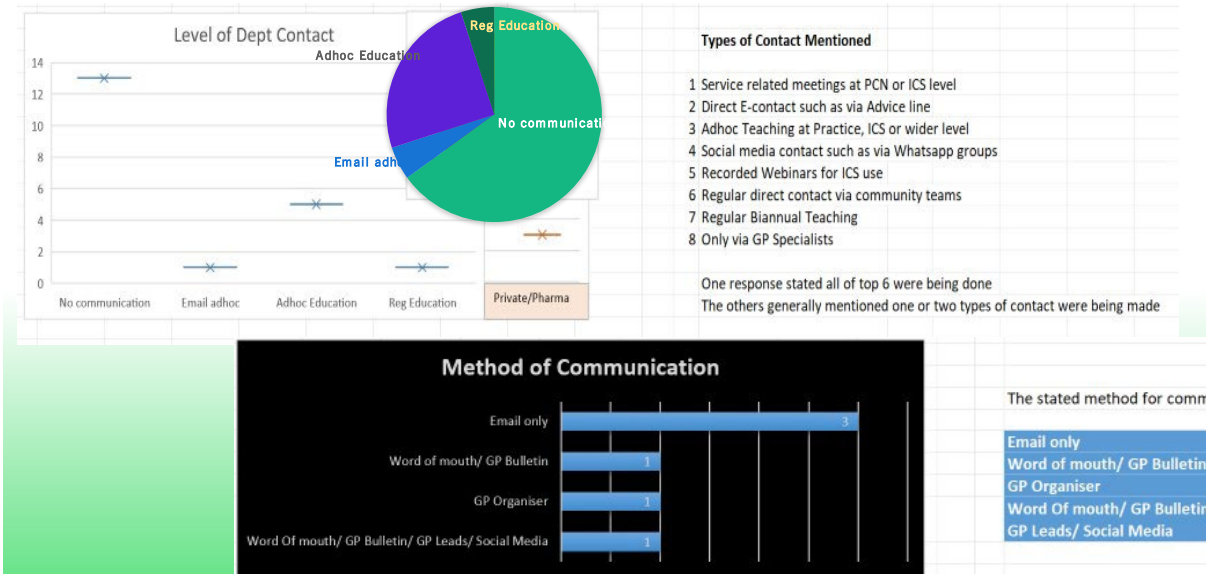



*Figure 2 Routes for Communication about Learning*

The Directory of Learning also indicated little shared learning, and that that learning was often piecemeal, often ad hoc and much was sponsored by pharmaceuticals or particular charities. At the time the Directory of Learning was completed the local Private Hospitals had no local learning events or programme planned.

| | | Department/Title | Topic | Target | Locality | Regul | Meth | Contact | Websi | E | Comments |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | D | ***Departmental*** | | | | | | | | | |
| 17 | D | ***MSK*** | | | | | | | | | |
| 18 | D | ConnectHealth | MSK | GP, MSK practitioners | Local | ? | F2F | | | | MSK Educational Netw |
| 19 | D | *?OU Musculoskeletal GP Education Programme* | | *GP* | *Local* | *Past* | | | | | |
| 20 | D | | | | | | | | | | |
| 21 | D | ***Dermatology*** | | | | | | | | | |
| 22 | D | Skin Club | Dermatology: | GPs | ICS/wider | mthly | Virtual | | monthly | | Pharma sponsored - in |
| 23 | D | | | | | | | | | | |
| 24 | D | ***Respiratory*** | | | | | | | | | |
| 25 | D | Asthma/COPD | Respiratory: | Primary Care | County | Adhoc | F2F | | | | Pharma sponsored |
| 26 | D | | | | | | | | | | |
| 27 | D | ***Women's Health*** | | | | | | | | | |
| 28 | D | OUH Obs/Gynae | Women's Health | GP | County | Biannual | F2f | | | | |
| 29 | D | | | | | | | | | | |
| 30 | D | ***TV Cancer Alliance*** | | | | | | | | | |
| 31 | D | | Cancer | Primary Care | ICS | ? | | | Y | Y | Gateway C, Macmillan |
| 35 | T | ***Team based*** | | | | | | | | | |
| 36 | T | Practice | | Individual Practice teams | Practice | | | | | | |
| 37 | T | BOB Locum Chambers | | GP Locums | | | | NASGP | | | |
| 40 | Q | ***?Drop In Clinics for clinicians*** | | | | | | | | | |
| 41 | Q | ?Diabetes | | | | | | | | | |
| 55 | P | ***Private Hospitals*** | | | | | | | | | |
| 56 | P | Nuffield (Manor) | Range of GP topics | GPs | more Cheltenham/Warwickshire | Adhoc | mix | | | | can attend practices |
| 57 | P | Cherwell | Range of GP topics | GPs | more West Midlands/Luton | Adhoc | mix | | | | |

*Figure 3 Directory of Learning*

In developing the Directory of Learning, certain groups such as GP Locums mentioned being even less well connected or informed about shared events.

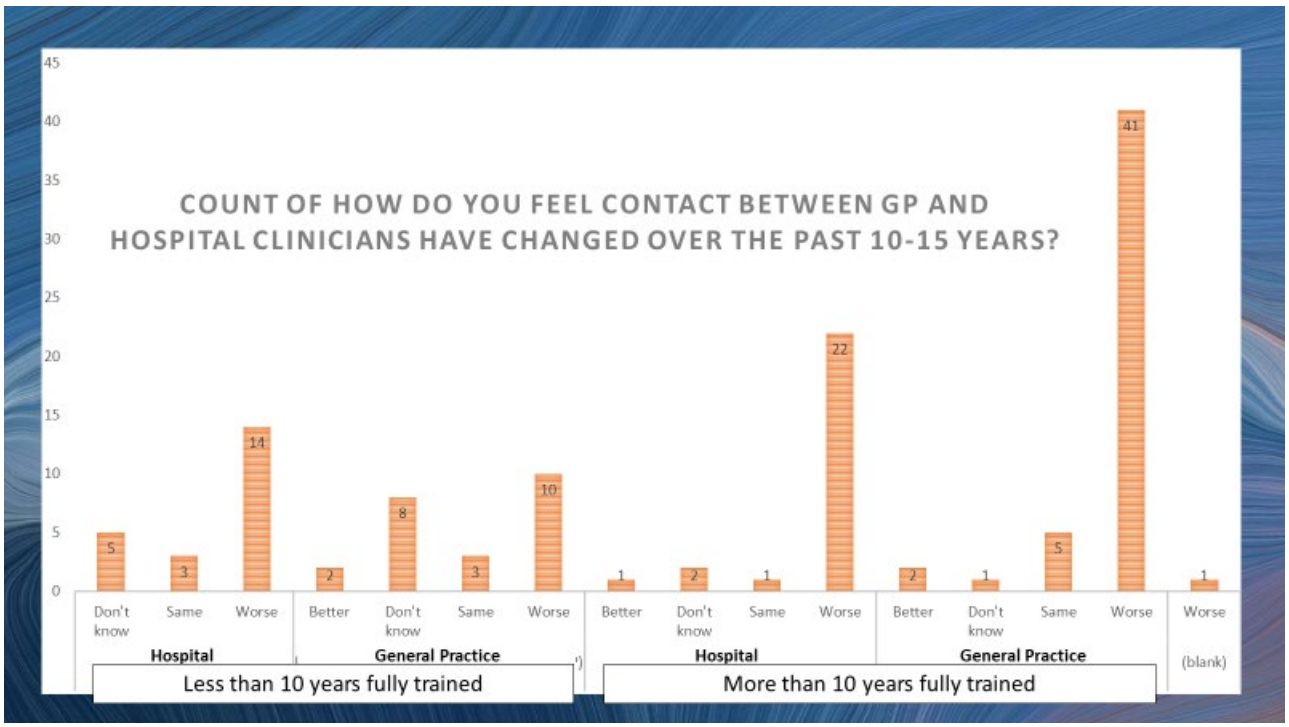
Leads with responsibility for education in primary care mentioned specific groups they had targeted, such as allied professionals or other subgroups within primary care, or issues regarding funding and decisions for more remote shared learning to widen accessibility for the resource available. A sentiment to link with others holding funding for primary care education and to improve focus on joining up primary and secondary care teams was expressed.

The 'Grassroots' Survey

This online survey was distributed in Oxfordshire through the ICB bulletin, the LMC team, Secondary care leads, the NASGP and via informal networks held.

Contact

Graph 1 shows how clinicians felt contact has changed over the past 10-15 years, splitting the result by whether they were more or less than 10 years fully trained (to CCT level), and where they worked.




*Graph 1 Perceptions on how contact between GP and Hospital has changed over the past 10-15 years*

Both Primary and Secondary care felt contact had become worse.

Those more than 10 years fully trained were more unified in their answer.

Learning

Graph 2 looks at different elements of education that support integrated working.

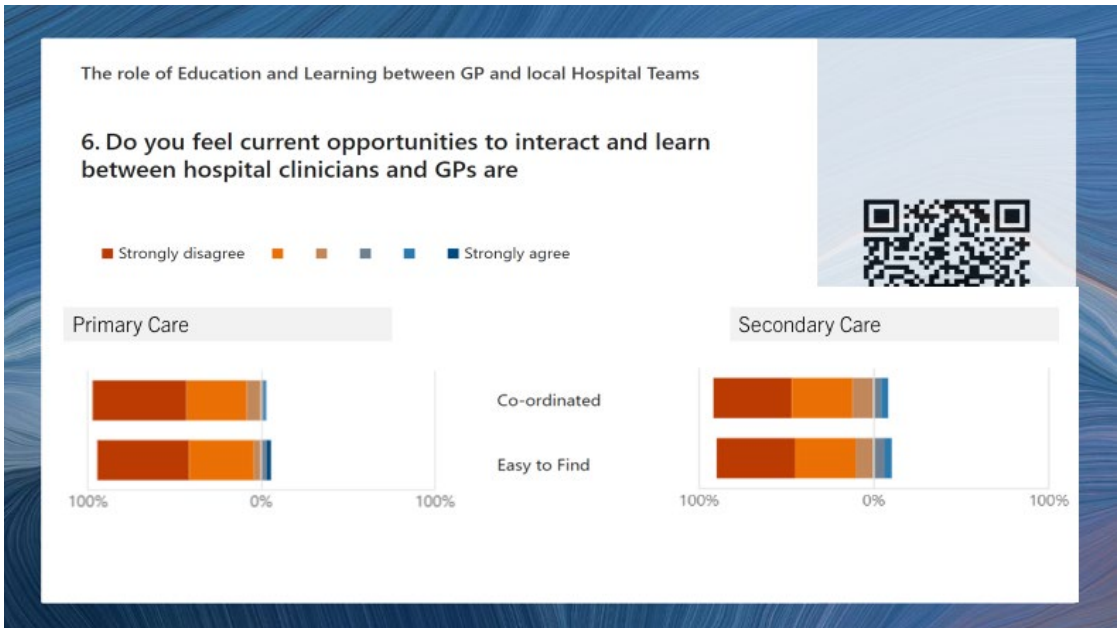
The red and orange are negative ratings, the dark blue the most positive.


*Graph 2 Perceptions on Opportunities to Learn*

Both sectors felt learning opportunities were poor, especially in General Practice and especially for collaboration, team building and feedback on services and care.

Organisation

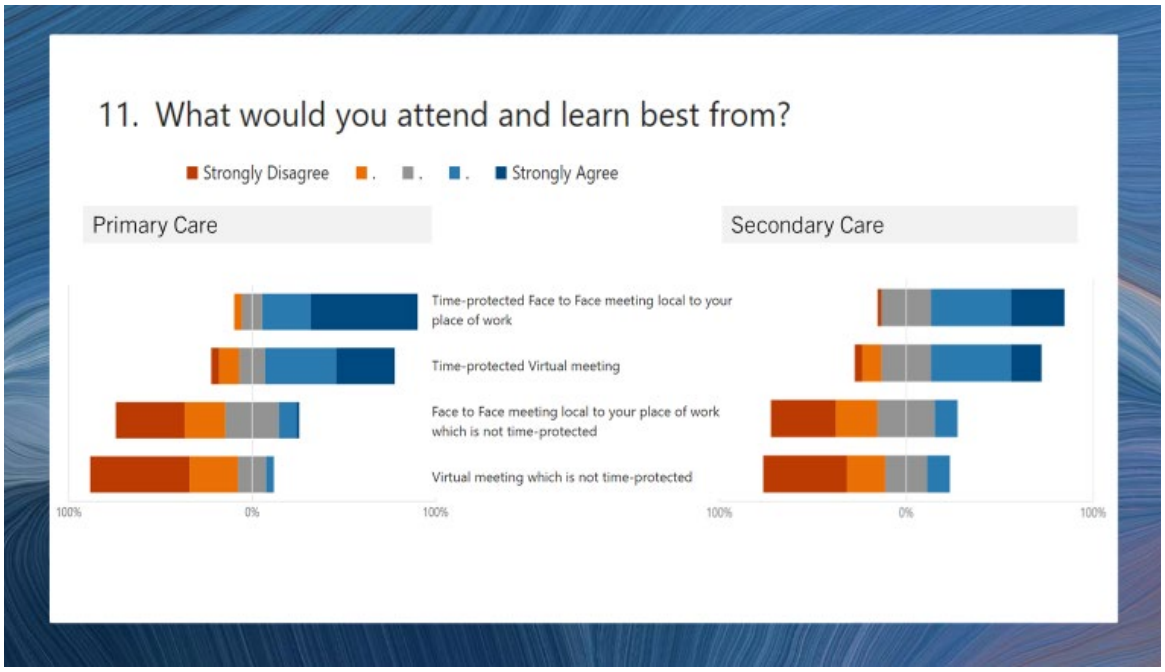
Graph 3 shows more than 90% felt those opportunities were not coordinated or easy to find.




*Graph 3 Coordination and Access to Shared Learning*

Attend and Learn Best from

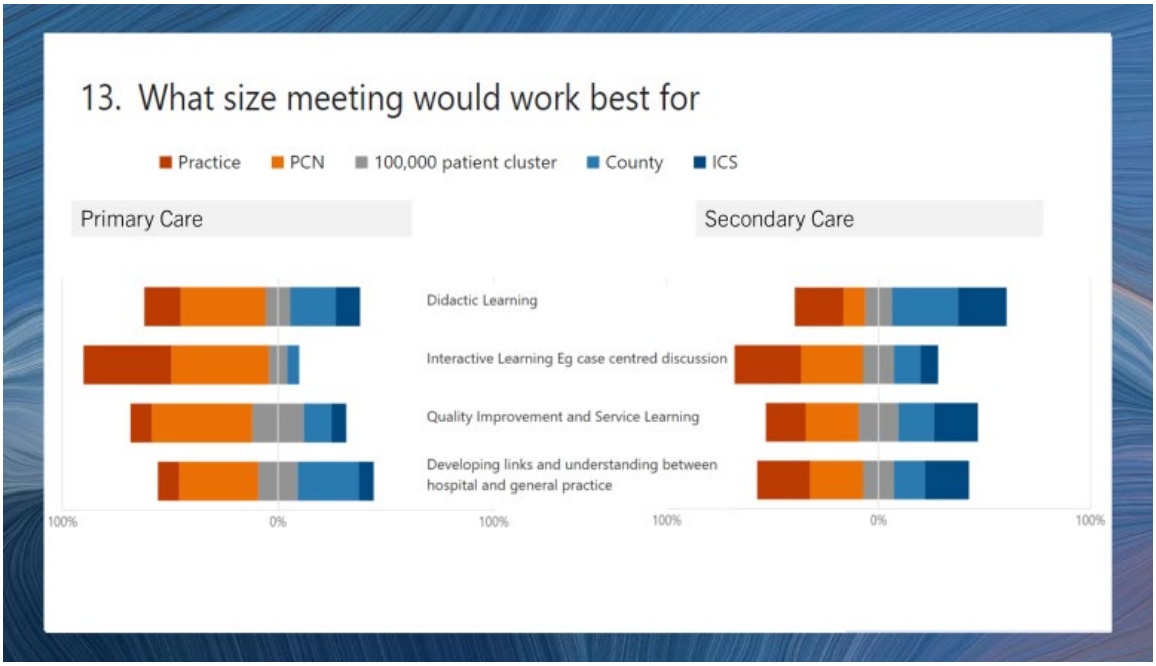
The blue bars on Graph 4 show strong preference or need for time being protected, the red bars are for non-time-protected meetings. There was a slight preference for face to face.




*Graph 4 'Best Learning'*

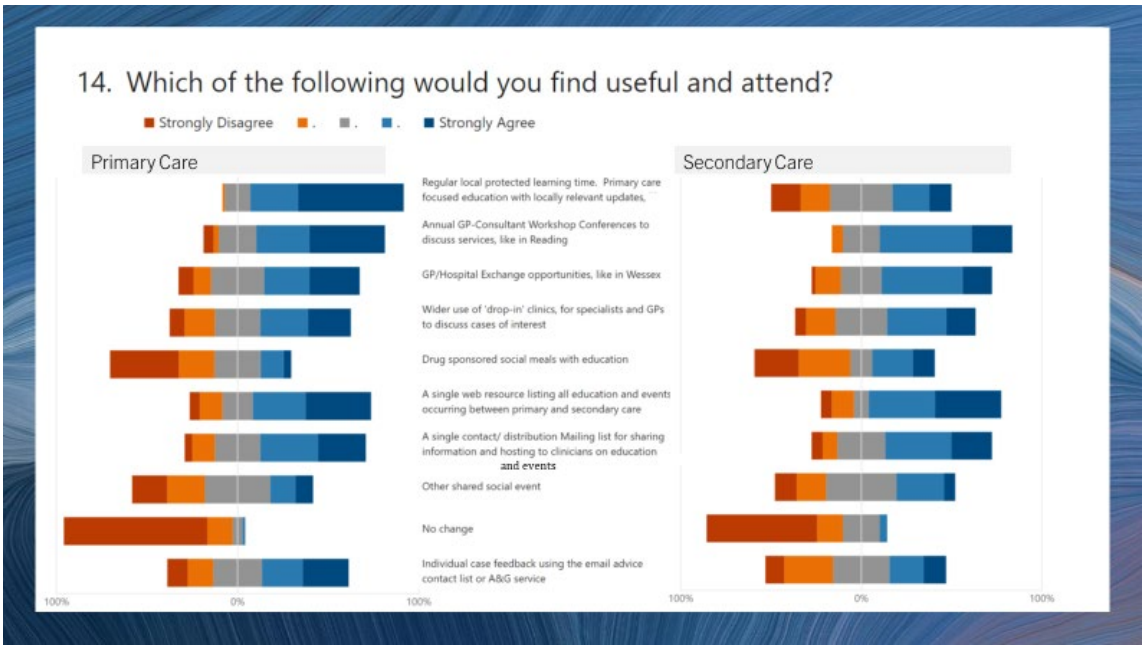
Size

Graph 5 shows PCN level is generally most preferred by primary care, in secondary care the opinion was more varied. Both groups favoured smaller groups for more interactive learning.



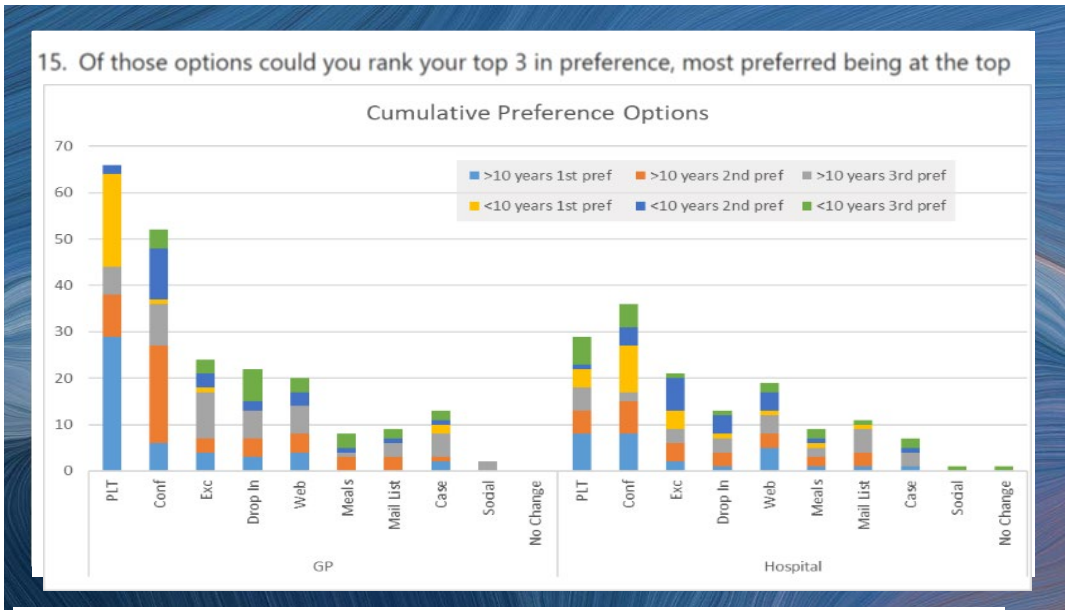

*Graph 5 'Best size'*

Preferred Future Option




*Graph 6 Perceptions of Different Options*

Graphs 6 and 7 I feel are the most significant. The biggest red bars in Graph 6 show 'no change' is the least preferred option, voted negatively by approximately 95% in primary care.




*Graph 7 Different options ranked by preference*

Graph 7 show those preferences again except by preference order. As outlined by the legend this is split by where the clinician works and whether they were more (>) or less (<) than 10 years post CCT.

The most preferred option by General Practice was for shared education through Protected Learning Time, 66 of 72 votes. Secondary Care favoured a GP-Consultant Conference with 36 of their 49 votes.

No change was registered by one clinician as a 3rd preference.

Both graphs indicate a marked desire for change, in primary and secondary care.

Primary and Secondary Care Views

There were many views expressed through the surveys, the slides shared indicate typical views expressed. Figure 5 from secondary care, about:

- loss of personal contact, communication, and sharing of ideas,
- being for local education rather than it being 'parachuted in'
- wanting a return to shared education meetings

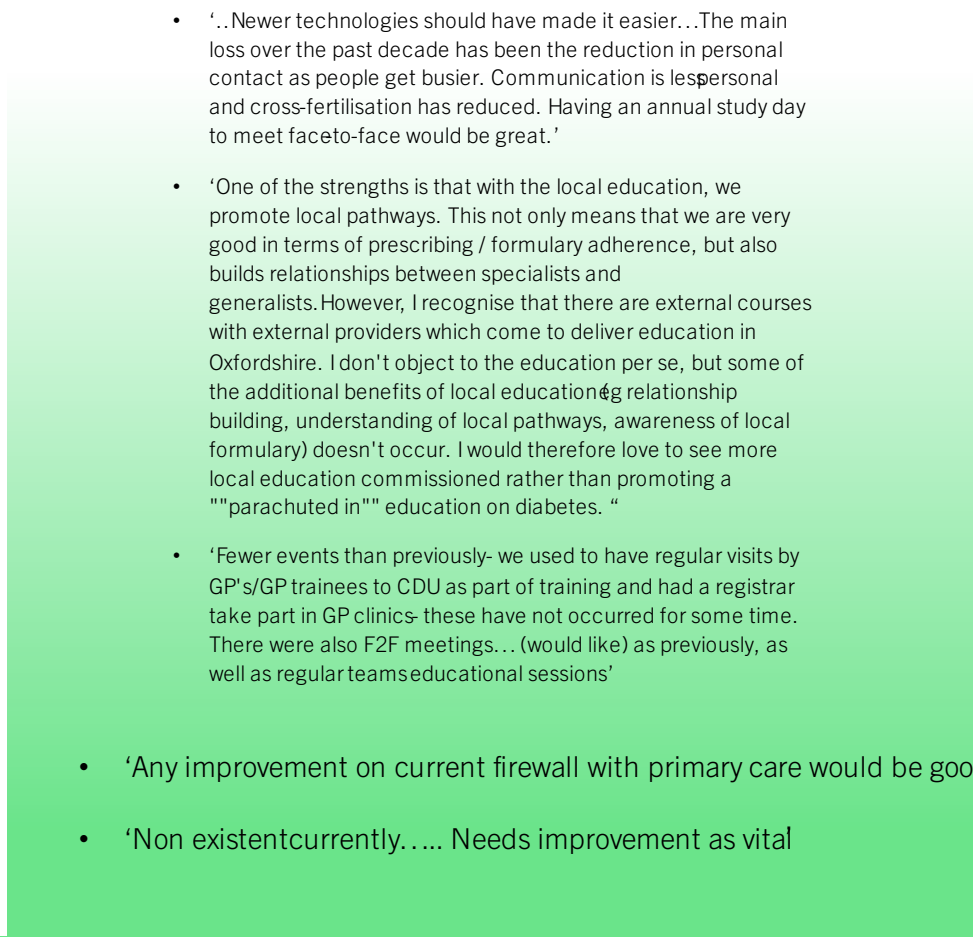



*Figure 5 Secondary Care Views*

Figure 6 from Primary care describing:

- lack of opportunities to meet,
- changes in workforce,
- changes in time and the priority of the GP Hospital relationship,
- and resulting changes in understanding and attitude.

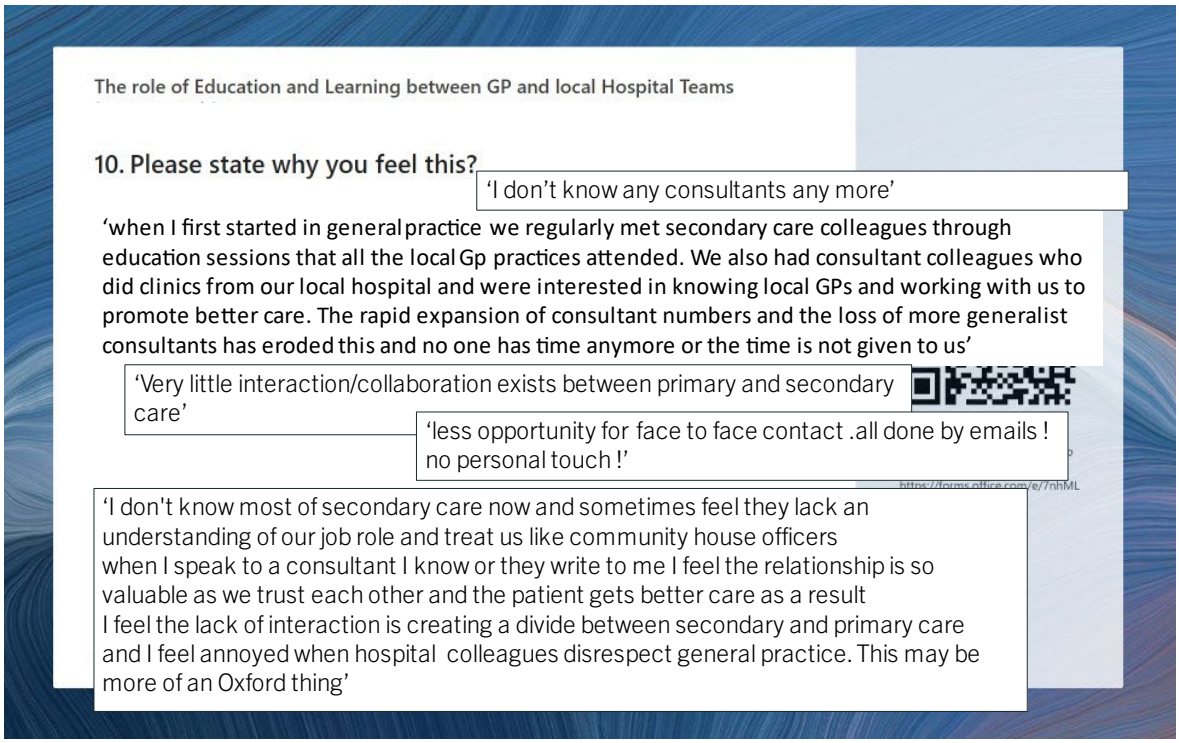



*Figure 6 Primary Care Views*

Interpretation

The findings indicate both a lack of opportunity for primary and secondary care to meet, and a strong desire from both teams to change this.

Not all the options require much funding, some simply strengthening or developing what we currently do such as how we coordinate resources and our routes for communication. It is also important to understand the different needs for contact with different departments.

It would seem shared education could improve our connections, mutual understanding, the culture and relationship across the interface, as well as having the potential to help policy for:

- seamless patient pathways
- improved quality of care
- reduced cost and time including from better knowledge and use, of pathways and
- improvements in our workforce, wellbeing, and retention.

These findings indicate preferences and views which our leads can take forward in their consideration.

Recommendations

Slides 1-4 are from the presentation made to the ICB GP Leadership Group in Oxford. As stated to them **my two main recommendations** are:

***i.*** ***To increase the opportunities to meet***
Through a regular coordinated setting from which primary and secondary care can meet and learn. Both primary and secondary care clinicians expressed that this learning should be two-way.

***ii.*** ***A GP Education Lead***
Responsible for linking in with the hospital, and also the strategy and resources across different GP teams from the ICB, HEE, RCGP, LMC, PCN Education leads etc to coordinate the post CCT primary care education.

*Slide 1*

# Improve Opportunities to Meet

Recommendation

A regular forum for Primary and Secondary Care clinicians to meet and learn from each other

Notes

- Different Secondary Care Departments have different needs for both General Practice and Hospital
- Determining Frequency, how to ensure Engagement and Appropriate Group size requires a coordinated strategy between the department, a primary care lead, and local and ICS needs and policy
- Targets for meetings as well as benefits that can be assessed; through measures of pathway efficiency and integration, quality of service measures, prescribing and activity costs, patient and staff satisfaction measures.

*Slide 2*

# Improve Coordination

Recommendations

A GP Education Lead

A GP Interface Lead

Notes

- Coordinating the diaspora of Funding and Resource for resilience and training
  - ICB/ GPLG/ PCN Education Leads / RCGP / HEE/ Appraisal/ LMC
- Facilitating dialogue with the Hospital Strategy/Departmental Lead
  - On Educational Need
- Strengthening engagement with GPs and practices to encourage feedback on services and feedback back to them
  - ?an LMC augmented role

*Slide 4*

## Strengthen and Streamline Information Shared

Recommendations

In GP

- A single point of access! Website or Person
- Ability to choose frequency of communication/events

In Hospital

- Develop an advisory/optional policy on how events/meetings are best shared with primary care to include primary care contact details
- Consider hosting a webpage of shared education available or link to education
- Agree a route for sharing information with primary care

*Slide 3*

## Personalise Communications

Recommendations

- Encourage Neighbourhood/patch working for larger/'closer' specialities
- Encouraging direct calls - ?drop in call advice/availability
- Ability to know and name clinicians (keeping cover)
- Enabling letters to named consultants and back to referring GPs
- ?accurx/practice emails on GP letters/ Consultant Email lists
- Redevelop Teams in Hospitals

An Acknowledgement and Thanks

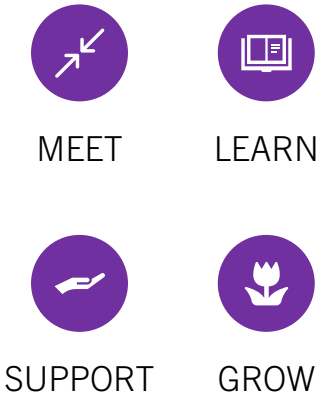
This work has been a privilege, as has the opportunity to meet and discuss with colleagues about an issue very dear to many of our hearts.

I owe a great deal of thanks to the many colleagues who have been very generous with their time, consideration, and help in shaping and contributing to this project, in particular Dr Natasha Jones, from the OUH Strategy Task and Finish Group, and Dr James McNally Medical Director of Oxfordshire LMC.

I hope I have been able to represent fairly the views of my colleagues and maximise the impact of their voice on our decision makers.

As the American industrialist and businessman, Henry Ford said:

> *"Coming together is a beginning; keeping together is progress; working together is success."*



## Appendix 1

## An Interface Activity: A Quality Improvement Project on Amiodarone

While doing Fellowship the LMC highlighted an out-of-date shared care protocol which required agreement between General Practice and OUH.

The shared care protocol related to prescribing Amiodarone. There were concerns about its historic prescribing, whether current monitoring was sufficient, and how to remedy this.

I conducted an audit into the amiodarone prescribing within a select patient group, its outcomes and recommendations are shown below.

The findings and recommendations were presented to both the OUH Cardiology department and the LMC, including potential solutions to quantify the workload and ease the historic work needed.

Through this work I learnt more about:

- the development of shared care protocols and of the nationally recommended shared care protocols
- Amiodarone, its indications and monitoring and knowledge of a gap in some national guidance
- EMIS, the GP record and potential ways it could be improved to aid care planning and document storing.
- different perspectives and pressures for service delivery from both primary and secondary care.

A Quality Improvement PDP is set from my own appraisal to develop this learning for wider benefit.

# Audit of Amiodarone Prescribing within one Oxford GP organisation

**Audit Timepoint:** 30/03/2023

## Aims

Ensure safe prescribing and monitoring of patients taking Amiodarone

## Gold Standards

Communication: All patients should have records available which are complete, accurate, relevant, accessible, and timely so clinicians can provide safe effective care. This includes communication about a drug being started, its indication, monitoring requirements and any action to be taken and accessibility to this information on the GP records

Monitoring: All patients should be monitored in line with the OCCG guideline on Amiodarone monitoring (dated May 2011)

## Methodology

GP electronic records were reviewed to assess

1/ Communication from the Hospital/On initiation

i on indication
ii requesting prescribing
iii on monitoring and how to monitor

2/ Monitoring in General Practice

i an alert/system to ensure the Amiodarone prescribing is noted
ii clear processes to ensure correct monitoring is occuring - for blood tests, ECG, Lung Field examination, Side effect and Interaction Review
iii Clear processes to ensure appropriate action from monitoring is occuring

## Observations

This is a small patient group cohort which has complex and co-morbid needs

*Documentation and Communication*

Trying to find information, not always easy - both from letters and GP records

Some really good examples on clear communication from hospital about the initiation of Amiodarone and its monitoring, however variable - The communication has improved in past 10 years

SCP advice on monitoring and subsequent actions needed on occasion vague

eg how often should ECG/rate monitoring occur - national SCP and other sources seem to indicate annually, however there is variation

Is ECG monitoring to check for rate, or is it to monitor QTc or bradycardia/conduction disorders generally or all

- What action should be taken if a change is noted? Should patients remain on a DOAC if they are no longer in AF? The SCP advises it is 'unlikely to be harmful unless QTC exceeds 500ms' - presumably Amiodarone should be stopped with referral to cardiology if qtc >500ms

How often should other side effects be monitored, visual/myopathy.. nb less opportunity for patients to present opportunistically now due to primary care pressure

The advice on the SCP is to 'advise the hospital conultant of any clinical changes where appropriate' however may be useful to have ranges for when action needed eg for changes in LFTs

*Monitoring*

Patients are being monitored with blood tests for U&Es, LFTs and TFTs

However no ECG or Lung Field (chest examination) monitoring is taking place as recommended by the OCCG SCP

There is no documentation that visual Sx or other side effects are being monitored for

There are no documented entries evidencing review of amiodarone for possible interactions with other drugs

Not clear action is always being taken appropriately to escalate abnormal findings to hospital consultant

It is not evident that there is a process to either stop or limit a patient's medication if a patient does not have their blood test within 6 months

There is variability in national and regional guidance on Amiodarone monitoring requirements. BNF and GP targeted advice such as GP notebook only mention Blood monitoring, BNF does not mention ongoing need for potassium monitoring. Different national guidance specifies different monitoring requirements for ECG, Chest examination, optician and Side effect review.

This is mirrored by a gap in awareness on these extra monitoring requirements when speaking with GP and Primary care colleagues

Medication reviews in GP are now often done by PCN based pharmacists who may not have the ability to examine or manage patients to the same extent as a GP/Specialist

**Recommendations**

*Clarity on Indication and Prescribing responsibility of Amiodarone*

- National SCP requests a formal written acceptance to prescribe and monitor amiodarone per the SCP
  However it is the norm in Oxford for GPs to accept prescribing and therefore responsibility for its safe monitoring. It seems appropriate and less workload to assume practices will prescribe with the local SCP framework to support this.
  I would recommend it is however made clear to practices that **1/** they should let the specialist service know if they are not willing to prescribe Amiodarone, **2/** ensure practices are fully aware of monitoring requirements as this audit suggests there may be a gap
- **3/** A template letter header when an SCP medication is started may improve and standardise clarity
  - to clearly communicate primary care is being asked to start a medication which needs monitoring under an SCP,
  - its indication,
  - how long this medication is currently planned for (eg till review after cardioversion/indefinitely),
  - reasons to stop the medication/seek cardiology opinion on stopping the medication (eg recurrent AF/side effects as indicated on SCP)
- **4/** The ability in GP electronic records to store key care planning documents such as the above shared care plan so they are predominant and easily accessible when the records are reviewed may help clarity and improve patient safety in these records

*Clarity on how to action abnormal blood results*

- **5/** Improve Clarity of the SCP cf South Tyneside and National SCPs
  - on when to action results
  - and who to contact - arrythmia clinic/consultant/endocrinology/…

*Clarity on how to action side effects*

- **6/** Improve clarity of the SCP cf South Tyneside and National SCPs on when to action results and who to contact
- **7/** Update and ?standardise monitoring guidelines made by advisory organisations such as the BNF and GP Notebook

*Responsibility for monitoring and action on blood tests*

- **8/** Develop a protocol for
  1. managing prescriptions when a patient does not attend for their blood tests,
  2. ensure abnormal bloods are highlighted
     i. as being related to Amiodarone
     ii. to refer to OCCG guidelines on how to manage this
     iii. to a select responsible person/group either in GP or hospital

*Responsibility for monitoring of side effects and interactions*

**9/** For opportunistic presentations (similar to Rec 4): Improve GP Record flagging systems to clinicians about amiodarone so they are alerted to its prescription, the SCP, and the
- medication's potential side effects
- **10/** For routine review
  1. Modify the patient information leaflet into a proforma of side effects that patients could complete prior to an annual review
  2. Consider whether a protocol driven PCN pharmacist led annual review discussion with the patient would be sufficient. What information would be needed to supplement this meeting eg another clinician examining the chest, an ECG, optician review? How would findings be escalated/supported?
  3. Consider whether an annual specialist review is required? The patient cohort is small, however complex, many are already under cardiology review. Could part of the amiodarone review be conducted by the specialist team?

**Plan**

Discuss findings and recommendations with Cardiology prior to wider discussion
Re-audit 1 year

**References**


1 OCCG Amiodarone Shared Care Protocol (May 2011)
2 National SCP for Amiodarone (July 22)
3 RCGP Data Quality for Record Access (May 2022)
4 DoH Good Practice Guidelines for GP Electronic Records (2011)
5 Amiodarone hydrochloride | Drugs | BNF | NICE (May 2023)
6 GP Notebook Amiodarone monitoring (March 2022)
7 South Tyneside Amiodarone SCP (Jan 20)
8 HEE/CSU Cornwall Monitoring of Drugs in Primary Care (Nov 2017)

## Appendix 2

## Associated Learning on Wellbeing and Resilience

Through the course of the Fellowship my learning on Wellbeing and Resilience was not as expected. Though my focus became the interface, I learnt about the wealth of resource and work already done through the Professional Support and Wellbeing Service (PSWS) however I also then had my own personal journey from my marital breakup which amplified that insight and learning.

I would like to share some of the associated learning and reflection with you, as I feel it is relevant and worth sharing.

*"Imagine spreading everything you care about on a blanket and then tossing the whole thing up in the air. The process of divorce is about loading that blanket, throwing it up, watching it all spin, and worrying what stuff will break when it lands."*

*Amy Poehler*

There are more than 100,000 divorces each year in England and Wales, affecting approximately 280,000 children.[37,38] Based on 2021 ONS figures, in a typical 10,000 patient practice this approximates to 40 adults and 50 children newly affected each year.[39]

Agreement on separation saves considerable cost, conflict and stress, however almost 56000 applications went to court for childcare disagreements in 2020, and ongoing family tensions is reported as a top cause for mental health problems in children, 67% of primary school children referred to Place2Be for counselling.[40,41]

The Children Act 1989 as amended in 2002 gives equal parental responsibility to fathers from 2003 who are either married to the mother when a child is born or who have their name on the birth certificate.[42,43] The legal advice is that courts start from a position of equal care.[44, 45]

However according to government figures from 2022 almost 60% of 4 million children in separated families have a child maintenance agreement in place with almost 90% of them being paid by men.[46]

Each family is different however a societal norm and pressure of women being the care givers and men the bread winners is recognised, as at the same time is recognition that in today's changing society this might not be right for either of them.[47,48,49]

While domestic abuse when it happens is not to be minimised in any way there are concerns about false allegations of abuse or mental ill health leading to separation of children from parents for many months before court process ensues, potentially damaging parent child relationships, causing ostracisation from networks and with potential to effect careers.[50,51]

There is the significant impact ongoing conflict has on children, their mental health and development, whether from witnessing conflict, toxicity, managing divided loyalties or simply from heightened stress.

In addition to dealing with separation and contact issues with children and the family unit, there could well be increased financial burden from needing and funding another residence while paying or managing Child Maintenance for a disputed separation, and expensive legal costs.

There is then the ability to contend with what can be a heavy volume of legal and related work plus managing ongoing conflict.

To give an example in the past 12 months I have had 5 court cases; I represented myself to save cost for the last hearing, submitting my own 372-page bundle to court. There are at least another 3 court cases left, 2 over the next month. Each court case requires preparation and time, which has admittedly given me much better understanding on Finances, Pensions etc. Over the past month in addition to deadlines and paperwork for these cases, there is communications and deadlines with Child Maintenance, and with Capita for my pension sharing on divorce. The articles about endless circular calls and correspondence with Capita are true![52] I have had similar possibly worse experience with Child Maintenance. There has been input and meetings with social services, Cafcass, 999 visits from the police, school for a strengths and weakness report, for the sale of a house, to manage breaches of court orders, from ongoing acrimony and frequent messages which unfortunately I am court bound to view each day, and more... After my experience accessing the legal process representing myself I re-employed a legal team for some, not all of the remaining court cases; this increased costs, so not only have I lost a house that would have been one year from paying off its full mortgage I've been trying however now not been able to gain any credit to pay those rising legal fees or potentially other fees expected as the tax year end comes close. To maintain contact with my daughter I moved area, and though working the same number of sessions managing the divorce has reduced my ability to increase income and the change in work has significantly reduced it.

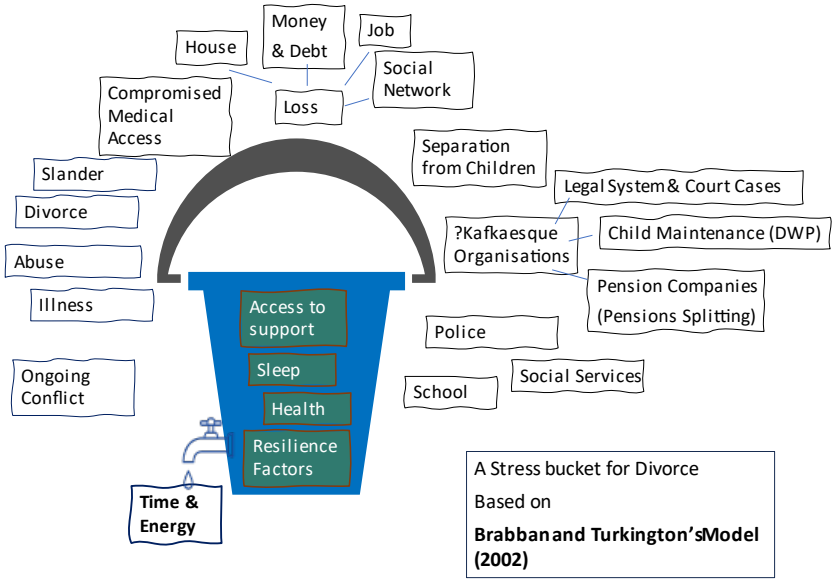



*Figure 5*

And of course there is a 5-year-old caught in the middle of all this turmoil, and all the related emotion especially from conflict.

It all takes time and energy, and can seem like an endless Kafkaesque chess game, sparring against a dozen players at the same time with no way out and at least 2 major dramas a week…

… the past month has been good.

Why would I like to share this:

Firstly to increase awareness of issues that can be faced in an oft not discussed health risk for men, women and children.

Secondly to ask and reinforce your objectivity and impartiality in your assessments and what we document for our patients. Not everything said by patients or partners may be completely true especially when there is conflict. Our records are a medicolegal document, now with increased public access.

Finally in a nod to 'Movember', to remind you about known differences in health outcomes between men and women.[53]

*If you can keep your head when all about you*
*Are losing theirs and blaming it on you;*
*If you can trust yourself when all men doubt you,*
*But make allowance for their doubting too:*
*If you can wait and not be tired by waiting,*
*Or being lied about, don't deal in lies,*
*Or being hated don't give way to hating,*
*And yet don't look too good, nor talk too wise;*

*If you can dream—and not make dreams your master;*
*If you can think—and not make thoughts your aim,*
*If you can meet with Triumph and Disaster*
*And treat those two impostors just the same:*
*If you can bear to hear the truth you've spoken*
*Twisted by knaves to make a trap for fools,*
*Or watch the things you gave your life to, broken,*
*And stoop and build 'em up with worn-out tools;*

*If you can make one heap of all your winnings*
*And risk it on one turn of pitch-and-toss,*
*And lose, and start again at your beginnings*
*And never breathe a word about your loss:*
*If you can force your heart and nerve and sinew*
*To serve your turn long after they are gone,*
*And so hold on when there is nothing in you*
*Except the Will which says to them: 'Hold on!'*

*If you can talk with crowds and keep your virtue,*
*Or walk with Kings—nor lose the common touch,*
*If neither foes nor loving friends can hurt you,*
*If all men count with you, but none too much:*
*If you can fill the unforgiving minute*
*With sixty seconds' worth of distance run,*
*Yours is the Earth and everything that's in it,*
*And—which is more—you'll be a Man, my son!*

'If' by Rudyard Kipling is one of my favourite poems, a creed to live by, however it may lend itself to a societal perception for men wanting to be seen as strong, 'manning-up', minimising their problems, which to others may seem to be sticking their head in the sand.[54,55]

Men do access healthcare differently. They often do not have the same networks to provide them with resilience or knowhow to ask or when to ask for support.[54,55] There are feelings of bias and injustice, whether or not there may have been a 'disingenuous' account of the divorce, and whether or not that bias is real.[48] (Disingenuous became my word for 2022.) That bias may feed into the number of dads wanting to fight for shared parenting of their children.[49]

I was surprised to learn figures presented in the 2021 NCISH (National Confidential Inquiry into Suicide and Safety in Mental Health) report on Suicide by Middle-aged men.[56] This stated 'men aged 40-54 have had the highest suicide rate in the UK since 2013, accounting for a quarter of all suicide deaths in 2019'. From their study 7% reported being a victim of partner abuse, 38% were fathers, 13% were separated but legally still married, 8% divorced, 36% of suicides were felt related to family relationships, 30% to finance.

The picture is of course more complex than the statistics extracted, however research from Samaritans into suicide and mental health in men seem to support these figures. In 2017 a Samaritans report found that deprivation, financial insecurity and unmanageable debt are strongly associated with an increased risk of suicide in men.[55] Their report in 2012 indicated partner separation increased suicide risk in men and separation from children was a significant factor.[57] The 2023 Crime Survey for England and Wales reported 'an estimated 3.0% of people aged 16 years and over had experienced partner abuse in the last year (4.0% for women and 2.1% for men)'[58], and there are accounts suggesting some men suffering partner abuse are ashamed of this or fear not being believed.[51]

The 2023 Government Cross-sector Suicide Prevention Strategy following on from this highlighted the need for raised awareness and appropriate response from all sectors, highlighting of course primary care's role! It is interesting that the Samaritans' call to services aimed at 'less affluent men in midlife' recommends a 'focus on building purpose and connection'.[55]

Appreciation has I feel been one of my large resilience factors;

Appreciating what I have, and what is important,

Understanding my values and purposes, some of which has had a hard reset.

Appreciating that 20-hour days back-to-back are not good for me,

And that health is important.

Appreciating that now almost 2 years later, my monkeys (jobs), are finally being shot down quicker than they come out,

Appreciating humour, and reacquainted arts and culture,

And the ability to do a locum, should you need a little help out! :)

And of course, through and beyond the Fellowship,

Appreciating connections and networks, for their support, their education and by no means least, their re-energisation.

Thank you HEE for having me on this Fellowship,

Thank you, Dr Maggie Woods and Dr Katie Collins, for your expert support and guidance,

& Thank you again to the many colleagues who have helped with their positive connections.

My final section is a summary of my learning this year.

## Appendix 3

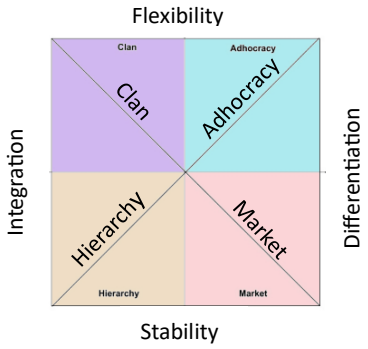
## A Summary of Fellowship Learning

Having less than a few years to 50, calling my time during the Fellowship a coming of age would not seem right, however it has been one of major transition and appreciating a different phase to my life. With this has come much reflection and learning.

My summary below covers my main growth and new learning.

Learning about Organisational Culture

- the Competing Framework Value Model, its concepts of Adhocracy, Hierarchy, Market and Clan, its Leader Behaviours and how it can be applied in health organisations
- from literature and research on NHS Culture




Learning about Leadership in Change

- From the NHS-I Improvement Leadership Guides – especially on culture and human Factors
- Concepts including Spheres of Influence, and the understated tool of Appreciative Enquiry
- Focussed/ targeted communication; the Elevator Pitch, the RACI matrix
- From literature, research and meetings on implementing change at the interface

Learning about policy and strategy related to Integrated Care

- From government, thinktank and local sources, including the Fuller Report and the ICS toolkit
- From literature and discussion on current system working local and national
- From many examples already in place to integrate care

Learning about Education resource

- From discussion within Oxford and neighbouring areas of education in place and challenges and benefits for that education
- through developing a Directory of Learning

General Practice Learning

- Amiodarone Monitoring
- The 2023 Cross-sector Suicide Prevention Strategy
- The processes behind Mandatory and Statutory Training, how this is set and reviewed

IT Learning

- From use of Microsoft Forms for my online surveys
- Increased skill in Excel and Powerpoint
- Increased knowledge of EMIS and its functionality, from exploring options relating to SCPs and Care plans

Miscellaneous

- The US FDA Shelf-Life Extension Programme for Medication

Learning about Resilience for colleagues and patients

- The vast resource in the PSWS
- Visual Consultations/Graphic Medicine/Cartooning
- Resources for patients and colleagues needing help through divorce or abuse

Financial

- Better understanding of the McCloud judgement and its impact both within General Practice and Hospital
- Better understanding of GP pensions and its systems
- Better understanding of Hospital and GP working arrangements and finances

Legal learning

- Learning about Law on Parental responsibility and information sharing
- Learning about law related to medical records (and when MDOs become involved)
- For patients and colleagues, a firsthand understanding of legal, police, social service and associated organisation process
- Much non-health related learning; from practice directives and legal process, to Child and Matrimonial Law, PODEs, libel, slander, home rights, Enforcement orders…

Learning about myself

- And that I am still learning

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