Adelaide PHN

GP / Hospital Consultant Workshop

Summary Report

NALHN

October 2019

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1 Introduction

On the 16th October 2019 Adelaide Primary Health Network (PHN) hosted workshop to give NALHN, GPs and Hospital Consultants working in the Adelaide metropolitan region an opportunity to provide us feedback, specifically – what do you want us to be doing to support general practice and how we can enhance the relationship between primary, acute and tertiary care.

This report documents the proceedings and outputs of the issues and opportunities workshop held at The Precinct Conference Centre and facilitated by Brett Haly from Enzyme.

2 Objectives

The Objectives of this workshop were to:

- Bring everyone to a common understanding of the background and current situation;
- Identify and prioritise the Issues, Opportunities and Critical Success Factors involved in reaching a successful and productive working relationship;
- Identify and agree a set of next steps for success.

3 Participants

There were 10 participants from across the metropolitan region – 4 General Practitioners and 6 Hospital Consultants.

4 Issues and Opportunities

4.1 Affinity Diagram

Participants individually brainstormed the Issues and Opportunities involved in reaching a successful and productive working relationship between APHN< NALHN and GP's / Hospital Consultants, for better health outcomes. They then selected up to 6 of the most important, transcribing them onto white Stikki notes (one Issue / Opportunity per sticker). The Stikkis were then placed on a wall in theme sets, and the group developed headings for each of the sets.

The affinity diagram method of combining and synthesising associated ideas was used to identify the Issues and Opportunities as follows:

A Funding that supports GP's to provide total care

- Increase funding to provide monthly meetings in regards to progress and liaison personnel

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- Lack of recognition of GP time over → indirect services (phone calls etc)
- Funding primary care? How – consider other sources other than Medicare
- Funding models between sectors e.g. salaried vs. fee for service. Medicare item numbers
- Funding GPs for educational attachments in hospitals – educates and builds relationships e.g. Renal and Palliative Care
- Governance and funding of all health professionals and organisations in the area
- Adequate resourcing of ACD and EOLC discussions
- Visit from nurse liaison in each area of chronic disease – GP practices e.g. Asthma, Antenatal and Diabetes

B Unified forward thinking strategy for better health outcomes

- Vision and directions. Have documented clear goals e.g. all bodies working to reduce waiting time for orthopaedics etc
- Proactive vs reactive approach
- Strategic approach to co-design of services rather than piecemeal activity
- Trials at collaboration have been very slow to progress in past – poor clinical engagement – lots of meetings!
- Willingness to make changes – appetite for change, shared by all sides
- "Unmentionable" – that we have been here longer than NALHN or APHN, so we know better
- Lack of necessary support for change – staff, time, financial
- Building and protection of empires
- Accountability and open performance measurement and discussion of variations

C Collaboration, understanding and trust to build relationships

- Building trust / relationships
- Lack of confidence from hospital doctors in abilities of GP's to manage their patients and some GP's not wanting to take on this care
- Improve ED / GP relationship
- Most important changes would be for GPs and specialists to share care of their patients in the others' workplaces
- Lack of trust and worry if not follow through
- Understanding by all concerned that the aim is for better outcome for the patient
- (Lack of) honesty about waiting times and rationing of health services
- Funding GPs to be parts of teams e.g. 0.1 FTE palliative care, DM, CHF, Renal
- Both sectors quite siloed from each other – limited understanding of each others' business
- Bad experience (from the past) with the other stakeholders
- Coordination between primary, secondary and tertiary care – initiate dialogues to begin with – meetings
- Understanding of each other – shared issues and challenges. What we can each offer?

D Sharing of clinical information

- Improve IT connectivity between sectors e.g. pathology results. Communication –formal e.g. letter; less formal e.g. email advice
- Telemedicine (from / between GP and specialist service)

- Delayed d/c summaries including medication changes. Electronic transfer of records to practice software. Liaison person from each unit patient d/c from
- GP's should have full access to hospital records (and vice versa) so discharge letter is not needed
- Lack of communication or failure of communication pvx (letter not sent, never received etc). GP / specialist availability
- Automatic notification of GPs or patients admission / transfer and discharge or discharge summaries, death
- Difficulties sharing information between primary and secondary care and back again
- Efficient electronic communication between health professional and between them and their patients
- Limited access to information, can Medical Director and EPAS / OACIS talk with each other?
- No opportunity for face to face handover especially in chronic disease management
- Communication – standardise – like referral forms rather than free text
- High priority to address is clear, consistent and easy communication between GPs, specialists and patients
- Flexibility / utilising technology
- Access by GPs to hospital patient records including radiology and pathology results

E Structure of care

- Every citizen to be formally registered with one GP or general practice at a time
- Access to services. Need for a directory accessible for everyone – updated regularly
- Removal of hierarchical system where work is delegated to intern / RN and CNCs
- Ego / politics
- Lack of clear pathways into tertiary care or lack of knowledge. Phone calls passed from individual to individual in hospital or GP not available at time of call
- Encourage (all) consultants to do home visits / case conferences
- Single point of referral into specialists care avoiding the unnecessary delays in Emergency Department for patients
- Joint working on integrated models of care to address shared challenges
- Improve primary and secondary care bridging services
- Unclear roles and responsibilities. GPs role? Secondary care? Coordination – common goals
- Streamline services / expert clinics
- Key person dependency – who is going to drive the prx? And decision making
- Limited continuity of secondary care, corporatization of GP practices

F Patient factors

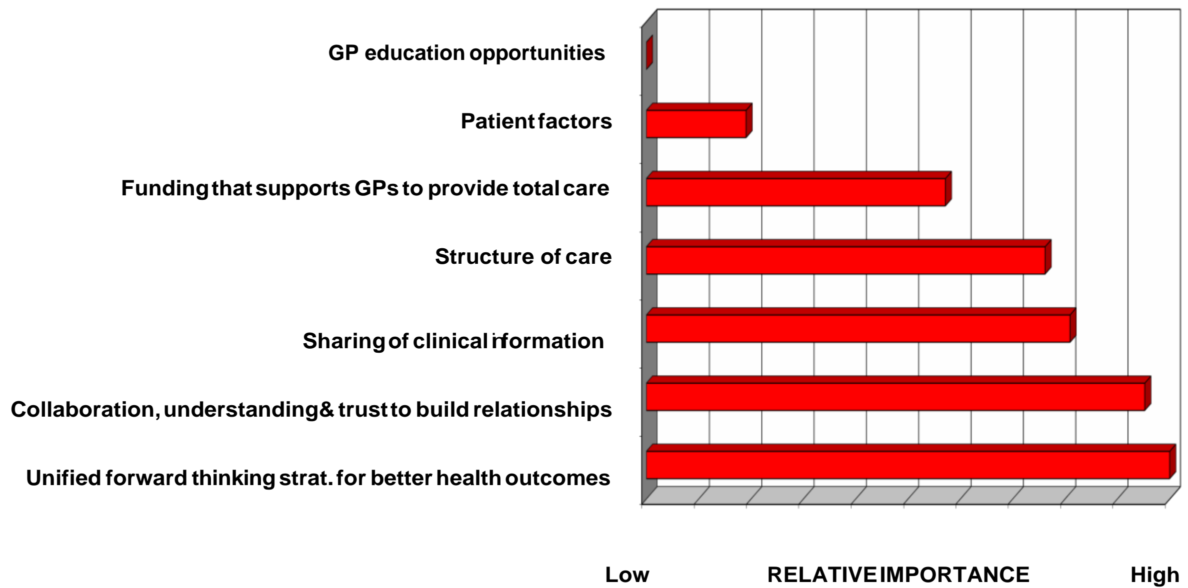
- Patient involvement / attitudes towards healthcare makes things harder
- Critical success factor will be what matters most for the patient
- Ensuring good health outcomes is not just the function of primary and tertiary care (housing, $$, employment, families, communities)

G GP educational opportunities

- GP support / educational opportunities – gap in knowledge

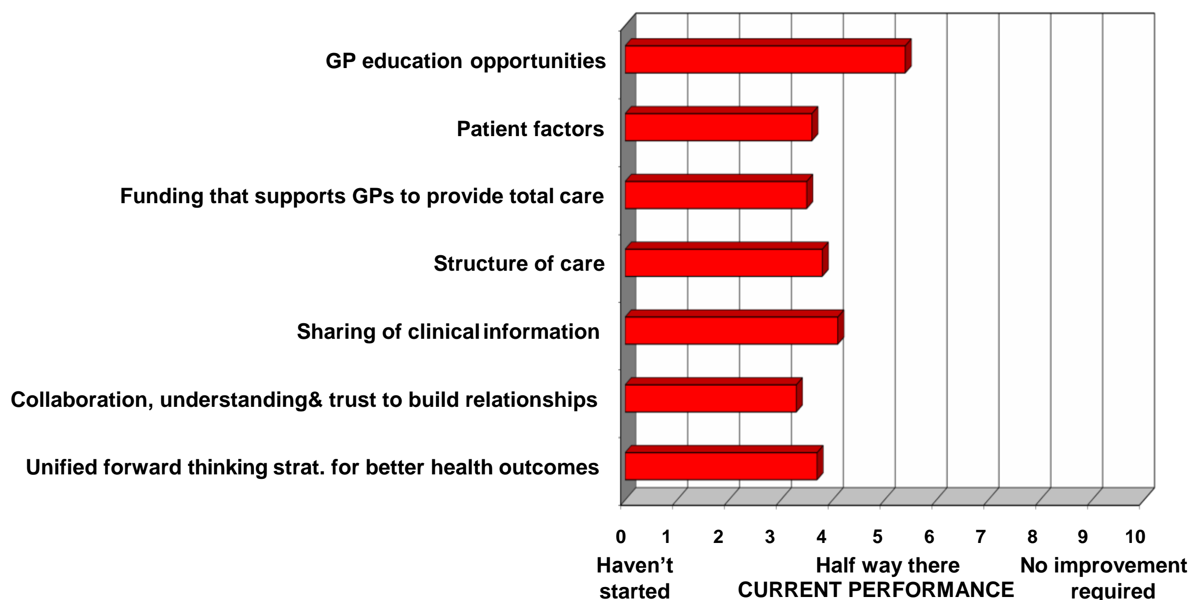
4.2 Critical Issues and Opportunities Charts

Hierarchy of Issues / Opportunities



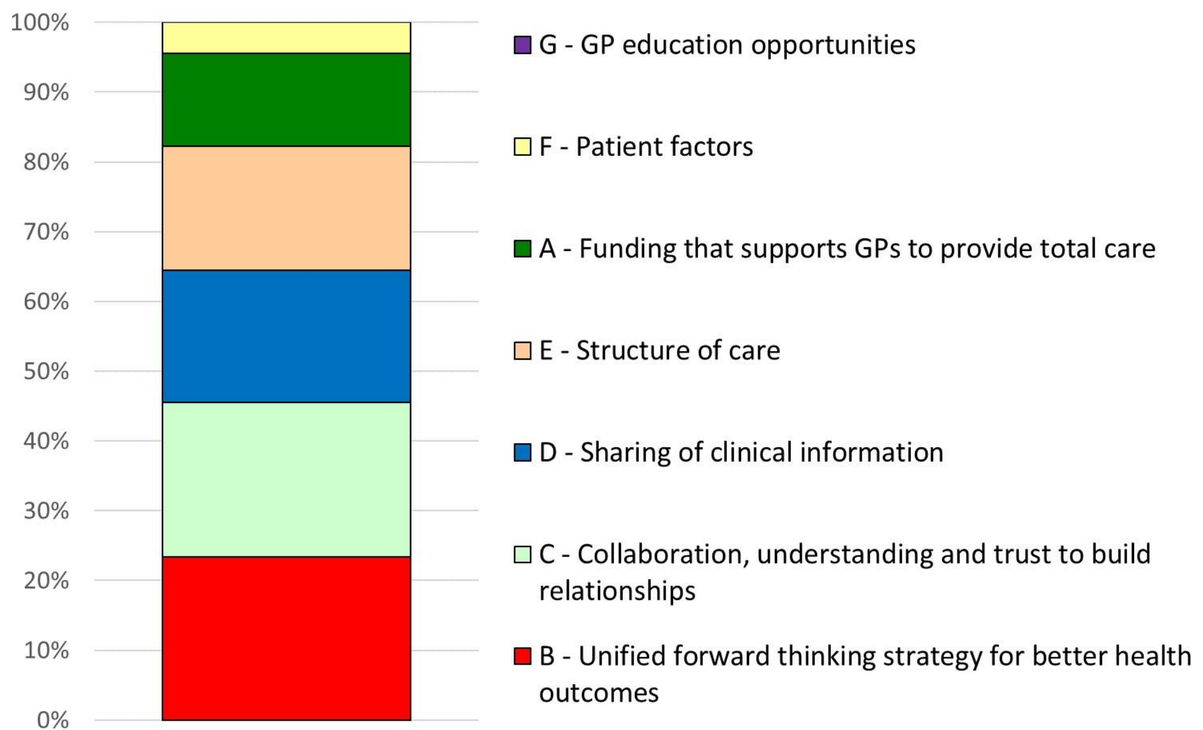
The most important Issue / Opportunity is set to 100% and the remaining expressed relative to the most important. As can be seen in the above chart the most important Issue / Opportunity is 'Unified forward thinking strategy for better health outcomes'.

Issues / Opportunities Performance



One of the OptionFinder® votes was Current Performance, where the Participants were asked to indicate the Current Performance of how well each Issue / Opportunity is being addressed. The outcome is shown in the above Chart.

Issues / Opportunities Pareto



The Pareto Chart is calculated by adding together the scores for all Issues / Opportunities and then expressing each as a percentage of the total. It helps to identify the few Issues / Opportunities that constitute the majority of the weight of importance.

The above Pareto chart shows that approximately 85% of the total weight is coming from four Issues and Opportunities:

- *B – Unified forward thinking strategy for better health outcomes*
- *C – Collaboration, understanding and trust to build relationships*
- *D – Sharing of clinical information and*
- *E – Structure of care*