

QUALITY IMPROVEMENT Improving care planning and communication for frail older persons across the primary–secondary care interface

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ABSTRACT

Collaboration between general practitioners (GPs) and geriatricians should be at the forefront of the design and delivery of the care of frail older people. Primary care teams require high-quality, relevant and timely communication around assessment and care plans when patients return home from secondary care settings.

The aim of this project was to develop effective handover communication between the frailty team and primary care for patients assessed and transferred home from an emergency department.

The ‘frailty letter to the GP’ was designed, tested and adapted to accomplish this aim. This involved two PDSA (plan, do, study, act) cycles through which the letter was tested and adapted.

Our measure of improvement was GPs’ satisfaction with the letter with regards to its usefulness. Based on feedback, the letter was edited to reflect what the GPs needed in order to continue their patients’ care.

Joint planning with the clinical commissioning group GP leads, as well as the trust’s transformation lead, was crucial to the final design of the letter that was well received by the GP colleagues.

Local departments should examine current communication mechanisms for these patients, and, if found lacking, work collaboratively to improve these while also tracking relevant clinical outcomes.

KEYWORDS: Collaboration, frailty, communication, handover

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Introducing the problem

The multifaceted interconnected nature of need, assessment and care for a frail older person is present whether they are seen in primary or secondary care. Collaboration between general

practitioners (GPs) and geriatricians should be at the forefront of the design and delivery of their care. GPs and geriatricians share holistic values in their approach to person-centred care in the context of the older person’s family, carers and wider community.^{1,2} Strong professional relationships across the primary and secondary care interface underlie many of the models of successful integrated care.¹ These relationships are built on good communication.

When GPs have expressed dissatisfaction with hospital specialists, it has been around issues relating to lack of information. In particular, failure to take account of important psychosocial information, lack of understanding of the information needs of GPs or an appreciation of the GPs unique ability to understand the patient within their family and social context, and delays in communication.^{3,4} GPs and community teams require high-quality, relevant and timely communication around assessment and care plans when patients return home from emergency departments (EDs) and other care settings.

Aim

The overarching aim of this project was to develop effective handover communication between a frailty team and primary care for patients assessed and transferred home from an ED. A secondary aim was that doing this in a collaborative way would build trust between the professionals working across the primary and secondary care interface in the care of older people.

Context and rationale

The East Lancashire Hospitals NHS Trust (ELHT) became a site for the Royal College of Physicians’ Future Hospital Programme in November 2015. Over the period of this project, a number of services were commissioned, reconfigured and expanded to improve care for the frail older people in the region, including the creation of the frailty specialty doctor role in the ED, working as part of a multiprofessional team. The frailty specialty doctor worked office hours, with no out-of-hours cover and saw, on average, six patients presenting with a frailty syndrome in the ED every day.

The aim of the role was to coordinate and contribute to rapid comprehensive geriatrics assessment so that the frail older person would be supported to be managed in the community by their

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primary care team. A barrier to well-planned discharges from the ED was the quality of information sent on discharge from the ED. Initially, information sent from the ED to the GP was derived from coding information sent electronically by the ED administrative staff, and was unable to provide the complexity or detail of the frailty team assessment or management recommendations on transfer. This particular challenge was directly influenced by the fact that ELHT still used paper notes in the ED and acute medical pathway with no access to the detailed community GP electronic records. Therefore, a ‘frailty letter to the GP’ was designed, tested and adapted to overcome this barrier and improve care.

Intervention; the frailty letter to GP

This involved two PDSA (plan, do, study, act) cycles through which the ‘frailty letter to the GP’ was tested and adapted. The PDSA method was chosen because of how its iterative approach reveals whether an intervention works in a particular setting, flagging up the adjustments that need to be made in order to deliver and sustain that improvement.⁵

Cycle 1

Plan (November 2016): A letter was designed with a focus on the key themes that are covered in a geriatrics assessment (mobility, mood, cognition, medication and continence). This first draft was sent to the senior GP lead in the clinical commissioning group (CCG) and to the trust’s service transformation lead for feedback. After their feedback, it was edited and ready to be used as a format to send letters out to the GPs (supplementary material S1).

Do (December 2016): For every patient who had been seen by the frailty doctor, a letter was dictated according to the set template agreed in the ‘plan’ phase of the cycle. The letters were typed by administrative support allocated to the frailty specialty doctor and posted out with a copy of the questionnaire as well as electronic saved copies for the trust’s clinical portal.

Study (February–March 2017): Each letter was accompanied by a short questionnaire for feedback. The target was to have a minimum response rate of 20% from the GPs (10 for every 50 letters). We reflected on the feedback received (see Table 1)

Table 1. Plan, do, study, act cycle 1 responses

How useful did you find this letter with regards to:	Very useful	Useful	Did not add to what I already knew
understanding the details of his/her emergency department attendance?	10	10	1
understanding the rationale for medication changes?	9	8	2
appreciating the Rockwood score and what to do with it?	4	12	5

Table 2. Plan, do, study, act cycle 2 responses

How useful did you find this letter with regards to:	Very useful	Useful	Did not add to what I already knew	Not applicable
understanding the details of his/her emergency department attendance?	13	13	2	0
understanding the rationale for medication changes?	8	9	3	8
appreciating the Rockwood score and what to do with it?	8	11	9	0

and made adjustments to the letter template and information provided. This reflection was supported by discussions with the GP leads from both CCGs.

Act (completed in March 2017): We designed a new format for the letters to the GPs of the patients seen in ED with a new set of questions for feedback (supplementary material S2).

Cycle 2

Plan (launched in March 2017): The new letter and questionnaire was formatted with support of administrative staff. In addition, a Rockwood clinical frailty score (CFS) fact sheet with guidance was printed off and sent with each letter.

Do (March 2017): We sent out the redesigned format of the letter to the GPs with redesigned questionnaires for feedback for every patient seen in and discharged from the ED by the frailty specialty doctor.

Study (completed in July 2017): The questionnaires had a higher response rate target (40%) based on the responses received in the first cycle. The responses were reviewed (Table 2) and shared with the senior GP leads and the trust’s transformation lead.

Act (completed in August 2017): A formal electronic template was completed with a plan to have it easily accessible on the trust intranet to be sent to GPs for every frail patient discharged from the ED by the frailty specialty doctor or other members of the front door team.

Measuring change

Every patient for whom a letter had been sent to the GP from the frailty doctor also had the usual coding information sent out as standard from the ED. Asking the GPs to comment on the usefulness of the letter sought to confirm if the letter was an improvement on, and not just a different way of presenting, the information that they received as standard. The proportion of GPs finding the letter very useful / useful compared favourably with those who said it did not add to what they had already was a measure of the effectiveness of the frailty letter.

We were not able to measure patient outcomes in these patients, or safety measures such as readmissions. The focus was ensuring the communication and handover of care to primary care was appropriate and acceptable, on the understanding that this will improve patient safety and patient care.

Analysis and results

Cycle 1

In cycle 1 there were 21 questionnaires returned; the response rate was 35% (Table 1).

Comments and themes from the responses (with examples) were:

- > satisfaction with the letter: *'Very good. Shows change,'* and *'Would not change anything about the letter received – very helpful.'*
- > no/limited knowledge of Rockwood frailty score: *'Assumes a knowledge of Rockwood score; not useful,'* *'What is Rockwood score?'* and *'I don't know what Rockwood score is – will look into it.'*
- > timeliness of the letter: *'Can be quicker? Patient seen 03 December, letter received 28 December.'* (single comment during a challenging time with administration support)
- > feedback also received about the questionnaires sent out requesting a 'not applicable' option.

Feedback from meeting with GP leads were:

- > a more structured letter with separate boxes for diagnosis, narrative, results, and scores and actions taken or recommended
- > careful wording of the recommendations, especially around referrals, investigations and treatments to allow for GP's discretion and clinical judgement and not be a 'directive'
- > a Rockwood grid at the bottom as a quick reference guide in interpreting Rockwood scores
- > very appreciative of the contact information at the bottom of the letter; very useful to know that the doctor is accessible.

Cycle 2

In cycle 2 there were 28 questionnaires returned; the response rate was 48% (Table 2).

Comments and themes from the responses (with examples) were:

- > satisfaction with the letter: *'A very useful discharge letter. I have not seen one of these types of discharge before, nice job!'* *'Great format; vast improvement from previous letters, as a matter of fact, I really appreciated this letter. It was precise with clear information and action plan. Excellent,'* and *'[I would change] nothing/nil'* was a recurring response in the comments section, much more so than in cycle 1.
- > no/limited knowledge of the Rockwood frailty score: *'Did not know what [Rockwood] was,'* *'I was not aware what [the Rockwood score] was. Thank you for adding the fact sheet,'* and *'[Is] the Rockwood score similar to the frailty score?'* was a recurring theme in the responses
- > timeliness of the letter: *'Letter to be received in a timely manner,'* again, fed back only once but taken on board
- > other comments outside the above themes were in reference to specific details in the letters.

Interpretation and discussion

GPs prefer structured letters that list problems and management plans to conventional letters, as the information becomes easier to transfer to the computerised records.⁴ Comparing cycle 1 with cycle 2 reveals that the proportion of GPs finding the letter useful to very useful did not differ significantly as a result of the change to the format of the letter. However, by reviewing the comments, it becomes apparent that the different format to the letter did more to improve GP acceptability than it did to improve the information that was actually being shared. This was reiterated in the feedback meeting with GP leads. It has been demonstrated in previous studies that letters from secondary care are sometimes too detailed for general practice needs.⁴ This project confirmed that what may be useful to a geriatrician may not be to a GP.

One of the advantages of a PDSA approach to quality improvement (demonstrated in this case) is that it allows new learning to be built in to the experimental process.⁵ For example, cycle 1 comments section revealed a lack of knowledge and understanding of the Rockwood CFS among the GPs; yet this score had been included as part of key information to be communicated in the letter. Application of the feedback from cycle 1 resulted in a fact sheet about the Rockwood CFS being attached to the letters that went out in cycle 2. This simple intervention resulted in the appreciation of the Rockwood CFS and what to do with it increasing from 13% in cycle 1 to 29% in cycle 2.

In addition, this information opened up a training need in primary care that was addressed via protected teaching time for the GPs in one of the CCGs. To improve healthcare quality and efficiency, the primary care sector must be empowered to engage with the rest of the healthcare system.⁶ Identifying and meeting their training need was an important outcome of this quality improvement project.

Joint planning is a key element in developing integrated care across the primary/secondary care interface.⁶ Every stage of this project involved joint planning with the GPs and their CCG GP leads as well as the trust's transformation lead. Their feedback and reviews were crucial to the final design of the letter that was well received by the GP colleagues. In addition, it is difficult to quantify how much their involvement impacted on the engagement of the GPs to fill out the feedback forms, outperforming our expected response rate of 20%.

The goal of this quality improvement work was to design a communication template that would facilitate safe transfer of care across the primary and secondary interface. Further work should include patient outcome indicators, particularly around ED re-attendance and medicines management.

Ultimately, our final template letter that was designed was made accessible to any clinician working in the ED and reviewing frail older people. Its simple layout meant that they only needed to fill in the blanks and then print it out for the patient to take home.

Conclusion

Appropriately detailed and bespoke transfer communication to primary care for frail older people discharged from EDs is essential for their ongoing care. This should be developed in collaboration with GPs, and geriatricians. Improved communication also highlights areas of educational need, again enhancing integrated working. Local departments should examine current communication

mechanisms for these patients and, if lacking, work collaboratively to improve these while tracking relevant clinical outcomes. ■

Supplementary material

Additional supplementary material may be found in the online version of this article at www.rcpjournals.org/fhj:

- S1 – Sample frailty letter to the GP.
- S2 – Feedback questionnaire.

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