General Practice in Norfolk:
Working relationships with secondary care providers (Part two).

***Stephanie Tuvey**, Project Officer*

Please contact Healthwatch Norfolk if you require an **easy read**; **large print** or a **translated** copy of this report.

Postal address: Healthwatch Norfolk, Suite 6 – Elm Farm,
Norwich Common, Norfolk, NR18 0SW
Email address: enquiries@healthwatchnorfolk.co.uk
Telephone: 0808 168 9669

July, 2017

Contents

Your voice can make a difference...

healthwatch Norfolk

Healthwatch Norfolk works with health and social care services in Norfolk to make sure that your views and experiences make a difference to the services we all use.

Call us on 0808 168 9669

Website: www.healthwatchnorfolk.co.uk Email: enquiries@healthwatchnorfolk.co.uk

Follow us on Twitter: @HwNorfolk Like us on Facebook: facebook.com/healthwatchnorfolk

Who we are and what we do

Healthwatch Norfolk is the local consumer champion for health and social care in the county. Formed in April 2013, as a result of the Health and Social Care Act, we are an independent organisation with statutory powers. The people who make decisions about health and social care in Norfolk have to listen to you through us.

We have five main objectives:

1. Gather your views and experiences (good and bad)
2. Pay particular attention to underrepresented groups
3. Show how we contribute to making services better
4. Contribute to better signposting of services
5. Work with national organisations to help create better services

We are here to help you influence the way that health and social care services are planned and delivered in Norfolk.

Acknowledgements

We are extremely grateful to all staff working within the NHS who took the time to share their experiences and enabled us to carry out this project. We would also like to acknowledge all Chief Operating Officers from Norfolk and Norwich University Hospital, Queen Elizabeth Hospital, James Paget University Hospital, Norfolk and Suffolk Foundation Trust, Norfolk Community Health and Care and East Coast Community Healthcare who gave us the opportunity to talk to staff and supported our work.

Summary

Across the NHS, services are under mounting pressure due to the sheer demands being placed on them routinely from day to day (National Audit Office, 2017). These demands and the capacity of services frequently do not match, suggesting that the NHS cannot continue working in this way. It is through the dedication of NHS staff that services continue to provide high-quality care, yet how long can this goodwill last and continue (Reed, 2017)? Even in this digital age, we are bombarded with information but communication is challenging across the NHS (Gallington, 2017).

Back in August 2015, Healthwatch Norfolk decided to explore the working relationships between health and social care services, focusing on General Practice from the perspective of both professionals and patients. This represented only one segment of our health and social care system. There are many other segments that shape that system locally, so consequently further work was initiated in the form of this project in 2016. This presented an opportunity for other services to share their views on working with General Practice and has enabled us to develop a clearer understanding of the interaction between services.

Adopting the success of our previous methodology, we used a qualitative approach with a singular line of enquiry for community services, mental health services and hospital services (excluding social care services). We conducted one-to-one interviews with 31 members of staff across six NHS provider organisations in Norfolk: Norfolk and Norwich University Hospital, Queen Elizabeth Hospital, James Paget University Hospital, Norfolk and Suffolk Foundation Trust, Norfolk Community Health and Care and East Coast Community Healthcare.

Since this work involved a range of organisations, staff described a mixed picture of the working relationships between services which was shaped by each organisations' viewpoint and priorities, leading to few key themes common to all services. One key theme established was the ongoing issue of ineffective communication between the IT systems used by health and social care services. Staff told us that the different IT systems are unable to communicate with each other, resulting in a lack of access to patient information, which often caused additional problems for many professionals and patients alike.

Overall the majority of services believed they had good working relationships with General Practice, yet staff alluded these are not as strong as they once were. It was evident there were some frustrations in relationships between primary and secondary care services. In particular, hospital staff recognised improvements were needed in terms of their written communication with General Practitioners (GPs).

Staff highlighted that communication with General Practice proved challenging, as a busy GP practice can be difficult to contact. This often resulted in multiple telephone messages being left and calls unreturned, yet it was perceived receptionists are doing their best. Concerns about GP 'out of hours' services were also raised, due to a lack of patient information on who to contact outside of office hours.

It was evident that some GP practices are reliant on longstanding communication methods, often asking services to fax information. Some staff said faxing was impractical; since so many community workers are highly mobile when visiting patients. Mental health services described the need to work more closely with General Practice, enabling GPs to better navigate the mental health service and choose the most appropriate service for their patients, reducing inappropriate referrals. They recognised that their service is confusing, therefore, they need a stronger voice to clarify what mental health services can and cannot do.

The staff interviews indicated that all services are under increasing pressure, demands are high and patients' expectations are rising. Due to the demand-driven society we live in, people expect more, wanting instant access to services and 'an instant fix'. Staff said they were doing all they can for patients but at times were unable to meet patient expectations due to a lack of capacity and stretched resources.

In general, staff perceived services could be improved by more joint working across the health and social care system, principally as patients expect services to be communicating effectively and do not want to have to repeat their concerns every time they meet a new professional (Glasby & Dickenson, 2014).

As a result our main recommendation is: System leadership is required to coordinate information systems in Norfolk across health services. Staff told us that this is not the case currently and urged that this needs to be addressed.

1. Why we looked at this

Our primary aim is to gather local people's views and experiences of utilising health and social care services across our large county of Norfolk. Increasingly over the past two years we have been receiving a growing number of comments regarding GP services. As a consequence, we felt it was vital to gather a deeper understanding of General Practice and its working relationships with other services in Norfolk. In response to this, last year we completed a project specifically aimed at examining working relationships between services, starting with a detailed view of General Practice involving both patients and professionals. A report entitled, ***General Practice in Norfolk: Working relationships with patients and other services (Part one)*** was produced in July 2016 demonstrating our findings from this work. As a result of undertaking that work it was identified that there was a need to further explore key aspects of working relationships across other services, as our initial findings highlight in section 1.1, below.

To conduct this follow-up project on working relationships it was important to now give other services an opportunity to share and express their view on working with General Practice. This enabled some of the counterparts of the health and social care service to have their say, to 'tell their side of the story' from their perspective, working in a different environment to that of GP practices. Other services within the health and social care system may have different views to those we have heard from General Practice, so it was vital give them a voice to build a wider picture. Involving all the services mentioned by General Practice was key, including mental health services, community services and acute hospital services. Our ongoing engagement with the public ensures we capture their experiences of services. Therefore, in order to get the best outcomes from our limited resources - and with this project engaging with many other services - it was decided that the focus would be to gather detailed professional views.

1.1 Our previous Work with General Practice

General Practice in Norfolk: Working relationships with patients and other services

In our previous work, whilst we were keen to understand patient's views and experiences of accessing GP practices, we also gained valuable insight from professionals working in General Practice. This developed our understanding of those areas of the health and social care system in Norfolk that - in the eyes of professionals - work well and those that require improvement. From patients perspectives we found that the majority (89%) were very happy with their local GP services and 79% of patients felt that they were listened to in consultations. We found that of the 388 patients we spoke to 69% were driving to their GP practice (233) compared to the 1% who used community transport, highlighting the possible lack of awareness of available community transport. Many patients were accessing GP services as their first port of call rather than another service such as A&E. Patients were very positive about the staff working within the tough environment of General Practice. Some recounted difficulties in getting an appointment but this was clearly not the case for all.

After visiting 18 GP practices across Norfolk and talking to patients we also conducted one to one interviews with a Practice manager, Nurse, General Practitioner and receptionist in each of the 18 practices. It was evident that from these staff interviews five key themes emerged:

- IT systems
- Demands on General Practice
- Relationship with Mental Health services
- Relationship with District Nursing services
- Relationship with Hospital services

IT systems were raised as a pivotal concern due to an unequal spread of practices using different IT systems, such as EMIS Web and SystmOne. This meant that there was no common system being utilised across practices, with professionals clearly describing that, as a result, this creates communication problems across the health and social care system. EMIS Web and SystmOne IT systems do not inter-connect; staff said the systems "cannot talk to each other" which means that patient information cannot be effectively shared when necessary. So professionals called for further pressure to be applied for one universal system across the county for GP practices.

Professionals described demands upon General Practice to be unwieldly and a constant battle from day to day, with supply unable to meet demand. Instances were described where service activity has simply outgrown the physical capacity of their building and the building restricts how many patients can be seen. Another example was where practices were being asked by NHS England to take on more patients from their local area. This leads to practices being unable to cope and having to stop accepting new patients, in turn creating a vicious circle beginning to commonly affect practices. Linked to this, professionals were concerned by the high expectations of patients in booking GP appointments whilst also specifying the clinician they wished to see. Staff perceived patients increasingly wanted appointments to suit their own convenience. The workload in General Practice was consistently referred to as 'unmanageable' as a result of rising demands. We were told that the phone lines were always busy, with one practice recounting they can receive up to 400 calls a day, yet it was evident that patients were not using the opportunity to book appointments online. From our observations on visits it was clear that online appointments were not routinely or clearly promoted to patients in practices.

In terms of relationships with other local services there were three main services in Norfolk that staff expressed some concerns about including; mental health services, district nursing services and hospital services. Mental health services seemed to be at the forefront of many clinicians minds and it was widely acknowledged that many staff had concerns regarding the quality of mental health services and the timely nature of their support. Some felt that the support offered for patients could be inappropriate and patients wait too long. In times of mental health crisis, timely access to mental health services can be critical and yet far too often staff described instances where support took too long, with particular concerns surrounding the NSFT mental health crisis team. General Practice noted the challenging relationship they have with mental health services and the importance of developing a good working relationship was vital. In particular reference to one group of clinicians, GPs highlighted their concerns about the confusing state of mental health services in

Norfolk, alluding to the difficulty in knowing the appropriate departments within the service when making a patient referral.

Professionals described how communication between GP practices and district nursing services had been effective and efficient in the past but this was no longer the case. It was felt that working relationships with district nurses had been lost as a result of changes to a new mode of operation through a district nursing 'hub'. In the East of Norfolk they operate slightly differently through a telephone single point of access that acts as a messaging service. However, across the rest of the region dislike for this hub was frequently described and at times seen as a barrier to good communication between services. Professionals referred to the 'stringent criteria' that has been developed to decide which patients can and cannot access the district nursing service. Within General Practice, this had led to practice nurses taking on additional workload in seeing patients who previously would have been seen by community nurse.

Finally, concerns were raised by staff with regard to the relationship between primary care (GP practices) and secondary care (hospitals). We found evidence to suggest that relationships between the two services was strained and communication was also challenging. In particular, the paperwork General Practice received from hospitals was often unclear or incomplete, often resulting in GPs having to double check information. A prominent concern was the additional workload that fell to General Practice as a result of patients having attended a hospital appointment. It was reported that patients were consistently sent back to General Practice for further tests and/or the results of tests. Often the end product of this was a wasted appointment when the GP did not have any results to share with the patient, since the information had not been sent by the hospital. This in turn led to frustration and disappointment for the patient which General Practice staff have to deal with.

1.2 Other follow up work conducted

Therefore, it was clear from our previous work that there were aspects that needed further exploration. To this end, we committed time to undertaking some follow-up work linked to the initial recommendations that we made. As a result of this initial work, we embarked on projects in a further three areas: community transport, patient feedback on health and social care services (Friends and Family Test) and working relationships between services.

- **Community transport:**
  Our previous work with Primary Care and GP Practices revealed a growing concern about the lack of awareness around community transport across the county. This has led to Healthwatch Norfolk working in partnership with the Norfolk County Council Total Transport Project to map and locate community transport. This involved a period of engagement with Practice Managers, Patient Participation Groups and the public to better understand what information they would like about local community transport and how they would like to access that information. All the feedback gathered has been shared with Norfolk County Council to inform the specification and production of a 'one-stop-shop' for community transport. Once this has

been developed we will be working with Norfolk County Council to make people aware of this resource.

- **Patient feedback on services (Friends and Family Test):**
  Our previous work with Primary Care and GP Practices highlighted the difficulty in collecting patient feedback regarding their use of services, in particular through the Friends and Family Test in GP practices. We have been looking at different approaches to gathering more feedback from patients on this service and have been working closely with a GP practice in developing a feedback tool which we are currently trialling.

- **Further working relationships between services:**
  Using our previous work with General Practice as a starting point, we had an opportunity to use what we have learnt from patients and professionals and conduct a follow up project. To help us gain a full picture of the health and social system, we wanted other services to have an equal opportunity to share their views and experiences. These four services are; mental health services, General Practice, community services and hospital services.

1.3 Working relationships between health and social care

The National Health Service (NHS) was first established in 1948 as a 'beacon of hope' in a plan to bring good healthcare, free for all to access across the UK. This was the first time that all organisations were brought together to provide services under the one umbrella of the NHS. The NHS has evolved and it remains "respected and envied around the world", yet it has become a different NHS to the one initially envisaged (EDP, 2016). Today it is reported that the NHS is being tested more than ever before since it began (BMJ, 2016). "Rising demand for care services, combined with restricted or reduced funding, is putting pressure on the capacity of both local health and social care systems." (National Audit Office, 2017, p5).

NHS improvement (2016) also advocates that record-breaking demand for services has been noticeable; services have risen to the challenge of this but further work is required to continue to improve services for patients. As a result, the NHS is struggling to maintain standards of care as the number of patients waiting for treatments continues to grow (Reed, 2017). In reference to the last financial year, 65% of NHS providers (157 out of 240) reported a deficit (NHS improvement, 2016) therefore, it is clear that the NHS is under growing financial pressure and as some suggest it is overstretched. Hospital services are under increasing pressure with a reported average of 89% of beds occupied in first three months of 2016 which rose again to 95% in early 2017 (BBC, 2017). This is coupled with an increasing need for community services; district nursing services are stretched and this can negatively affect patient care (The King's Fund, 2017a). In 2014-2015 there were an estimated 372 million consultations in General Practice alone, which is has risen by 60 million over the last five years (National Audit Office, 2015) demonstrating the strain on GP practices. Finally, mental health services are also struggling with bed capacity and coping with patient demand. In 2014-2015, 1,835,996 people were in contact with mental health services, revealing an increase of 4.9% from 2013-2014 (Health and Social Care Information Centre 2015).

It is clear that across the health and social care landscape today all services are affected by increasing service demand and this is no different for Norfolk. Dedicated and committed staff are working hard to get the best outcomes for patients. It has been suggested that it is their hard work and goodwill that has enabled high quality care to be delivered, but for how long can this continue? (The King's Fund, 2013; The King's Fund, 2017a; Reed, 2017; EDP, 2016). A new phenomenon is the ongoing pressures that are felt throughout the year, rather than in previous years when pressures upon the NHS increased across the winter months:

> "*As we entered 2017, we are presented with a clear picture of what happens when health and social care services struggle to meet demand, with widespread reports of ambulances queuing in car parks, people stuck on trolleys, cancelled operations and staff working long hours to keep patients safe. These are not challenges exclusive to winter. Our health and social care system is under increasing pressure throughout the year leaving little flex to respond to the peaks in demand by cold weather or winter bugs."* (Royal College of Physicians, 2017, p2).

It is increasingly important for the NHS to work as a whole system rather than the current often poorly connected silos (DeBene, 2017). Clear communication becomes even more vital between services, to enable joint working. We are currently living in a changing world of communication with information channelled to us 24 hours a day through smartphones, tablets, internet and emails. Yet, despite all these advances there are many challenges facing communication (Gallington, 2017) particularly so in the NHS. To improve patient care, data sharing and the exchange of information between services is vital, yet this is not a new prospect, the first information technology (IT strategy) for the NHS came about in 1992 and again in 1998 and 2002 (The King's Fund, 2016). The latest programme calling for a single electronic care record for patients connecting primary and secondary care across one IT system. However, this is not a current reality for many NHS services despite Jeremy Hunt's challenge for the NHS to go 'paperless' by 2020 according to the NHS five year forward view. Yet patients do expect services to be working closely together and sharing information (Glasby & Dickenson, 2014).

The NHS should not be focussed on one area of health such as bed capacity, A&E or dementia; it is about emphasizing the whole health and wellbeing of local people and therefore there is a need for collaboration and partnerships working across all services to guarantee the best care that benefits patients (DeBene, 2017; The King's Fund, 2017b). DeBene (2017) believes that there is still work to be undertaken to reshape the NHS to focus upon the needs of patients instead of organisations, valuing the importance of joint working across the NHS. If you are a professional working in this environment the work will involve working with other services and professions, consequently, this illustrates that working together is a necessity (Glasby & Dickenson, 2014). "*Across the sector there needs to be much closer collaboration between specialists and generalists, hospitals and community, and mental health and physical health workers*" (The King's Fund, 2013).

Suggestions indicate that progress is being made by some at a local level in joining up health and social care services (BBC, 2017), yet this can be patchy. Whenever patients and the general public think about their health and about health and social care services in general, they are aware that there are many professionals involved from different services and agencies. Most patients they do not make a distinction between 'health care' and 'social care' (Glasby & Dickenson, 2014). Patients just

see themselves as having a need that requires some support and as a result want to be seen and treated by a professional in a timely manner.

Glasby & Dickenson (2014) also suggest that the general public may not differentiate between services or professions, as to how the NHS (health and social care system) is structured or whether it is nurses or physiotherapists they see etc. It does not matter to them. Yet in contrast, for professionals working in health and social care it really does matter, particularly when they are working within a system not initially designed for integration and collaborative approaches. This can become frustrating for professionals and may result in a poorer patient experience due to services not feeling connected and integrated (Glasby & Dickenson, 2014). They also imply that when services are not joined up it can lead to poorer outcomes such as duplication, gaps in service provision and wasted time. Equally patients do not like to have to repeat their story for every new professional they come into contact with, especially if they are in pain or unclear on what is happening, yet they are being batted between difference services.

2. How we did this

2.1 Project aims

We have been keen to further understand how relationships between local services can affect people's experiences of care within Norfolk. To encapsulate experiences this project is closely entwined with our previous work: *General Practice in Norfolk: Working relationships with patients and other services (Part one)*. Initially we specifically gathered General Practice's perspectives, composing a detailed examination of one segment of our health and social care system. There are many other segments within the health and social care system in Norfolk comprising of a range of other organisations such as; community services, mental health services and acute trust hospital services to name but a few (see figure 1). All services hold a view of their working relationships with General Practice and this gave us a means to develop a clear understanding of interaction between services.

Therefore, this project has acted as a follow up to our previous work to understand other services perspective of working with General Practice in Norfolk. This has highlighted the other side of the story from different perspectives amongst professionals working in the health and social care environment.

Figure 1. Health and social care services

Three questions were formed for the outcome of this project:

- What works well and what causes difficulties for professionals, when working with General Practice?
- What works well and what causes difficulties for professionals, when working with other services?
- What effect does this have on patent care and experiences?

We wanted to learn from professionals across services as they can provide a valuable insight into patient care.

2.2 Project approach and development

The success of our previous work *General Practice in Norfolk (Part one)* was due in part to the methods we used which proved fruitful for the questions we were trying to address. With this in mind, we decided to adopt a similar approach to this follow up project. However, rather than combining a mixed methods approach, this project focussed on a single line of enquiry by utilising a qualitative method to query in-

depth experiences from professionals, working in local health and social care services.

This project focused on the involvement and cooperation of many other local services to gather their views and experiences. Throughout the project we involved six key stakeholders: Norfolk and Norwich University Hospital (NNUH), Queen Elizabeth Hospital (QEH), James Paget University Hospital (JPUH), Norfolk and Suffolk Foundation Trust (NSFT), Norfolk Community Health and Care (NCHC) and East Coast Community Healthcare (ECCH). Allowing voices to be heard across the health and social care system including local community services, mental health services and acute hospital services.

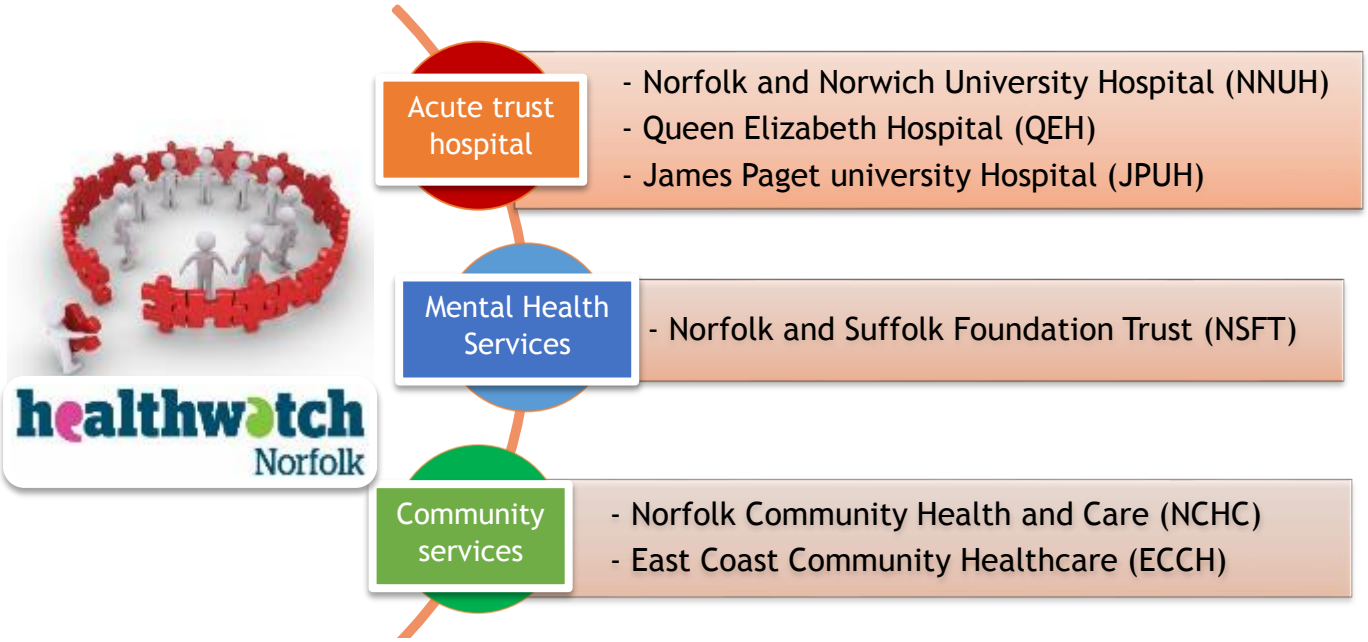

Figure 2. Services involved in project

With those six stakeholders in mind we wanted to ensure we spoke to the relevant people working with patients who also had experience of working with General Practice and other services. In the first instance letters were sent to the six Chief Operating Officers of the organisations, requesting involvement from them and their staff. The key to this project was finding the roles and individuals that would be most beneficial to engage with, to answer our questions through sharing their experiences in a series of one to one interviews. Therefore, we asked each organisation to propose three individuals that it considered were the most appropriate people to participate in interviews. We hoped that this would lead to working with a total of 18 professionals throughout the course of this project, on a one to one basis.

On the whole Chief Operating Officers responded promptly and were keen to be involved in our work, providing suggestions and contact details of staff in their organisations that we could contact. Initial contact was then made with a range of staff across NNUH, QEH, JPUH, NSFT, NCHC & ECCH through introducing Healthwatch Norfolk and the work we were conducting.

2.3 Professional Interviews

This project focused on looking at the complexity of the health and social care system in Norfolk and the interface between services in the system. Focusing on the working relationships and our previous findings from General Practice, a set of initial interview questions were created. The next step was to consider service user reviews and comments drawn from our Feedback Centre which includes comments gained through our general engagement. Together, triangulating feedback from different sources enabled us to identify recurring themes. Using all this information to create some interview questions which we then piloted in our initial interviews with professionals.

Once some interview dates were confirmed we used this step to initially pilot the project and test the interview questions with professionals, when meeting them in person. This enabled us to make some appropriate amendments to the conduct of the project.

Individuals were contacted according to the suggestions from the Chief Operating Officers. It was evident from our initial pilot that it was vital to involve staff working in the frontline of services that had contact with both patients and General Practice. Consequently, when making initial contact, we outlined the importance of this, which often led to additional staff also being involved. Many professionals proved hard to contact due to their roles and nature of the busy daily working lives and environment they worked in. As a result, it took longer than anticipated to arrange all the planned interviews which had a knock-on effect in terms of the project timeframes and deadlines.

In each of the six organisations we spoke to a range of professionals using one to one, face to face interviews which enabled detailed explanations and experiences to be shared. These interviews provided a good opportunity for the project aims and purpose to be explained clearly and any questions to be raised by the participant and addressed. Interviews were facilitated by the same Healthwatch Norfolk researcher each time, enabling a consistent approach throughout, whilst utilising an informal style to encourage participant's open and honest expression. We had planned on speaking to a Director of Nursing, a Medical Consultant and a Head of Therapy from each provider but these suggestions often proved difficult to comment on the working relationships due to the senior nature of these roles, therefore lacking the frontline experiences. The professionals we interviewed had varied roles across each of the organisation with some similarities that could be found, in each we tried to speak to someone in therapies, nursing and consultants to enhance the array of insight that's demonstrated across services.

All participants received an information sheet about the project and consent form prior to the interview and again on interview day. They also received a themed list of topics we wished to discuss during the interview, before meeting (Appendix 7.1). To limit the need for note taking all participants were asked to give informed written consent to an audio-recording of the discussion, to capture detailed comments in full so they could later be transcribed. Interviews took the form of a semi-structured discussion with some key questions ensuring the interview took 20 minutes. This was

vital as from the previous work we learnt that keeping interviews tight and succinct allowed more professionals to be involved purely because of how busy they are. Professionals were asked a range of questions which remained the same for all participants on the following topics:

- Relationships with General Practice
- Communication with General Practice
- Communication with other services and referrals
- Things that work well and not so well with the system.

2.4 Data processing and analysis

The interviews were recorded and securely stored. Recordings were then transcribed using TranscribeME into clean verbatim. The transcriptions were then transferred into Microsoft word documents and input into NVIVO v.10 for content analysis. A conceptual coding model was defined and developed by the initial interview discussion guide and questions and refined to mirror the content of the transcriptions. All transcripts were manually coded and information was organised into the coding model (please see Fig.3 below).

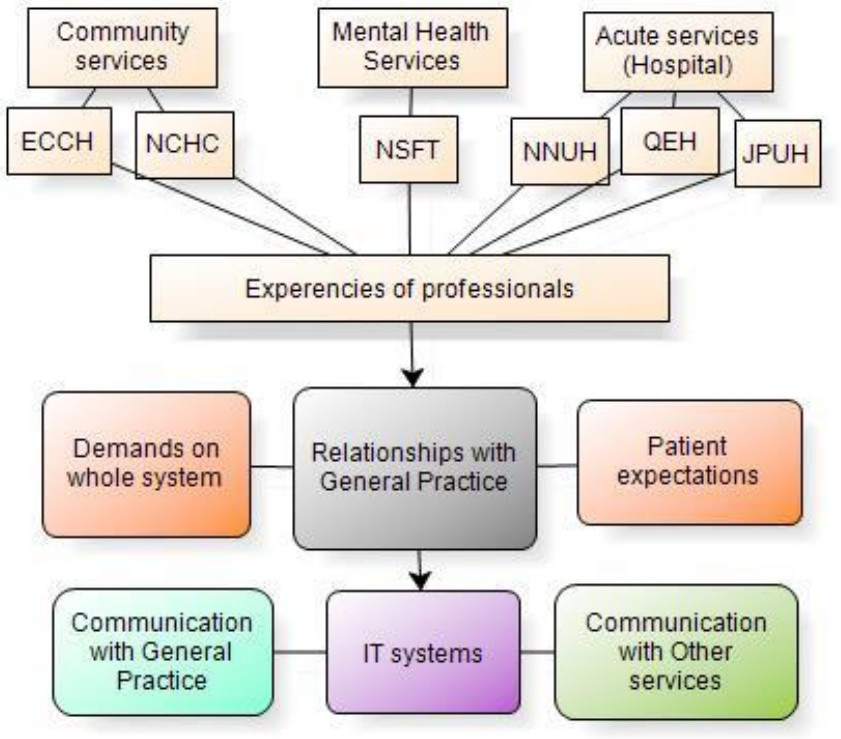

Figure 3. Model for categorising and coding content.

2.5 Strengths and limitations

Healthwatch Norfolk recognises that this project work has some limitations. This project provides a snapshot of local services from the eyes of professionals working with the wider system.

Strengths of the project:

- A follow up piece of work that portrays the other side of the story, enabling us to develop a system-wide view of services when our previous work is combined with the findings of this project.

- This was an in-depth system wide study, which used a qualitative methodology based on a key line of enquiry on working relationships between services, enabling us to capture rich detailed information from the perspectives of professionals.

Limitations of the project:

- All staff interviewed in the project were selected by Chief Operating Officers of their organisation, so it was likely we would meet people with strong views about health and social care systems.

- This is a snapshot of professional's experiences and is highly dependent on who we spoke to and the roles they held within NNUH, JPUH, QEH, NSFT, NCHC or ECCH.

- When working with so many organisations is was evident that each have their own priorities; therefore it is recognised these individuals may hold very different viewpoints across the system and have differing aspects they want to share in their experiences of working with their organisation.

- Engagement with local services proved difficult at times due to the busy nature of staff working in the NHS, their role and availability, which was further compounded by the strain across services.

3. What we found out

3.1 Participants involved

All professionals involved in the project worked within health and social care services across Norfolk: NNUH, QEH, JPUH, NSFT, NCHC and ECCH. The focus was on professionals working on the frontline caring for patients and interacting with General Practice on a day to day basis. The professionals were from a variety of domains such as: nursing, accident and emergency, service co-ordinators, therapies, discharge and consultants. As a result our findings from this project were dependent on what staff we spoke to therefore shaping and influencing the experiences we heard. A total of 32 NHS staff were interviewed during 28 sessions, 3 of the 28 interviews were conducted with pair of staff (see Table 1).

Table 1. ***NHS staff interviewed.***

Organisation	Number of staff involved	Number of one to one interviews	Number of Paired interviews
NNUH	4	4	0
JPUH	5	3	1
QEH	5	5	0
NSFT	6	6	0
NCHC	6	2	2
ECCH	5	5	0
Total	31	25	3

3.2 Professionals' experiences across Norfolk

3.2.1 Working relationships with General Practice

Working relationships between health and social care services are important across the wider system and is key to enhancing and improving patient care. This project has placed a spotlight on the working relationship of some services (community services, mental health services, and acute trust hospital services) when working with General Practice in Norfolk. The majority of professionals expressed that on the whole they felt they had good working relationship with GP Practices: *"I think by and large it is cordial and we have a good working relationship"* and *"We have a good relationship in terms of being able to communicate quite effectively with them."* Others highlighted a good professional relationship when visiting patients within the community: *"So on the whole…at ground level we have a reasonably good relationship with them to make it work."* and *"The professional relationship with the GP when they come out with us and do visits with us, generally is good."*

There was a sense that GP Practices are communicating and working with other services as best they can. Services were able to gather information efficiently and effectively from GP practices. *"Every time I've ever spoken to any GP practices. It's always been very good, and they've always been willing to help…So they've always been very good in giving us information quite freely."* One restriction apparent at times was how the working relationship can be influenced by the capacity and staff available within practices, due to the increasing demands placed upon the health and social care services in Norfolk.

> *"I would say that for our staff, they are working closely every day with the GP surgeries. We see patients in the main, our GPs have referred to us. However, it depends on the relationship with the surgery, that we have as an organisation and from a nursing point of view have…some surgeries are much more open to our staff than others are." [NCHC]*
>
> *"…because it's important that we get that working relationship between someone who they can go to. I'm the lead nurse of three surgeries. So I have a pretty good relationship with those surgeries, but I wouldn't necessarily say that, that relationship was with the GP. To me it's the front line, so it's the receptionists. So if I say, "Oh, it's so and so," they know who I am, and they try to be as helpful as they can." [ECCH]*

Many organisations highlighted that they often work closely together day to day, with some recognising improvements in working relationships developed over time amongst services: *"I would say that it's improving."* and *"I think generally the bridges have been built and I think the two-way, it works quite well."* However, it was highly evident that the working relationships developed can be variable and mixed across the county, often developed with the frontline of a GP practice. With so many GP practices all working slightly differently displaying varying levels of engagement from practice to practice, experiences can be fickle: *"They're all very different. I think that's the key bit. On the whole, we probably get on well, but it's been mindful that each practice does it different, and it's trying to do best to work in with their systems."* and *"…So it's very difficult to generalise for all of them."*

> *"…I think on the whole that the local teams do work together because they all really care about the patient's care and want to do the right thing for the patient. And that does normally drive relationships and conversations." [NCHC]*
>
> *"The patients come first at the end of the day, don't they? Generally, the surgeries that I'm with, with the exception of the one that's having staffing problems, are pretty good and try to be as helpful as they can." [NCHC]*

Consequently, some deemed working relationships with General Practice to have caused friction between services, leaving working relationships damaged and lost. This may have led to challenges for all services for whom are working together to get the best outcome for the patient: *"Sometimes there are issues with both sides*

are busy, and there may be problems with communication from the team. So sometimes that causes a bit of a friction, but it is understandable, I think."

> *"And we're often like, "Oh, we'll hover right outside their [GPs] door." That's what we're told. So that persons not expecting us. So in-between a patient I'm having to hover out, so he's annoyed straight away, as soon as I walk in the door, because he should be calling his next patient in but he can't because I'm outside his door." [NCHC]*
>
> *"We have some frustrations, not all the time, around drawing up syringe drivers. So when a patient's maybe discharged home from hospital, then they will have a syringe driver chart written, but it's the hospital as well as the general practitioner's…that's not prescribed as it should be, so that all the time you might not get diluent on there. You might give this dose but you won't get any increment. So, say you went out the next day and this person was in pain. Well, you can only give set dose, you can't increase it. Whereas our drug chart specifically have increase by into a max of, to give us scope as nurses so we don't have to call the doctors all the time. And when they haven't done them for a while, they get a little bit rusty at doing them, and often they do them wrong. For example, last week a colleague had to go and see a GP three times before it was written up correctly. And you can imagine the GPs getting really frustrated with us, we're at the front line. We're very often than not, having to say, "You need to do this," and that's not really our job…I mean, we know they're busy, and we understand that. And I think you have to understand that. When I'm given a patient to do a syringe driver, I get 40 minutes for that. That includes my visit, my travel, and my documentation. So that doesn't give me 25 minutes to spend with the doctor until he gets the drug chart right…" [NCHC]*

Staff suggested there has been some difficulties in the past: *"I think it's true to say that relationships with general practitioners in the area and [community services] have at times been a little bit fraught…that's one of my roles to try and bring us closer together"* and *"What I would say is that we know there have been problems in our relationship between us and General Practice."* Others echoed this by highlighting working relationships were no longer as close as previously but equally hoped that in time this would be enhanced.

> *"…I guess personally, in comparison to previous years…I would have described it as pretty close. But I think in recent years, because we've undergone some changes over the last three to four years, for me personally, its made things feel more distant with less direct contacts. But having just gone through other, further recent changes, I think, one of the key parts of that being that we're going to be closer to the GP surgeries again, which we all think is a good idea, I'm expecting it to become closer again. That's the hope." [NSFT]*

"Relationships with GPs in general in Norfolk have been strained. I've come from a primary care background where me as a mental health person/worker used to work heavily in the surgeries, and I struck up very good relationships with the GPs by having that close contact. With changes in contracts and things like that, obviously, that service was pulled some years ago. So now what I'm seeing is a complete removal of that relationship. We don't see each other, as in colleagues. That's my overall impression, what I'm seeing very much is there's a big rift. And yet, when it comes down to the…if you actually do get to speak to people, actually we're all trying to do the same thing, but distance and out of sight and out of mind, you are a faceless service. So we don't have overall good relations with GPs." [NSFT]

3.2.2 Communication with General Practice

Contacting GP practices via the telephone

For some staff communication with General Practice usually proved to work well, through regular contact with GP Practices. Often daily contact regarding queries or concerns about patients, care plans, medication or other issues were reflected on positively, including the exchange and requests for information across services: *"I haven't had much come up to me that's a real issue about getting relevant information."* This supports the earlier indications that working relationships with General Practice on the whole can be good bearing in mind this can vary from practice to practice. It was expressed that communication with a GP Practice on the whole worked well but difficulties may arise if you needed to speak to a specific General Practitioner (GP).

> *"Just pick up the phone and you can speak to reception, who generally pass the message on or document on the records they have in the SystmOne. It's generally quite easy. We don't really have a problem like that and it's specifically if you wanted to a specific GP, I think, that's more where the problem comes. So, actually getting to the surgery itself is quite easy. You can try and call or you can just drop in…"* [NCHC]
>
> *"Yeah. Absolutely. I think for those that phone in and/or when we have to contact, I think it's very positive. And there is definitely a drive to want to communicate and work better, but what seems to happen is that that's not always the case. Nothing is sort of routine and there isn't always that sort of pathway."* [JPUH]

However, this was not shown to be the case for all professionals' experiences, particularly when it came to communicating with General Practice on the telephone. A large proportion of professionals recalled the difficulty involved in contacting GP Practices across the county and the barrier this can then create to receiving timely and efficient information about patients or to patients getting access to another service. Staff felt this was a concern because there is often only one telephone number for a GP Practice. This number can be operating a telephone queuing system and staff can be on hold for long periods of time, before any initial discussions with a receptionist. It was felt that a direct line for professionals may help this process.

> *"I would say its hit and miss depending on what the GP practice is. I guess one of the things that's always quite annoying is the fact that most GPs don't have a number for professionals to phone, that you have to go through their normal switchboard process. And obviously, if you're wanting to try and phone a GP at peak times when patients are wanting to get appointments, you can be on hold for a very, very long time before you actually even get to talk to a receptionist. So the ability to have a phone number that professionals would be able to kind of get through that queuing system would be really helpful."* [NNUH]

Despite this, staff felt that receptionists do the best they can to address their concerns and pass on messages, but it was evident that this can lead to frustrations when there is a lack in timely response. As a result this can lend itself to a very time consuming process for the professional involved in trying to communicate with the GP.

> *"I don't think it's the receptionists that block, to be honest. I think the receptionists generally are quite good with us. They'll certainly give us information, and if they can't help, they'll put us on to someone. They'll try and get through to the doctor. But I think it's…yeah, I think if the GPs are busy all the messages maybe don't get through. Then we don't hear back. And then we try and phone again and it could take…it can be very time-consuming to try and get hold of GPs. But I don't know how you improve that."* [ECCH]

This is further complicated by the busy environment of a GP Practice with many patients to see and at times the practice can be under extreme pressure. Typically GPs are in clinic seeing patients most of the morning, then they may be out conducting home visits away from the Practice in the afternoon, so trying to speak to a GP and matching availabilities of professionals can be very difficult: *"I think the main difficulties everybody's busy and sometimes trying to get to speak to the GP can be a bit of a challenge. Generally we leave a message and they will call us back."* Particularly so when considering the busy environments that all other professionals are working in, such as A&E. *"I think it's getting hold of the right people at the right time because everybody's busy, so that's always a challenge."*

> *"Or we try to phone, but phoning, for me to phone a GP and for a GP to phone me it's actually really difficult. Because, if they're not with a patient, I'm with a patient. And it can go three days batting backwards and forwards, basically. So it's not great. We could really do with email…because the communication is always difficult. It's always difficult and very often it is stuff you can sort out on the phone in ten minutes, five minutes."* [NSFT]
>
> *"I won't say it's difficult. At the same time I wouldn't say it's easy, either. Yes, particularly, we are busy. Sometimes we have to get to the phone and talk to them, and they might be seeing a patient, or they're might not be there. It might be their admin time, or they might be in surgery. They might be busy otherwise. So yes, it can be a problem, but not always. Sometimes they're easily accessible, it's not always that they're not. But it is not always easy. Otherwise, we can always leave a message to their secretaries. That is not a big problem, but direct communication, yes, it's not always possible."* [QEH]

Associated with the busy working environments, it was also evident that a GPs' workload can also have an influence upon timely responses when communicating across the health and social care system. These all present as factors that can make the direct communication with GPs very difficult. Principally it was expressed how difficult it can be for professionals to relay the urgency of a situation to a GP. Particularly due to patient confidentiality, meaning they cannot disclose any patient's circumstances during initial discussions with a receptionist working within a GP practice. This suggests other forms of communication may need to be considered, especially in relation to the IT systems that services are using.

> *"And I think sometimes its priorities, isn't it? We know, obviously, the GP surgery is very busy, but when you're in a patient's home, and that patient is very poorly, and all you want to do is get the okay to do something, when you're sat there waiting with the patient. I've been waiting with a patient for up to an hour before, before I've got a call back. And actually, I've already done it before the GP's rung me back because actually, you have to go with what's best for that patient at that time."* [JPUH]
>
> *"…It's quite difficult because they're obviously time restricted and they've got their own work to look on as well. So you're logging an extra thing in which tends to get put on to a list. Especially for the on calls you'll get put on to the list. And it depends how urgent they see your request, really, as to whether it gets dealt with quickly or not."* [NCHC]
>
> *"Sometimes that can be a block in practices because the nurses will pitch up if they're particularly worried. They will pitch up and then ask to see the GP and there can be some internal bocks at that, actually getting access to the GP, especially in palliative care situations because they can become crisis situations quite quickly, actually. And you're doing everything you can to pre-empt that. So that can be a block. Yeah, otherwise, they were usually really quite responsive. It's the urgency, I suppose. Sometimes it's a difficulty getting across the urgency…but it's for the surgeries to understand that we're not working against them. We're trying to work with them for the benefit of patient care because that's what we're here for, really."* [ECCH]

Conversely it was evidenced that some GP practices may be aware of this issue and have been forward thinking in setting up specific times for services to contact them, giving them direct access to a GP which had proven to work well.

> *"Well, there's a couple of practices that we have that have certain times that you can contact. We have hour sessions…there's two practices that we can just ring through within them hour time-frames and we'd get straight through to the GP. So that expedites things quite a lot."* [NNUH]

Communication out of hours can be difficult

Our results seem to indicate that there are times when attempting to contact General Practice, in particular specific GPs, can prove challenging. In addition concerns were raised stating that any communication with General Practice 'out of hours' was extremely problematic. In this instance professionals emphasised the complications caused when services are not open, thus halting communication. It was raised that GP Practices are not operating the same opening hours as other services, so complications arise often due to the lack of available information regarding a patient. Other services have no other means of getting further information, for example if a patient comes into the hospital early hours of the morning via A&E or on a weekend then GP practices are closed: *"Well, during hours because we can just phone them up. But obviously after hours, it's a bit harder because they're not open."* and *"…so that's when this communication can break down a bit when you go into the out-of-hours period."*

> *"If we phone the GPs that are open - which obviously is our issue that we're open 24/7 and GPs are open for 50 hours a week - but if they are open, then we normally often phone up and get receptionists to give us medication lists or to fax stuff across to us, and that does work quite well. And the frustration comes that if they're shut, we have no way of getting information. So if we could get access to…if they eventually do some centralised notes, then we can get access too, it would make a big difference."* [JPUH]

This implies that in these 'out of hours' instances there may be the need for IT systems to work more effectively than they currently do, across all health and social care services so that access to information is possible during these times. So that services don't feel the restrictions and constraints outside of the normal 9:00- 17:00. This also can have a knock on effect on a host of services particularly at weekends where services are unable to provide timely discharges for patients into the community due to the lack of GPs available.

> *"We struggle with weekend discharges and supporting discharges on a Friday especially to care homes and things for our sicker patients because of the lack of GP cover over the weekends and stuff. And the care homes don't feel supported at a weekend to be able to take a patient from us on the Friday so they often sit here until the Monday when they'll take them back which obviously blocks our beds over the weekend for new admissions."* [NNUH]

It was evident there can be frustrations concerning primary and secondary care communication due to additional workload sent to hospitals at the "front door" - the A&E department. Staff felt that A&E is often seen as the "mop up for everything" with many instances where patients are sent to A&E if unsure and in other circumstances, rather than being referred to an appropriate speciality team. This

can impact on the capacity and demands placed in secondary care and it was felt that often there is very little information that follows that patient to A&E. As a result of little if any communication between primary and secondary care in acknowledgement of a patient being signposted to A&E. Again this evidences the concerns that IT systems are not utilise effectively across all health and social care services.

> *"…we do get quite a few patients sent up by their GP without any sort of information. So they don't always come with a letter. They don't always come with their sort of medication or background history. A lot of them who attend fall into a telephone consultation. So that's probably the reason we don't get letters on those patients. But equally, the GP hasn't…so they never let us know in advance. We just know when the patient turns up."* [NNUH]
>
> *"Some of the GPs are really good and they'll phone when they're sending patients over in. Some of them, well quite a lot of them, will send patients in because they can't get hold of a speciality team because the specialty teams refused a referral or…it's proving too much effort, shall we say, to contact the specialty teams so they'll just send the patient in. Some with a Dear A&E Doctor letter, some without a letter, or the other thing they do that we get very frustrated with is they say to the patient, "Take these antibiotics for 24 hours, and if it's no better, if it's worse, just go straight up to A&E and they'll get you sorted out." The other issue is patients waiting a long time for hospital appointments. Again, the patients will tell us that the GPs say to them that if you go pop up to A&E they'll be able to sort that out for you."* [JPUH]
>
> *"So those are the frustrations that we have. And we have tried to address it with the CCG, and we have got the CCG to send out generic emails to GPs to say, "Please can you phone up before referring patients in?" Which some of them do and some of them don't. And they'll phone up and discuss and then quite often, we'll say, "Well actually, that sounds medical and that sounds surgical. Can you refer appropriately?" So that's the frustration we have. And the main issue for the patients is that then they wait longer because instead of being sent to see the surgeons and being seen straightaway by the surgeons, they come up, they wait two and a half hours to be seen by A&E, then we wait two hours for investigations to be back, and then they get referred to the GP. So the surgeons are four and a half hours, and so not being seen by the surgeons straightaway. So it's not good for patients and it clogs up our system as well."* [JPUH]

With reference to communication with primary care, secondary care did recognise that there are some issues and improvements needed in their communication with GP practices, in particular concerning their written communication. Certainly there was clear recognition of General Practice's views on this issue. This supports and ties in with our previous findings from General Practice, echoing their trepidations regarding the paperwork they receive from hospitals and the timely access to it. Once again the use of discharge summaries was highlighted as an area in need of improvement for some. *"They're really good with us, but I think they'd probably find*

that we don't communicate particularly well with them, and our summary letters are poor…"

> *"Hit-and-miss. Some are really good, others not so good. Once you're past the receptionist, if you get to the GP point, they'll always give us the information we need. I think from our point of view to them, we could be much slicker on our discharge letters and things that go out because we try and make sure a patient has got a copy, but sometimes one is automatically generated for the GP, but then sometimes that does take several days, so they get a patient report back to them and they know very little about the admission and stuff. So I would imagine from a GP's perspective, that's frustrating."* [NNUH]

However, it was clear that some organisations are trying to address this issue, resulting in changes being made in trying to make this process productive and much smoother for all professionals involved. It was rumoured that improvements were afoot regarding better access to advice and some hospitals are beginning to utilise electronic discharges which often meet the requirements in the hospital contract to be provided to General Practice within 24 hours.

> *"Obviously, the key thing is about communication. So, I guess an example of something that we've done within speech and language therapy is that we now input directly onto the electronic discharge letter. So obviously all patients when they leave hospital, should have media written for them. We were finding that we wanted to make sure that information was timely and it was accurate. And therefore, as a consequence…any patient that we've seen, we would write directly on that electronic discharge letter to make sure that that information goes to the GP and that they're aware of our recommendations. So I think it's about ways of trying to find out good communication, but I'm not aware of any big issues within the world of therapies around GP engagement."* [NNUH]

Reliance on longstanding methods of communication

One individual highlighted at times the best way to communicate with General Practice is through the written word, then that may ensure that the clinician (GP) receives the information accurately; *"…it is easier to communicate by letter. But I'd say, really you'd want to be able to have that conversation over the phone sometimes. But actually the only way that it's going to get addressed quickly is by letter."* This also resonates to the significance of a reliance upon longstanding methods of communication. We were told that across some organisations in health and social care services in Norfolk professionals are still reliant on longstanding methods of communication to share information.

It was often recalled the need to fax information to General Practice; *"It is really difficult, actually, because we have some very antiquated communication systems, you see. Either we want to get to talk…or we, if it's more urgent that we fax, we must be the only people who still use fax…we're faxing quite a lot."* However, it seems this may vary from practice to practice, as every practice seems to work slightly differently; *"Whereas other GP surgeries will ask us not to send faxes, to*

phone and speak directly to the GP, which, obviously, sometimes is quite difficult to do."

> *"They also want to have consultant opinion all the time, which obviously, we've got very few consultants. So again, it's very difficult to get them to take any suggestion from us without having something faxed to them. And faxing, obviously, as we know, is such last century stuff. But anyway, so we have to then send things that are signed and faxed over, so. And that isn't always to our fingertips to do. Because depending on where we are, in the patient's home, often we can't get a patient seen which is always difficult. So if we think they're physically unwell, we can't always get them to have an appointment or get the doctor to go ahead and see them…"* [NSFT]

It felt quite shocking in that across Norfolk, the NHS doesn't seem to have caught up with technology in the 21st Century. This may also be as a result of the IT systems issues that seem to both hinder and surround communication between services, as without access to a system that stores all the information in one place, services have had to find other means of sharing information, for example; *"We're still using very archaic methods of communication because of the different IT systems, so we can't task anybody on the same system to do something."*, *"I think most of…our lists are faxed at the moment still. But I'm hoping there'll be a direct link between our computer system and the GP. So it'll just go straight across onto the patient records."*

For some GP practices there seems to be a reliance that services fax through information or requests; *"…obviously, we deal with a lot of medication changes and things like that. They prefer to have a written copy of what we want them to do, why we want them to do it and, actually, they're happy to do it."* Some seemed to suggest that it gets things done quickly and works well, yet this may not be the case for all professionals. In contrast if you contemplate this may not be the best method, for instance for those working within community services. Routinely these professionals will be in patient's homes, out in the community seeing patients day to day and therefore are often classed as mobile workers. As a result asking to fax information across can cause complications and at times delays to patient care.

> *"We do have one particular surgery that are busy, like we all are, and it's just very difficult to get things done. Say we needed some cream for a patient, then instead of just phoning up and saying, "Can we have this cream?" We've probably had it 10 times before, we know what creams that we use. It's ah, "Well, you have to fax it." Well, we're mobile workers so we don't have a fax machine. So that involves us coming back to the office, having to get it all written, faxed. It's just not realising that actually, that's making are life quite difficult. You think about how many faxes we have to do. I mean, we cover about five surgeries and there's only like one or two that want us to fax. The others are fine to take verbals over the phone. So it's like that consistency between people and actually understanding that we are mobile workers and we're trying to work effectively. And actually, that's not effective use of our time when we're having to keep coming back and finding a fax machine to be able to send them requests when there could be a better way of doing it."* [NCHC]

General Practice and referrals

Confusion from GPs of where to send patients in the Mental Health service

In particular reference to GPs, mental health service professionals expressed their concerns about General Practice's difficulties in understanding and navigating mental health services across Norfolk. Akin to our previous findings from General Practice, it was evident once more that (from mental health services view point) GPs found it difficult to know the appropriate departments within mental health services that patients should be referred to, in order to receive the best care. *"…we [NSFT] think we've communicated it and they [General Practice] don't."* Again highlighting the vital need for clear communication pathways between GP practices and mental Health services, that don't currently seem to be a reality in Norfolk. So it is clear from our previous work and this report that evidence suggests that something needs to be done to address this issue.

> *"I think one of the biggest difficulties is people understanding what it is that we can offer and do well and what isn't appropriate for us. And when you've got that gap that doesn't sit in secondary service, doesn't sit in GP service, so what do we do? That's where I think the angst can come."* [NSFT]
>
> *"…the limited time that we have to have face-to-face, we need to make better use of it…But from my position, I think we are getting better. We've recognised there's an issue. But I don't think we've got anywhere around to solving it yet. And it might be that we can't make it perfect. But the more we are able to say, "This is what we do, and this is what we do well," then people will understand what is appropriate. But it does leave a gap."* [NSFT]

It was also recognised by staff within NSFT that the way their service is commissioned and its many different components can cause a confusing picture of its service to others; *"and you've also got different CCGs that commission different service. But we're one trust across two counties and many CCGs. I know they've got STPs which should hopefully draw that. And I think it's recognised that that's not helpful."* Some staff emphasised that mental health services need to use a stronger voice to make it clearer what they can and cannot do as a service.

> *"And we've got a bit more of a strong voice in what it is that we do. And we'll do it well, rather than being the jack of all trades which I think being the underdog of services, we tended to be. But I think that we are getting a better voice now, but the voice needs to make sure that we clearly communicate what we do, not what people might wish that we did."* [NSFT]

One staff member highlighted the difficult reality for GPs to know of all the services available across Norfolk, because there is so many. They suggested that often GPs may be unaware of a new service and whilst working within health and social care services it can be difficult to know everything. Therefore, communication proves

vital and often at times awareness of new things can be communicated through practice managers and not directly with GPs.

> *"I think the problem is communication. So because of having a fantastic resource - I like to call myself and my colleague - having a really fantastic skillset. The problem is that some GPs will not know about the service because of the volume of information you have to get in. So we have done communications strategies and programmes, whatever, with every practice you'd know. If the point of contact is the practice manager and then poor him or her is filtering such a tsunami almost of data information, how do they know what's important, and what the GPs will want to know? And what's old news and they're just not interested in, and what's new news? So there are patches that seem to not know."* [NSFT]

There was evidence that demonstrated mental health services are trying to involve GPs more across the county and have made some of their current changes as a result of talking to GPs, on what they want from the service, which seems positive. We were also told that they propose to hold GP engagement evenings as an opportunity for GPS and NSFT to work together and learn from each other. Again this seems a positive process to enable a more collaborative approach across services. Yet our evidence implies that in reality there is the need to address what mental health services can and cannot do, as one professional recalled his experience of talking to GPs about these plans.

> *"We're going to have an education evening for GPs. When I was [in a meeting] talking to GPs, I said, "Our trust wants to engage with you. "Our trust wants to educate you. What can we do? What can we offer? Have you got burning issues?" And these very qualified GPs, partly CCG, might answer differently to nearly qualified GPs, but I'll take it from their perspective. They're like, "We don't need education, we're GPs. we deal with 90% of mental health problems happen in the community. They don't happen in hospital. And we're very experienced." And I was saying, "Well, I'm a GP and I know that. What can we help you with?" [They said], "We don't need education. We know what we're doing. What we need to know, what you can offer us, is how we navigate your trust." [NSFT]*
>
> *"But it seems like engagements quite difficult because GPs are so stretched or frustrated and have given up time to communicate with the trust. Because it feels like, "Oh, I'll write a letter. And I'm a GP of 20, 30 years' experience. This patient needs a community mental health appointment and a psychiatrist and this and this and this." And of course, triage or the front door, which is meant to make it simpler. It's like, "GP, don't worry. Just send it to our front door. We'll do the internal stuff." Well, it doesn't end up at the team that the GP wanted. And 9 times out of 10, the GP's been absolutely right. This is a complex case. Six sessions of IAPTs is not going to help. They need longer term follow-up. But of course, that's what's being cut, is the longer term key coordinators, link workers. And in their absence, unless they're really unwell, then they're pushed back down to primary care wellbeing. And then there's frustrations for the [GPs]. So I think the GPs are doing a really good job. And I don't question the level of education. And I think that was words of wisdom from [that meeting]. That…it's not about us being thick, it's about knowing how to reach the point…get our patients to the pathway that we want." [NSFT]*

Yet it was anticipated that involving GPs with mental health services can be difficult due to the rising demands on their service and the strained relationship between General Practice and Mental Health services, that may often lead to GPs frustrated and not wanting to engage as they have tried before with little affect.

Mental Health Service GP referrals - inappropriate

One particular concern strongly highlighted was as a consequence of GPs being unsure of where to direct patients most appropriately with mental health services for referrals. This has led to many inappropriate referrals now being received by mental health services, specifically in relation to the mental health crisis team. It was thought that the lack of clarity has left concerns for timely support so some GPs are referring patients urgently; *"…it might be appropriate that it's a 5-day, 28-day. But because people are unsure, they'll put them for a four-hour urgent. But then that knocks on hugely to the other resources that we have."*

> *"I think that we get lots of referrals that, perhaps, don't need to come to the crisis team, and I've no doubt that the general practitioners have their own reasons for that. But we tend to see a lot of people that there was probably other teams or other interventions that could have been done rather than being referred to us."* [NSFT]
>
> *"It's very clear when you see the referrals coming through…you go in and cry, "I'm miserable." There's a referral there. There's no watchful waiting. Very few of them follow NICE guidelines before we get a referral. It's just ping a referral, straight off. And if you saw the referrals, they are such poor quality that there's a huge amount of work that we have to do before we even get to the point where we say, "This isn't for us." But immediately there's an urgent referral in. And I think whether it's they're under pressure...yes, I know that. Whether they're frightened of litigious actions, I guess so, but at the same time, all they're doing is pushing the risk elsewhere because we can't get to the people who need to be seen."* [NSFT]

One professional believed this may be happening as a result of difficulties in other areas of the mental health services (mental health trust) and therefore inappropriate referrals are becoming more common because clinicians are worried patients won't get the timely support they need. It was made clear that this just influences capacity elsewhere within the mental health services team and can lead to longer delays being apparent.

"I think because of the problems in other areas of the trust, and the sort of waits and stuff, I think GPs have had this service commissioned that they can ring up and get an assessment within four hours. They've got no confidence that if they wait, a patient will get seen, so to be on the safe side, they send them through us in four hours. I can't really blame them for doing that, as much as it frustrates me, I don't like it. I can't say in their boat, I wouldn't do the same. …I'd want to know that the patients were going to be okay. So I can't really blame them, but what doesn't get understood is that, if we get 20 referrals for our end, we're not going to be able to see all those within four hours. …You can only resource with so many staff. And some days, you might get 2, and other days we get 30. So impossible to predict…but it doesn't work like that. People don't plan their crises." [NSFT]

It was widely acknowledged that mental health services are stretched due to reductions in resources allocated to local mental health services financially and therefore staff said they need to be as efficient and affective with what they have; *"…our primary aim to be as efficient as we can because we're essentially under-resourced and we have to make the best of everything we've got."* Having such demand in referrals does not allow them to achieve this. Often many hours are spent and resources allocated to providing assessments, writing them up, arranging further services involvement all of which may then find that some patients did not need to be referred or mental health services are not suitable for them; *"So if you get 15 assessments in a day, you do all those assessments…you're only going to take on four of those out of 15. So you can do absolutely nothing with 11 of those referrals once you've seen them."* and *"But essentially, in terms of crisis or acute care, you're not going to do anything. So it's 11 patients' worth of assessment that no-one ever really sees, because it doesn't go anywhere."*

"But the crisis team should only be for crisis. But they can be overwhelmed with referrals of people to come through to see. They've come through to the inappropriate level. Okay, so it's not that there isn't an issue. And that word crisis is the worst word I know…because it means so much to so many people. And they can have 20 referrals and maybe two or three take-ons. But a referral takes hours to process from getting it, getting the information, going out seeing the person, and writing it up. It's hours. And whereas that detracts from the active home treatment, active support….But because they're having these referrals that are coming through and because sometimes the information that's given is incorrect or it's not fully enough. But if there is risk then we have to go and see them. But that's across the board and I think that flips right the way back to GPs understanding what you're going to get from your referral. And if you put this through, what it means…the knock-on effect. And we're as much at fault as anybody of not making that very clear. We think we have, but it just doesn't compute." [NSFT]

3.2.3 Working with other health and social care services across Norfolk

Working relationships

Throughout both phases of this work (including our General Practice in Norfolk report- part one) it has been indisputable that communication is critical to seamless effective patient care. In order to build effective working relationships, communication is key. Likewise, without clear communication local relationships can be strained resulting in further implications on patient care. The majority of professionals highlighted good working relationships amongst local services with the ability to communicate and gather information as required. Overall, they shared the regular contact they had with local services which they believed they worked well together, whilst trying to maintain communication.

> *"On the whole it's good, and actually I think we work well as partners together in terms of acute trust, in terms of social services and community healthcare. So I think we're all making that concerted effort to work together. So to my mind, that works."* [NNUH]
>
> *"…I think, in different situations, if we do we need to get through to people, to speak to them, my experience is usually we can. And usually it's okay, and usually it's useful and gets the job done. So over recent months and very recent years, doing more work with [a colleague]…we worked very closely, and that necessitates a lot of inter-agency work. So I know that [my colleague] is in contact with various agencies. Whether it's parts of NSFT, whether it's other parts of the health system. Whether it's parts of police or probation services. So a lot of communication does go on, even if there are barriers sometimes, we still…make it work."* [NSFT]
>
> *"…certainly within speech and language therapy we have close links with the Community Service, the Learning Disability Service and ECCH. It depends again on who the service is, so NCHC we meet with regularly again to try and keep communication up, we meet together as two teams to do sort of joint planning and joint sort of working."* [NNUH]

Other examples of productive communication were given such as hosting daily teleconference calls with a range of organisations. *"we have a daily teleconference at 10 o'clock every day, where all of system partners ring into."* Whilst others mentioned opening training up across the system to other agencies. *"so I ran some mental health capacity training…and opened it up to the police and other services to come in so that we could have joint discussions."* With reference to communication a common issue raised, was how working relationships and communication go hand in hand, therefore, difficulties can arise to the forefront when you don't have a working relationship. Some suggested that they work hard to build working relationships *"I invest quite heavily in personal relationships, relationships that actually you get a group of people who you can call-on."* This was supported by another comment received setting the scene on the importance of working relationships.

"I think this organisation works very, very hard at relationships…We rely on relationships because we're sort of like…the cement in the bricks. Patients come to us and they're in transition between primary and acute, so they're really, really important to us. And we need to think how we can strengthen that at a local and a strategic level. And, of course, this organisation, this size there's going to be variation. But I think the intent is there. So I think it's very important to us. There's always room for improvement. With the pressure on the clinicians, it's harder to do. It's the first thing that goes, isn't it often, communication." [NCHC]

This was acknowledged and reiterated by many staff we interviewed, they highly valued close working relationships with other services. The majority placed value in having onsite professionals working within their buildings and premises allowing the communication and relationship to be much stronger than previously. Examples of services that were integrated into premises incorporated social services, district nursing and mental health services. This mirrors and triangulates with what we heard from General Practice in our previous work, providing evidence that having individuals on site from key organisations can lend itself to forming better working relationships with crucial partners and may be seen as a step forward for some in Norfolk.

"…so we've got mental health liaison nurses that are part of our establishment here within the hospital. So they're an excellent conduit into the right people." [QEH]

"And obviously we have social care in our team. We have social workers and a social work assistant and that's proved really successful because we…don't tend to have the problems of moving patients from health into social care." [ECCH]

"Mental health is brilliant because we now have an in-hospital mental health team, and we can phone them up." [JPUH]

"From mental health services, we now have 24/7 cover. So there's always a mental health liaison around." [NNUH]

"We've also got a community liaison nurse who's actually employed by our community partners but works here in the hospital. We work very closely with her. She's kind of a link with the District Nurse Service." [JPUH]

In order to help build relationships some staff voiced that better trust can be manifested in an onsite conversation with someone allowing for a personal connection to be made and trust to be built, which is vital.

> *"…but I suppose sometimes it doesn't help with actual building relationships in the sense of, sometimes actually it's better to have a conversation with somebody. But the difficulty is time and as we say, actually being able to have that contact with somebody. So I think sometimes having been based where you can physically go and chat to somebody, I think you form a better relationship. There's better trust, rather than just being a name that's…there's not that sort of personal connection about it, which I think can improve relationships quite a lot."* [ECCH]

Joint working

Some professionals perceived there was room for improvement for services in the form of joint working across the system. Some felt this would lead to more effective patient care and patient pathways through the complex health and social care system of Norfolk; *"and the more we join up the more effective we'll be and less pressure on time."* In light of the current climate of health and social care services in Norfolk, with the development of the local Sustainability and Transformation Plan (STP) some professionals felt this was critical to improving the way services work in the future. Many concerns highlighted the nature of 'silo working' of organisations across the system resulting in often feeling that they are working in different systems rather than the one health and social care system; *"I think, still, in terms of communication, we're still working as organisations. And so we are still all working…but we still are managing in really difficult times and all trying to kind of protect our own organisations."* Others suggested organisations need an awareness of the demands and constraints on the whole system rather than focusing on their individual organisations issues.

> *"I mean to me, the key things are communication isn't always as good as it could be. And that there is some, I think, silo working. And that isn't so much with GPs, but I think it is with the trusts where they feel that there's a threat for services, and therefore kind of commissioning services…you sometimes get issues in terms of competition and kind of I think certainly with the more business focus sort of hat in terms of where the NHS is going, sort of commissioning for services and kind of that kind of much more reluctance to kind of talk and communicate on that level. …The other issue that probably all of us find is in terms of sometimes trying to pass people back to the community services. So for example, we are the regional head and neck specialist centre. We find it very hard to pass patients who need community input back out to the community because they don't feel they have the skills to see patients with which they class have a specialist condition. And that's a consequence the patients are having to travel long distances to come in to access our service. So there are issues about the fact that there's not the same joined up working as perhaps there used to be, and that people are very much, 'This is ours. This is yours. We're not doing this.'" [NNUH]*

"But I think it's being aware of each other's pressures, isn't it? And I think there is more collaboration and more understanding. And I think as a Trust, we've been good at actually…at least, even if we know we're under pressure and we're under financial restraints, we have an education such that you understand that everybody else is in the same position and all those things are going to impact on one another. It is actually working for the best possible solution given the restraints that you've got." [NCHC]

One example of joint working was highlighted to us between two organisations in Norfolk. Upon the conduction of our interviews the initiative was being piloted for one year, a partnership between NNUH and NCHC through City Reach Health Service. This was an example of services working together to improve patient care. This involved a discharge co-ordinator from NNUH based in City Reach as a method to preventing admission to hospital and supporting patients upon discharge. This was in its embryonic stages but staff highlighted it was working well for those involved.

"So there's an increasing large homeless population, so we get quite a few homeless coming into A&E. Some you can discharge direct from A&E. Some of them, because they've been on the streets for so long, have complex conditions that require an inpatient stay. So City Reach is in Norwich and they support, along with the county council and various other organisations, homeless people. So we have seconded out a discharge coordinator to work in City Reach. So their job is primarily to help prevent admissions. So a lot of the homeless people, City Reach will be aware of, or the ambulance will contact them and say they've got a call out. And so they will see, do they actually need to go in? Not from a clinical point of view, but is there anything…because they've got nurses in City Reach as well so. And so the discharge coordinator and the nurse will review and say, "Do they actually need to go in?" And if they do need to come in, they will work with them to get them out as quickly as possible. And also, when we've got patients in the building, work with the teams to get them in temporary housing as soon as possible. So that's good. And so that, City Reach is part of NCHC, so that's a partnership that's working very well." [NNUH]

"So we've been working with City Reach, but the discharge coordinators were based with us, so moving them out into City Reach. We started that probably about a month ago…So we're funding [the staff member] to work in there, and then evaluating to see what the difference is, is it more effective. And also, we do get the horror stories of discharging homeless people to the county council. But actually, they don't often get there. And so this way, we're able to work with the people and get them into some temporary accommodation, just to give them that heads up. And actually that stops readmission straightaway as well. If you discharge them straight back onto the street, they're probably going to come back in the next day." [NNUH]

Communication between services

One concern expressed regarding communication amongst services was the challenging nature of this when there are so many organisations they liaise with, who staff may need to involve in the care of a patient.

> *"I think one of the things is we look in lots of directions, so we've got Lincolnshire, Cambridgeshire, and West Norfolk. And then, in terms of tertiary referral, we send to the NNUH and to Addenbrooke's. So we've got lots of providers to interface with, which is challenging. And what the acutes always say is that we can't close or shut the door, can we?"* [QEH]

Linked to this, the consensus was that communication with tertiary referral centres can often be difficult, specifically with neurosurgery. This may be due to the busy nature of their work, they're treating patients in theatre so trying to match a time when both professionals were free was challenging. Equally it was suggested that the procedure for contacting could be improved to enable professionals to leave a message rather than waiting for long periods on hold.

> *"The massive, massive problem we have is with neurosurgeons, which are Addenbrooke's, and you can wait up to four hours for them to get back to you because they'll be in theatre, they'll be busy. I've sat on the phone for 50 minutes before to the neurosurgeons, when you're trying to look after other patients at the same time, and they're…yeah, it's pretty appalling to be honest. So they've got an email form that you can fill in and send over the internet, but they still say you've got to phone up and sit on the phone and wait to talk to them. And the problem is there is one neurosurgical reg and they might be in theatre, and so you just sit on the phone, and that's not ideal. So that's something that we've…well we've brought it up before, but ideally we'd like to be able to leave a message with the coordinator who then get to phone us back. We should be much more accepting of the fact that our time is precious too, but that doesn't seem to be forthcoming. So, yeah, neurosurgeons is our main bug bear. But that's the biggest issue that we have."* [JPUH]
>
> *"I think there are problems especially communicating or getting in touch with tertiary centres obviously because they're very busy and they're stretched as well. So it's difficult to find the person you need to talk to. It takes a long time to go through the switchboard and for them to get in touch with that person, especially with neurosurgery. They're most of the time in theatre; they're very busy and stretched. So our juniors have had to wait 45 minutes or one hour on the phone trying to refer an acutely ill patient for neurosurgical input. So that happens quite often. There are some difficulties with other units as well, but neurosurgery is particularly difficult, obviously because they're busy. They're in theatre as well, so it would be good to have some nominated person who can take the message rather than the consultant themselves or the registrar."* [QEH]

It was evident that communication can breakdown as a result of the capacity and demands on both individuals and organisations. Staff described that in times of extreme pressure communication can be negatively affected; *"it's a thing that happens, isn't it, when we're all sort of stretched and busy, short staffed. People then do what they can in their little corners and don't make time to connect properly"* and *"when there is severe sort of pressures then opportunities to talk or opportunities to pass on important information can sometimes get lost."* Without effective communication around patient care it was evident that it could cause confusion across services for patients and services within the system. *"I think where the communication falls is where we're not always aware that everybody's involved."*

Similarly, professionals said there was no single services that it was challenging to engage and communicate with, yet it was often reliant on clarity of understanding and capacity across the system.

> *"So I don't think it's the communication. There isn't anybody, any one service that's harder to get into than another. I think you learn how to, on the ground floor and operational, you learn how to tap into a service that might be difficult. I think sometimes the difficulties come because of pressures, lack of understanding of what that team can do."* [ECCH]

An example provided within an interview demonstrated the affect lack of communication can have on patient care, to the detriment of a patient within the community setting in their end of life care.

> *"I'd probably say the biggest problem is the out of hospital team, really. The communication with them and us, really…there's one example I can think of. I was involved with this patient for two years, and they needed the out of hospital team. And in that last week of their life she needed their support, but because they didn't communicate with me what they were doing there was three or four people going in, in a day having the same conversations, because there was no communication. And actually that resulted in a massive complaint, because the family were confused about who was doing what, what was happening and actually wanted to know why - after I had them for two years - the out of hospital kept saying, "You don't need her. You don't need her anymore. We're here now."* [JPUH]

In further support to the above statement, professionals stated that patients do expect services to be communicating with each other about their care. It was suggested that patients do not wish to and should not have to repeat and recount their situation and story to every professional that they come in contact with, but unfortunately they do. This implies that there is a need to co-ordinate information better between services in the future, communicating as one, as a whole system rather than in small pockets spread across the health and social care system.

> *"So I mean, there are a few things that patients expect which they should expect. They do expect us to all being communicating and having access to the same information about them. They don't expect to have to tell the same story over and over again, which they do. So that expectation is right, and we have to do something about that. Of course, all joining up and doing that, and agreeing is more challenging."* [QEH]

Coinciding with our previous work with General Practice and their views of the working relationships amongst services in Norfolk, access to mental health services was raised as a concern. One professional recalled problematic experiences for patients accessing mental health services, particularly the crisis team. It demonstrated the lack of timely support when involving the Mental Health Crisis Team due to the times they provide support within the hospital. Suggesting that out of these hours timely support can be difficult as they are often out in the community supporting other patients.

> *"There's 24 hour support but there's delays, because it's underfunded. And I think we've had issues with the openness of how the NSFT and the commissioning of mental health services has been, and I'm sure the GPs have said the same. There's no clarity, and we're not sure what services we're getting and we're not fully engaged. We're being more involved now, but we haven't been, and I think that's a real concern. And I think for the patient in the middle of all of that…but ultimately if the patient comes in here needing mental health, within 8:00 to 20:00 they should be seen, within an hour from referral, by us. And, pretty much, that is what happens, but overnight it's a massive issue, because the crisis team could be out in the community." [QEH]*

This concern was compounded by the poor relationship between other services and mental health services. It was felt at times to be strained particularly due to a lack of clarity on how to navigate mental health services in Norfolk. A point that was also reiterated by General Practice in our previous work suggestions that some of our findings coincide.

IT systems across health and social care services

One issue indicated and evidenced very strongly throughout staff interviews in this follow up piece of work, was the use of IT systems across health and social care services. This issue has been echoed, just as strongly from the previous work with General Practice. This indicates that it is an ongoing concern that many professionals have working across the NHS locally in Norfolk and is a battle that many continually face. For some professionals IT systems presented as a barrier to effective patient care, as we were told that IT systems at times cannot work to pace, are often slow and can be a hindrance in a busy healthcare environment. Others found that writing up assessments can also prove problematic with IT systems being unresponsive often causing delays. As a result this work has developed a deeper insight into the use of IT systems in health and social care services, learning much more from professionals working with these systems on a daily basis.

"And the IT system haven't even understood the pace at which we have to work in A&E. IT systems, I think are not geared for it, they are not fast enough. They freeze. The equipment sometimes doesn't keep up to the expectation. The system is slow, it's not very friendly either. And we find it very difficult…it almost seems sometimes there is a bit of fighting with the technology to make it to work for us rather than it working for us smoothly. I think it's a big issue and I don't know why nothing's been done about it because it's very frustrating for everybody. Junior doctors especially, who deal a lot with technology, they have huge problems. And it's particularly frustrating because we're not able to readily access the GP system because they use SystmOne. It's a huge concern…we invest a lot of money, we have the technology and yet…it's not of any use to us. Some use, but it could be of much better use, especially when you have a large floor of patients. You cannot be bogged down with trying to retrieve information because there are patients waiting to be seen. It's a real frustration." [QEH]

"Yeah. If you've been out and saw four people for assessment in one day, by the time you've written risk assessments, care plans, referrals to other teams, clustering, put in a frontal referral on in the first place, that in itself can be three, four hours work just for one assessment. And when it stops working properly, that becomes absolutely ridiculous, because you just can't get things written up. And then, you lose work. If you write a long assessment about a patient, and then that gets lost in cyberspace because the computer's not working properly, are you going to write that as good the second time?...It's a fairly consistent view within the team that they don't particularly like that system." [NSFT]

> *"And the other thing is none of the systems talk to each other. So we've got a really good electronic note system for A&E, which means you can go back and find old notes and stuff, but that doesn't talk to the blood requesting system…[it] is a separate login. The x-ray requesting/reporting system is a separate login. The electronic health records is a separate login. The electronic discharge is a separate login. The electronic prescribing system is a separate login. So even though we've all got smart cards, you can't put your smart card in and just get logged into all these systems. And they all log you out after a certain period of time, so you spend your life putting in passwords. And it's just clunky at this trust. It's not great."* [JPUH]

Within a busy Accident and Emergency Department (A&E) one professional described the frustrating delays systems can cause by not interacting with each other.

The majority reported that IT systems are not communicating or compatible with each other, owing to the wide ranging IT systems that are currently being used across the health and social care services today. Across larger services it was evident that as a single organisation they were using different IT systems internally, which often do not engage with each other and share information easily. For example:

> *"So this isn't just about us communicating with other providers. Within the hospital, we have multiple, multiple systems that don't talk to each other. So we have a system for theatres, a system for the ED, a system for diabetes management, a system for renal management. So there's loads of IT systems even within hospitals."* [JPUH]
>
> *"Even Norfolk Recovery Partnership…it's part of our trust, it's drug and alcohol services. It's across the road, you can see it out the window. But we're [using] completely different IT systems. So they can't see what we're doing. We can't see what they're doing. We've got a lot of shared patients, and it's basic stuff like that. You think if we had one IT system, we could all see what we're doing. We wouldn't have to do it all again, or contradict each other…"* [NSFT]

To add to this you also have General Practice using both SystmOne and EMIS across the county which again further complicates communication and sharing of information. Some believed in the past organisations have worked separately focusing on their own needs, instead of look at this from a system wide approach; *"…previously, we've all worked in isolation. "We got IT solutions for ourselves and not for the future. Fixed the problem in the here-and-now…"*

> *"Whereas we all look at an IT system from our provider's point of view. Whereas where are we looking at it from a whole system? And there's been some sites where actually they have done IT sharing between acute, community and GPs. So if they can do it in that way, where can we learn from those sites?"* [ECCH]

It was recounted that IT systems do complicate communication around patient care particularly when patients may have multiple and or complex needs, which can mean they may come into to contact with numerous professionals, but there is not one system that all can easily access; *"…so it might be lots of different people involved. That's complicated. Because we don't have an information system that shares relevant information across all services easily, a lot of effective communication can be based on relationships."*

The main barrier established from the professional interviews was the lack of compatibility and communication across IT systems and the knock on effect this can have; *"It might be, because our respective IT systems don't talk to each other. That possibly would make it easier"*, *"The difficulty is that we don't have the same sort of IT systems, which is probably quite a common factor across the county."*

Differences in systems can really limit the sharing of information, because one service cannot view the others activities, for example; *"IT is complicated, and regardless of what system you use…you can access them but other people [can't]…certainly, systems never like to talk to each other, and no one uses a system that will accept someone else's system easily."* and *"…it is a major barrier to us being able to put together a sensible package of care."* With these differing systems being utilised and unable to communicate with each other, the consequences for services can be enormous due to the lack of information about a patient. Professionals cannot view a patient's journey through services or see what services the patient has come into contact with, meaning they may be unaware of others involved.

> *"And I think that comes back to what you were saying about IT systems and how things integrate. So we'll maybe might be involved with somebody who goes into hospital, but actually, they don't know that we're involved because they haven't got the same IT systems. So they might be then now pursuing another form of care, whereas we've been looking at that and we know that that hasn't been working because of X, Y, and Z."* [ECCH]
>
> *"So all of the partners say it's a complete pain because from a health perspective, social care can only see what's written in the notes. They can't see any of the computer stuff. We can't see any of theirs. The community team can't see any Care First. It can be a real nightmare."* [NNUH]

Often this equates to clinicians 'being left in the dark' about a patient due to having very limited information. This could have serious safety concerns for patients.

> *"A lot of patients that you see in crisis, and then you see on wards, unless you've known them before, they've been through mental health services, they won't be on Lorenzo [our IT system]. So lots of things you do, you're doing completely blind. You don't actually know what's coming through the door, or know whose house you're going round."* [NSFT]

"I had a lady in the other day who came in and said she'd been admitted to NNUH. And she'd been told she'd got a problem with her neck that was making her black out...but nothing she said made me think she had one of those conditions. But I had no way of accessing anything…again, nothing really talks to each other. So sometimes you're left in the dark. As I say, the problem is we're open 24/7 and GPs are open 50 hours a week, so outside those hours you've got no way of verifying what patients are telling you." [JPUH]

"Sometimes it's around what we get on referral. Because we do a telephone referral system, so we get the calls through and we get a tiny bit of information. And the rest of it goes with the patient. Which is fine, the patient can deliver…But sometimes the two don't marry up. And, look, we're often going in blind to a patient, which isn't safe." [NCHC]

This is further undermined by the use of differing methods of documenting actions taken by different professionals and services. A lack of knowledge on what has been actually carried out, when and by whom can also cause concerns for patient care.

"…the out-of-hospital team will often come into the hospital and do work with our therapists, and we're trying to have that collaborative working. But it's really difficult because we're working on different communication documentation systems so they will go back and document on their SystmOne, we document, written at the moment, so in our little blue books that the patients have when they're admitted into hospital. Out-of-hospital team don't always write in our blue books, we don't write to SystmOne's, so it's making sure that the right information is going the right places. And because we don't know what they've done and they don't know what we've done, that can be a bit of a struggle." [JPUH]

For some professionals it was suggested that the lack of information evidenced when they first receive a referral may warrant further detailed information to be sought, otherwise they are not fully informed of the needs of the patient they will be providing care for. This highlights there is a need to share information between services where applicable, as this may be critical to the future care a patient may receive.

"Drug allergies, other medications that they're already on that might not mix with what we might want to give them. Past histories, so often it's a chronic illness, and we need to know what's gone before. And if the treatments that didn't work well, we're not going to go back over old ground. We need to know that." [NSFT]

"It would be nice to have access to their GP records because then you can see all, because what sometimes happens is one of our patients disappears off the radar. We're obviously really then worried about that, and so we start ringing around everywhere, relatives, and then we ring GP surgeries, to find out if they've been in. But it would be great if we could just look and see, oh, yeah, that they were there yesterday." [NSFT]

This appears to create issues when information and systems are not shared and accessible. Often professionals recalled having to chase other services for information and the additional time and effort this takes impacts on the limited time professionals have. All because systems are not connected and information is not easily accessible.

> *"So we use SystmOne as our clinical record keeping tool, and we use that across ECCH, and some of our practices are all SystmOne as well. That really helps with the sharing sorted. Because that's where the…general information sharing around patients' condition, actually SystmOne really helps. It's easier than it is with the practices on EMIS because that doesn't talk…"* [ECCH]
>
> *"So 99% of people are happy to share information, so if their GPs are on SystmOne, then it's brilliant. We can see everything that's gone on, if they're been seen by the SALT team for speech and language, we can see everything. But if the GP surgery isn't on SystmOne, they're on EMIS, then what we have to do is contact the surgery and ask for a summary, a medical summary, and drug summary as well. And then that gets scanned into SystmOne, so that's when the problems happen."* [ECCH]

Alongside the concern over information systems and the associated problems this can cause for services within the health and social care system, there was a notion that one universal system across the county if used would alleviate some of these issues, however consent to share information needs to be rectified and established. Working practice currently across the system has highlighted evidence that indicates that even using the same IT system can have drawbacks if organisations do not have their sharing preferences configured appropriately. For example:

> *"Things are better because a lot of the surgeries that we cover now are on SystmOne…So that has made things easier. We can see each other's notes as long as we share the record and the district nurses use that same system as well. So for a patient perspective, that's quite good that we all know what we're doing. However, this morning when I went to the GP surgery, they do use SystmOne, but some of the GPs there don't like to share the notes because they fear that it's…about confidentiality, they fear that they can't do that. So it's not normal for them to do that, it's not standard procedure to share the notes so I can't see their notes. And I think that does hamper it and then that causes more time. We're chasing to find out, say, if we've asked a GP to go and review something that we've done, it takes time then to chase up to find out what's actually happened about it…but the GP's then still say, "Actually, no we don't want to share our notes." So, again, its GP preference, but I think…once they see that how well it can work, it might improve things."*[JPUH]

"One of our surgeries, we've difficulties with because they haven't been sharing the information. They've got the sharing preferences. So most of the time our patients will be happy to share. You got the odd few who don't. But one of the surgeries specifically was set to do not share with anybody…That was quite difficult because then we'll have to go to the surgery and ask them to read that specific entry that we wanted to know about. So it's just about chasing things all the time. It's very time-consuming." [NCHC]

"We've also got a GP surgery that we work with that don't share their records with us, which is infuriating. We've been asking them for, I should think…I've probably had at least five conversations with the lead doctor…And he says that they're trying to get that sorted and it's still not happened. So for example, today I go to see a patient, the family are wanting to know the swab results from the wound, and I'm not able to provide them that information because that's not on the system for me to see, because that GP surgery doesn't share. So the same way that I'll go in and see someone, I want a doctor to go out and I can't see that doctor to visit. So I then have to walk to reception, and the receptionists are all really lovely, so because they're our front line and they are all really supportive, luckily, that they will say, "Oh, yeah." And they'll let us have a look at it. But if we could just see it, it would be so much easier." [NCHC]

So this is about sharing the right information, at the right time, in the right way to ensure that work is not repeated and all clinicians are involved and informed appropriately; "*So the barrier is that we don't have the same computer systems and its maddening.", "You think if we had one IT system, we could all see what we're doing. We wouldn't have to do it all again, or contradict each other…"*

"So I think we have lots more ways of communicating, but it's finding the right way to communicate at the right time, really. I suppose it's also making sure that we're giving each other the right information and asking the right questions. And I think that's quite key….So I think although there's a big choice, actually there's lack of clarity in terms of perhaps finding the most efficient and effective. So I think, myself, certainly for our service, that's still a challenge about getting the right level of information in the right way." [NCHC]

"I think it creates a barrier for something to be timely. In the fact that, actually, I might not have to bother a GP if I could see the consultation. I know that they've had their bloods done. They've recently had a urinary analysis for a faller or something like that. I could see what the results would be. Do I need to bother that GP? Or I might be able to task them to say, "This is what we're planning on doing. Would you be happy? Could you review them?" So I think it kind of leads to those ways. Sometimes the systems and everything, we're a little bit too polite with one another. And actually, some joint working could do better with how do they use their system to how we would use our system." [ECCH]

An opinion evidenced strongly across the majority of professionals involved in our project work was that resolving some of the IT systems issues through the use on a universal system across the county would be a step further forward. As you will see each of the six organisations expressed their views on the need for such a system across Norfolk.

"Yes, it's a huge issue. It's a huge issue. I don't know how to describe it. It seems so simple that we should all have one system, seamless system across the practices. They should be able to open up a computer and see what we're doing for the patient and we should be able to do the same thing there. But unfortunately it doesn't work like that. At times it's a huge struggle to even find out what drugs the patient is on at primary care level." [QEH]

"It does depend on whether the practices on the SystmOne or not, and whether they've allowed you to have their rights where they can sort of share information. Where practices and community teams are using SystmOne to communicate, that works really well." [NCHC]

"…we're not all using the same IT systems. So it in terms of all using SystmOne, as a future concept, would be the way forward…because then you can write your message to the GP on SystmOne. So at the moment, we're primarily using SystmOne just as read only. So we get the information coming in with the patients, but we can't communicate it back out on that system. Most are now. So that's what I'm led to believe. Most are. So if we followed suit, I think that would help a lot in terms of the patient pathway and the communication between community and acute." [NNUH]

"…one of the things that I've had feedback from GPs concerning is that they don't have access to our blood results, so all of our results. So often, one of the things they say [which] has come back to me is that on the summary it says, "Blood's taken, blah, blah, blah, results to follow," and then results never do follow. And they can't actually access our IT system, so they can't…or we send a patient and say, "Go back to your GP, they'll give you results," and they can't actually access those results. So there's something about our IT systems or using the same IT system within the local area, I think is really important. And also, we all don't have access to SystmOne. As a trust we don't have access to SystmOne, and I think that would be a really good link in terms of social services access it, community access it…So it can be done in pockets, but it's one of those systems that is really useful if you want to get everybody sharing information and the patient not having to have repetition, and everybody understanding that patient pathway. We all need to be using the same IT system, really." [JPUH]

"…Only if everyone went on the same system. I've worked in primary care….I know some surgeries, it's just going to be an absolute nightmare trying to get them to move over. I think a lot of them invested quite heavily in things like EMIS and Vision…But until, I think, everyone's on the same system, I think it's going to be quite a challenge. My other thought was even if just a surgery had a desktop with SystmOne on so that GPs could look in and see, but then actually they might [as well] all have it. I mean, that's what we've discussed with the surgery in Suffolk, who will take GP cover for the intermediate care ward, was around actually well, they could just have one unit, so they could write up the notes in SystmOne. But yeah, it would be so much better if everyone was on the same." [ECCH]

"Norfolk, it seems to be a little bit better, but there is still a barrier in that the computer systems are not the same. And if it could work between GPs and community nurses to talk about Mrs Blog's dressings on her lower leg for her weeping wound, then I don't see why there should be stigma around mental health and it's excluded. So I think it was a poor decision…but I think the principle is we should all be communicating much better, and that means joining up access." [NSFT]

3.2.4 Rising patient expectations

Across all organisations involved in this work it was clearly portrayed that patient's expectations have changed particularly in the eyes of those staff that have worked in the NHS for many years. Over time staff articulated that patient expectations have risen and may continue to do so for all health and social care services; *"I think that the expectations are forever rising."* Some professionals felt that patient expectations have increased as with advances in the NHS has meant that they can do far more for patients than they ever could previously due to advancement in medicine and patients are living much longer than previously.

"I mean, there's no doubt patient expectation has increased immensely in the 28 years that I've been in practice. They're very, very different. That has increased for many different reasons. I mean, partly because there is so much more we can do for people now. So, when you use the word expectation it sort of implies that it's unreasonable expectation. Whereas I would say actually a lot of the increased expectation is reasonable because we can do so much more." [ECCH]

For some the increased expectations of patients is impacted upon by the growing expectations of relatives. This is hardly surprising given the vulnerable nature many patients can be in when accessing services, that their loved ones would want the best care for them. Staff suggested this could be wide ranging such as wanting updates from medical staff regarding a loved one to what their relative is entitled

to and how quickly they should be seen and discharged. Some professionals highlighted again that increased expectations from relatives has also amplified over recent years, for example;*"…the expectation of the patient is high, but I think it always has been. There's a huge expectation from relatives….I've got a visit this afternoon where I have to meet your relative, because they almost want to hear what you've got to say."*

> *"That can be seen from the emergency department in terms of patients attending for non-emergencies but seeing the ED as almost an extension of a GP surgery, through to expectations around discharge. And in terms of patients and relatives expecting their relative to stay in hospital longer than they need to be here. In terms of how they can qualify for continuing healthcare, they often feel that their relative should qualify when in fact they don't have that primary health need. And also, in terms of how long they feel that they can take in discharging a patient. So how long to find a residential home for a relative. They would expect to be able to take two, three, four weeks, five weeks to get the residential home or nursing home of their choice and not think that that is a problem for them or their family. So in terms of within a ward area, I think relatives…throughout my career, now relatives much more want daily updates, want to have much closer access to the medical team in terms of catching up, whereas 5 years ago, 10 years ago, they might have been happy just to speak to the nurse and have a five-minute discussion. Now often you see most junior doctors quite busy in the afternoon talking to most relatives..."* [JPUH]

Staff were keen to advise that they are doing the best they can for patients continuously across all health and social care services but at times staff are unable to meet patient expectations. This is often owing to the lack of capacity many services have today across the system and as a result services are under resourced and frequently stretched when trying to cope with the demands on their service. For example; *"…there's been no access visit, or home visit, for patients. And as much as we would love to do them for every single patient, we just don't have the capacity to do that."*

For others it was also noted the difficulty of matching patient expectations with what you as a professional, would like to deliver and what you can actually provide within your service; *"…there is that difference between what you'd like to provide and then what you can provide. And I think that is that difference. And then marrying that up with patient expectations as well can be really challenging."*

> *"Every day we have to move patients around because we just don't have the nurses to go and see them all or the healthcare assistants. And so then you have this really difficult element of our staff who are on the frontline getting aggro from patients who because their expectations are up here, they're higher and actually we can provide. So historically it was like a gold service, British Airways, first class, lovely. It's now EasyJet. We can still get you there. It's still safe. But you don't get a little tray with dinner, and you don't get all the things. It's that difference that patients don't understand and we've don't have those honest conversations. And so, I believe that patient's expectations probably have gone up but the service has gone down, so we can't meet them because we don't have capacity or the resources to. It's a really difficult concept…"* [NCHC]

Perhaps as a result of the society we now live in patients are becoming far more informed with the enhancement of technology and the internet. The public are far more aware of the health and social cares targets and what they should be meeting such as the four hour treatment time for A&E. So this can have implications on what patients expect when accessing services, again adding to the demands across the system. For example; *"They've got the Internet which is either a blessing or a curse, depending on how you see it. So often people come armed with, "I'm entitled to this," whatever this is. And actually sometimes they are, but sometimes they aren't. And so it's happening really often in the community services, we struggle enormously with demand."*

> *"I think it has changed with the advertisement on the Internet etc. Patients are more aware of what could be done and what's on offer, whether it's entirely appropriate for them or not. They do expect at least a conversation on certain specialist investigation or specialist treatments. It's more among the younger people. I don't think it happens too often with the elderly part of the population."* [QEH]

Further to this, the majority of staff raised conclusive views that due to the demand driven society we live in people expect more and more. Patients want instant access to treatment and want what was phrased as 'an instant fix' but services indicated this is not always possible. This in turn provides repercussions on the demands of services as staff reported more frequently patients are not willing to wait and will access the service that is easiest for them. For example; *"But, ultimately, they're human beings and they choose the easiest most convenient route to getting something sorted out that's important to them at the time…do we just accept that we've created a culture where people want to get everything now?"*

"I think the problem is everything's 24/7. Tesco's is 24/7. So if you can go and buy a pint of milk at 3 o'clock in the morning from Tesco's, if you've got earache, you don't want to wait for two days to go and see a GP. You want to be seen and sorted out now. I think it's widely regarded as being a place [A&E] where if you're prepared to sit and wait for long enough you will be seen and sorted out." [JPUH]

"So they do expect a quick-fix, and as health care providers, for us to have the answer and being able to sort things, and that's not the reality. In certain circumstances, there's a slight culture of less ownership around one owns health, and the expectations are that the NHS will pick that up." [QEH]

"The wellbeing side, again, we can't make people's social network better….we can help you look at how it affects you, but actually, I can't make it better. And sometimes people's thoughts are, "I'll go and get referred and that will make it all better." No, it won't. So there is a culture that, "A tablet might make me better," or, "They'll be able to solve all my issues." But actually, it's hard work to get well, no matter who you are. And I think expectations have changed that there's an easy fix. But there isn't." [NSFT]

One professional recounted that for some patients if they don't feel that their health need is improving, they will sometimes view this as a result of services not working properly when in actual fact, recovery does take time and is not always as straightforward particularly if there are other health issues that may restrict a patient's recovery. This in turn can be very frustrating for the patient and confusing at times.

3.2.5 Demands on health and social care services

One aspect of demand that stood out across our interviews was the notion that all services are under increased pressure and demands are high. Often capacity and demand may not match leading to continuous pressure across the health and social care system within Norfolk; "High. High. Very high. We don't really have peaks and troughs that you used to see. So winter it used to rocket. We're busy all year." Some professionals highlighted the complexity of care due to the growing and aging population for example; "*I mean, sometimes we just don't have the capacity. We're only so big. The populations growing. Our elderly populations growing. People are living longer, more complex situations." Whilst pictures were posed of the affect demands are having on services locally.* Another said; *"So the emergency services, sometimes we are almost down on our knees at certain periods of time. And I think the demand is huge, there's no doubt about it. It has become much more the last 8-10 years. There are times, it seems as if we are just unable to manage."*

This demonstrates a flavour of what each of the six organisations voiced when they were asked about the demands on their services:

"So we've had a 16% increase in ambulance attendances, so people are sicker when they get here because there's so many other interventions going on by the time they get in…they're really poorly. And we've gone from 56,000 to 63,000 a year in a really short time. So we used to see 160-170 [patients] a day. Now we're going over 200 [patients] every single day, with no further resource and no budgets to deal with that…So, yeah, I mean, the GPs are seeing exactly the same. And everyone moans about 111 and out-of-hours [services], but they're having the same unprecedented demand on our commissioned service that can't provide…" [QEH]

"It's a massive, massive issue for us. I mean our referrals have gone up massively and as I said at the beginning for all kinds of reasons, our urgent referrals are, yes. So our referrals have gone up massively. There is no way that we can respond to that. I mean yeah, with the best will in the world, but if we did that we'd do nothing else…" [NSFT]

"We are demand led so it's been…it's really challenging, really, really challenging, because we don't have enough supply either, which means the visits are spread out more because we can't close….it's going to be things like leg ulcers and that, that really take the knock for that because the palliative [cases] are prioritized. And your elderly person with your leg ulcers may be on a three times a week visit that might slip to one for some of the pressure area stuff…So we struggle with supply as well. And you've got increased infirmity in the community and that as well there's more, just more needs really." [ECCH]

"I think it is just the demand is so great. And it's every service, and that has a knock-on effect of every service. So if the district nurses are short, the patients are expecting us to pick up the extra. Or if the GP can't go and visit a patient the GPs will say, "Well, x, can you go and see that patient because I can't today?" And it effects on them when I'm off on holiday. So it has a knock-on effect for everybody that everybody is short." [JPUH]

"It just felt like we didn't have enough nurses to do the job. But we have got a nurse on maternity leave. We've got a nurse who'd be on long-term sick. So, already, you're two full-time people down, and they're not replaced. We can only use agency if we're allowed to. I think the demand is high in Norfolk. I don't think it will ever change. We have a lot of people with really complex, long-term conditions." [NCHC]

"We don't have the capacity to manage that kind of demand. I think in terms of human resources, financial resources, and even the physical space within the hospital, the bed capacity. So everything starts to become very vulnerable at times when we have this wave of patients coming through on the emergency services." [NNUH]

Demands on services, misuse and A&E pressures

One concern evidenced was the increasing number of patients arriving at A&E departments across the county, and the impact this is having on capacity in hospitals. Patients are continuously being admitted, often alongside a stream of ambulances. At the one end you have many patients needing beds in the hospital. Then at the other end you have many patients who are classed as 'medically fit' within the hospital and could go home, but who are unable to be discharged due to lack of capacity within the community. This causes blocks within the hospital itself and the wider health and social care system which in turn has consequences on other services trying to discharge and admit patients.

> *"The main issue we've got at the moment is bed capacity and exit block. That's a massive thing that we've got at the moment. Yesterday, I think at one point, I was told I had 13 ambulances just waiting outside they couldn't offload. Certainly on, what's it? Last Thursday we had eight at one point. Monday night was awful; we had patients in the corridor. A lot of it is that there's no beds, because the community beds have shut. I think yesterday they had over 70 patients waiting in the Trust who they couldn't get into…who were medically fit for discharge but couldn't go to community beds. So they all sit in the beds, so we can't get any patients who need admission, who are unwell."* [JPUH]

Yet this is further impeded by the volume of patients accessing A&E as staff expressed 'far too easily' rather than for emergencies. For example staff told us; *"So I think that people seek advice from A&E and things like that far too easily now, and that's clearly evident in our A&E attendances."* Some staff stated that for some patients there is the notion that they feel that they will be treated quicker if they attend A&E.

> *"I think they don't see A&Es in emergency department anymore. We're meant to be able to…they expect us to be able to deal with anything. And it's just a convenient place to come to, to get things sorted really. So we have quite a few that the GP's said, "You need an X-ray of your chest." And they've ordered it, and it'll be in a few days' time. They turn up to A&E expecting it to be done there and then. So, yeah, so certainly their expectations are that if they come to A&E, they will get things quicker and just sorted out quicker really…"* [NNUH]

One professional was concerned that unless hospitals start to have honest conversations with the few patients that may use A&E out of convenience rather than necessity this will not improve.

"I'd say that unless there's some clarity to tell people that, "Unless you're urgent, you won't be seen in four hours. If you're urgent, yes, if you're not urgent you could wait..."…but if you've got a sore throat and you've had a triage, and you're not triaged as urgent, I think people have to be honest, the government has to be honest, and say, "Actually, the expectation is you may well wait eight hours to be seen, because we're dealing with the ambulance patients, the resus patients, the septic patients." [QEH]

A spotlight was placed on the demands upon hospital services and specifically A&E departments by many staff working in the acute trusts. It was felt that some patients will come to A&E because they believe they may get a better service – a much faster service - and the hospital is the best place for them. When actually for many this is not the case, as one professional was keen to address.

" I think people's expectations of you'll come into a hospital, you'll be fixed, and you'll be perfect before you leave, is an unrealistic expectation because we don't have the convalescent units anymore, we don't have respite units anymore, we don't have that sort of intermediate level care of beds anymore. So you're coming into hospital, you're medically stabilised, and then you will discharge. But medically stabilised doesn't mean that you have to be 100% perfect before you're going home…

…I think the perception of hospital is a safe place is a wrong perception of patients. Now there's lots of clinical evidence to say the longer you stay in hospital, the more damaging it is to your health. There's been quite a big study recently which has proven that 10 days in hospital for people over 80 is like 10 years worth of muscle wastage and things. So getting that across to patients, and the fact that if you're here, it's not a safe place to be, or at more risk of catching hospital-acquired infections, noro, diarrhoea and vomiting bug, and deconditioning yourself so you can come in here, you will be…not institutionalised, but you come in to get a pattern of their behaviour. So the lights go on at a certain time, the lights go off at a certain time. Meals are at a certain time. You quite often, "Oh, I'm in hospital so I'll stay in my pyjamas all day," and during all that process - especially for the elderly - you're getting less and less as the days go on….

…So we see it regularly where patients come in reasonably - I'm talking elderly patients - will come in reasonably independent, mobilise them with a frame so to speak, spend a few days in the hospital bed and then they can't wait there any longer. So, I think the perception of them needing to stay in hospital is wrong now. You don't need to stay in hospital, you need to get back into your own environment and that's quicker for your recovery in the long run. I do very much feel that there is still this perception that you have to be 100% fit before you leave and that isn't the case anymore." [NNUH]

4. What this means

Undertaking this project has enabled us to gain valuable insight into the mechanisms and interaction between services within the wider health and social care landscape within Norfolk, allowing this to be evidenced and drawn to the attention of the general public and others working in local services. Utilising one-to-one interviews attested to be a productive approach, providing fruitful and rich experiences from professionals working within the system. Without using such an approach it would have been very difficult to have gained such detailed comments using other methods. Attributed to this is the large number of organisations involved in working with us therefore demonstrating perspectives closely linked to their organisations priorities and concerns. We have gathered a very diverse range of opinions and experiences. A consequence of this, however, is that services and individuals raised many points and few can be interpreted as common to all. At this point, therefore, it is important to highlight some of the recurring key messages that have emerged throughout this project and summarise them in this section.

4.1 Validation of our findings

It is always useful to validate our work and further investigations have found that many of the findings of this project resonate with two very recent documents published by The King's Fund (2017b). One is entitled *"Organising care at the NHS front line: Who is responsible?"* with this publication supporting our findings in these areas:

- Frequently teams require information on patients but it is not readily available
- Communication with GPs can be difficult
- IT systems don't communicate with one another and are not interoperable
- Patients often have to repeat their story
- The importance of working relationships between professionals
- The speed of hospital discharge notes have improved
- Primary and secondary care communication can be dependent on one another
- No regular standards for communication

The other report by The King's Fund (2016) is entitled *"A digital NHS? An introduction to the digital agenda and plans for implementation"* and that publication also supports our findings, on these topic areas:

- National bodies need to consider better use of IT systems as a priority for NHS.
- Through a self-assessment of IT systems, mental health services were seen as improving, district nursing services have improved yet hospital systems were reportedly less digital.
- Clinicians work better if IT systems are interoperable, aiding communicating.
- The NHS has a fragmented system for IT due to no interoperability between systems.

4.2 Working relationships and communication with GPs

Staff described on the whole good working relationships with General Practice and identified that there is the appetite amongst services to work together coupled with a desire to improve how they work together in the future. But there was concern that working relationships were not as strong as previously and recognition that this is something services are trying to work towards addressing.

Other key messages acknowledged by staff we spoke across the range of services involved are summarised below:

- Staff highlighted that often GP practices can be difficult to contact due to a range of factors such as, their opening hours, a busy telephone line, no direct line for professionals and clinicians are busy holding consultations with patients.

- Some professionals suggested that communication is not always as good as it should be between them and General Practice, due to the poor channels of communication. Often hindered by strained relationships particularly between General Practice and mental health services, as well as between General Practice and hospital services.

- One area of concern was General Practice's reliance on using longstanding methods of communication, for example, with some GP practices requesting other services to fax information to them. This was known to cause barriers to effective patient care resulting in delays, particularly for mobile workers out in the community visiting patients, who may not have instant access to a fax machine (if at all). For instance, one experience shared was a district nurse who needed ointment for a patient that they had requested previously and were told to fax through their request.

- From some hospital staff frustrations were aired regarding the lack of communication from GPs when they are sending patients to hospital, recalling GPs often sending patients to A&E rather than a specialist team. There was also further tension evident as some hospital staff felt that A&E is often seen as the 'mop up for everything' with many instances where patients are sent to A&E if unsure.

- Some staff from mental health services expressed that they realised that there has been a difficult relationship with General Practice. This is due to confusion surrounding GPs, on navigating the appropriate access points for patients who may need mental health services input. So mental health services need a stronger voice in depicting what their service can and cannot provide. Consequently frustration has been growing due to inappropriate referrals into mental health services from GPs.

- The majority of staff noted that communication can be difficult as a result of organisations using different IT systems, therefore, noting a decline in information sharing as IT systems are not integrated.

4.3 Working relationships and communication with other services

It was clear that many professionals valued close working relationships between their colleagues and other services and had worked hard to achieve this. It was highlighted that having onsite professionals (e.g. working within their premises) allowed for much easier communication and stronger working relationships to be developed; these individuals were advocating this was something that worked well when applied. Examples currently included hospitals with incorporated social services, district nursing and mental health services.

Other key messages acknowledged by staff we spoke to included:

- Some staff conveyed the challenging nature of communication across services, particularly if there are many services and or organisations involved in a patients care. It was referenced that when working in an A&E department that collaborates with many other health and social care providers, communication can be complex, so it's crucial there are clear pathways for this to happen.

- Communication with tertiary referral centres for hospitals proved difficult (in particular neurosurgery was given as an example). It was felt that the procedure for contacting them could be improved to enable staff to leave messages rather than waiting on hold for long periods of time.

- It was felt that more often than not communication can breakdown as a result of the rising pressures services are under as staff time is restricted. Communication can be negatively affected by increasing demands yet it was acknowledged that without effective communication around patient care, this could cause confusion for both patients and other services.

- Staff emphasized that services need to communicate more effectively across the wider health and social care system as patients assume that services frequently communicate. Patients do not want to have to repeat their condition and concerns to each new professional they may come into contact with, but unfortunately this is still happening today across Norfolk. Staff insisted that something needs to address this going forward.

- There was no one service that proved difficult to communicate with, however, there is no one IT system across all health and social care services that allows for ease in information sharing. This often resulted in professionals referring to 'going in blind' due to a lack of background and information regarding specific patients.

- Another key point evidenced strongly throughout was that at times IT systems can get in the way of efficient and effective patient care.

- Many highlighted the nature of 'silo working' of organisations across the system resulting in staff often feeling that they are working in different systems, almost against each rather than co-ordinated in one health and social care system.

4.4 Access to the Health and social care system for patients

It is important to realise that professionals working in health and social care services have the patient at the heart of the care they provide. This was evident across all professionals we interviewed, who wanted to do what was best for the patient. This becomes more challenging as demands increase and services become stretched.

Other key messages acknowledged by staff in relation to this include:

- One factor often overlooked but that was strongly emphasised by all professions involved, was the extreme demands that all services across the health and social care system are currently under. It was highlighted that supply and capacity doesn't match, with many services experiencing pressures surrounding funding and staffing complications. As a result this led to services being stretched across the large rural county of Norfolk.

- Many staff reported concerns regarding health and social care services and its ability to manage patients with many experiencing delays in discharging patients due to a lack of capacity elsewhere, which in turn impacts on all services. This was described as 'the system becoming blocked' for instance a patient may be medically fit for discharge out of hospital, but there may be no support to get them back into the community. This is due to no community beds being available meaning the patient may need to stay in hospital longer than is required.

- Some staff shared their belief that some patients access A&E fair too easily as they want instant access to treatment and care and may not wish to wait three weeks for a GP appointment. It is not seen as an accident and emergency department anymore which has begun to lead to misuse of services.

- It was portrayed that patient's expectations have changed particularly for those staff that have worked in the NHS for many years. Staff believed patient expectations have risen and may continue to do so for all health and social care services. Patients have become more informed and are far more aware of targets in health and social care, but at times staff are unable to meet these high expectations often as a result of demands placed on the health and social care system.

- Due to the demand driven society we live in people expect more. Patients want instant access to treatment and want what was phrased as 'an instant fix' but staff and services indicated this was not always possible.

4.5 Next steps

The findings from this piece of work will be shared with all staff participating in this project, with General practices and those involved with the previous report: General Practice in Norfolk: Working relationships with patients and other services (Part one). This report will also be disseminated to our key stakeholders and partners across the health and social care system. We have made one main recommendation as shown below based on the evidence we collected and we will monitor this to ensure that the public and staff are informed of our progress.

5. Recommendations

Evidence	Recommendation	For	Follow-up action *"HWN will…*
1. IT systems used across health and social care services Potentially to the detriment of patient care, staff told us services are operating on different IT systems. Leading to a lack of information sharing and places strain upon communication between health services across the county.	System leadership is required to coordinate information systems in Norfolk across health services.	STP Executive Board & STP ICT work-stream lead.	Through the Norfolk & Waveney STP Stakeholder Board, ensure this information is used to inform future planning. Request for STP Stakeholder Board to monitor what progress is made. Conducting a review in May 2018.

6. References

BBC. (2017, January 20) *Fewer beds, higher patient demand- NHS pressure mounts.* Retrieved from: http://www.bbc.co.uk/news/health-38681383

BMJ, (2016) NHS in 2017: A service under pressure. *British Medical Journal, 356* (i6691) Retrieved from: http://www.bmj.com/content/356/bmj.i6691

DeBene, J. (2017) Swimming together or sinking alone. *National Health Executive.* (January/February), p36.

EDP, (2016, January 11) The EDP says it's time for a radical rethink on our NHS. Retrieved from: http://www.edp24.co.uk/news/health/the-edp-says-it-s-time-for-a-radical-rethink-on-our-nhs-1-4374754

Gallington, S. (2017) Communication problem in the digital age. Really? *National Health Executive.* (January/February), p30.

Glasby, J., & Dickinson, H. (2014). Partnership working in health and social care; What is integrated care and how can we deliver it? (2nd Edition). Bristol: Policy Press.

Health and Social Care Information Centre (2015). Mental health bulletin. Annual report from MHMDS Returns 2013-14. Available at: www.hscic.gov.uk/catalogue/PUB18808 (accessed on 12 May 2017).

National Audit Office. (2015). *Department of Health and NHS England: Stocktake of access to general practice in England.* (House of Commons Papers HC 605;SE /2015/16). Retrieved from:*https://www.nao.org.uk/wp-content/uploads/2015/11/Stocktake-of-access-to-general-practice-in-England-Summary.pdf*

National Audit Office. (2017). *Department of Health, Department for Communities and Local government and NHS England: Health and social care integration.* (House of Commons Papers HC 1011;SE/2016/17). Retrieved from: *https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration-Summary.pdf*

NHS improvement, (2016, May 20*) NHS providers working hard, but still under pressure.* Retrieved from: https://improvement.nhs.uk/news-alerts/nhs-providers-working-hard-still-under-pressure/

Reed, R. (2017) Very real risks to resilience. *National Health Executive.* (January/February), p17.

Royal College of Physicians. (2017) Against the odds: Experiences from the NHS front line. Retrieved from:

https://www.rcplondon.ac.uk/projects/outputs/against-odds-experiences-nhs-front-line

The King's Fund. (2013) NHS and social care workforce: meeting our needs now and in the future? Retrieved from: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/perspectives-nhs-social-care-workforce-jul13.pdf

The King's Fund. (2016) A digital NHS? An introduction to the digital agenda and plans for implementation. Retrieved from: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/A_digital_NHS_Kings_Fund_Sep_2016.pdf

The King's Fund. (2017a) Understanding NHS financial pressures: How are they affecting patient care? Retrieved from: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/Understanding%20NHS%20financial%20pressures%20-%20report%20summary.pdf

The King's Fund. (2017b) Organising care at the NHS front line: Who is responsible? Retrieved from: https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Organising_care_NHS_front_line_Kings_Fund_May_2017.pdf

7. Appendix

7.1 Professionals interview themes guide

Healthwatch Norfolk Project on Primary Care Relationships with other services in Norfolk (Phase 2)

Project Lead: Steph Tuvey

Interview questions outline

Below is an example of the outline/topics of questioning for each staff interview.

1) About you
- Your role - Contact with patients - Relationships with other services.
2) Communication & relationships
- Effective communication with providers & GP practices. - Developing relationships with other services. - Information Technology and service providers. - Communication about patient care. - Referring patients to other services. - Inclusive methods of communication. - Sharing information with patients and providers.
3) Current working practices
- Examples of effective practice. - Examples of constraints in practice. - Ways to overcome issues and new ways of working.