NORTHERN REGION CLINICAL GOVERNANCE FORUM INFORMATION PAPER

Title of the paper	**Primary care inbox rationalization**
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Endorsed by	Campbell Brebner
Purpose of the paper	Rationalize, modify, and/or eliminate selective medical and administrative information sent from secondary to primary care inbox.
Meeting date	26 October 2023

PRIMARY CARE INBOX RATIONALIZATION

Recommendation:

That the report be received.

And

That the Northern Region Clinical Governance Forum endorse the recommendations as listed out in the executive summary for Te Whatu Ora Northern Region

Terminology used in this report

- **Results** – for all procedures or investigations (e.g. laboratory, radiology, histology, echocardiogram/treadmills/Holter, endoscopy etc).
- **Care Summaries** – electronic discharge summaries, clinic letters, operation notes, interventional radiology etc.
- **Notifications** – e-Referral associated acknowledgements, patient admission notification etc.
- Primary Care Clinicians – this includes General Practitioner (GP), Urgent Care Providers, Nurse Practitioners (NPs)
- Primary Care Practice Management System (PMS)
- Hospital Patient Administration System (PAS)
- Primary Health Organization (PHO)
- Royal New Zealand College of General Practitioners (RNZCGP), Royal New Zealand College of Urgent Care (NZCUC), Nurse Practitioners New Zealand (NPNZ)
- First Specialist Appointment (FSA)
- National Enrolment Scheme (NES)

1. Executive Summary

The increasing amount of information sent to the Primary Care inbox is causing significant burden and reduced 'joy in practice'.

- Increased clinical time spent on non-patient facing paperwork
- Increased toll on mental health, leading to further reduction of patient-facing hours, increased burnout, earlier retirement and leaving Primary Care as a career.
- Increased medicolegal responsibility from copied results

Thus, the provision and sustainability of quality Primary Care is adversely affected.

From the survey of Northern Region Primary Care Clinicians (2023), these following recommendations are meant to **improve patient safety by reducing ambiguity of responsibility.** It is also to ensure that the administrative burden related to viewing and actioning of medical investigations that are requested by clinicians outside of an organisation is reduced.

1. Cease all current routine/automatic cc'd to GP **results** ordered by **Te Whatu Ora Northern Region secondary care providers (based on Result Responsibility principles in Appendix A)**
    - Any future **results** cc'd to GP will require, on a case-by-case basis, agreement from the primary care recipient (phone call from the requestor to either the GP or practice nurse whether the recipient is expected to act on the result, or if it is just for their information)
        - An electronic closed-loop communication system between secondary and primary care would be the best solution. This will also allow primary care to decline the request if they believe to be inappropriate.

- **Rationale**
  - All **results** are and have always been available to view on Testsafe
    - >99% of Primary Care clinicians in the Northern Region are aware of Testsafe, and >97% of them use Testsafe
  - **Patient admission to hospital notification** will notify the primary care providers and it will be up to each individual practitioner to choose whether to follow their patient's admission
  - **Discharge summary** will inform primary care of patient admission outcome (as it should already include all relevant **results** and **notifications**)
  - **Laboratory, radiology** and **histology results** requested by a secondary care provider are to be interpreted by the requester themselves with responsibility to action on the results
    - This includes ordering follow-up tests **unless this responsibility has been agreed and transferred to primary care with closed-loop communication**
    - Otherwise, **discharge summaries** and **clinic letters** will inform primary care of the action taken/planned by the secondary care provider
- **Transition Plan**
  - Notification of Primary Care in the Northern Region will need to be notified 1-3 months in advance through Medinz, RNZCGP newsletter, RNZCUC newsletter, NPNZ newsletter and PHO newsletter.

2. Draft copies of **clinic letters** be available to view on Testsafe
   - **Rationale**
     - Primary care is currently unable to view clinic letters outcomes in the community until the letters are finalised. This is in comparison to within the hospital where the draft copies of clinic letters are visible.
3. Cease all **notifications** associated with inpatient-to-outpatient e-Referrals
   - **Rationale**
     - **Discharge summaries** will inform primary care of any e-Referrals done
     - All e-Referral statuses are available to view on Testsafe
     - Secondary care is responsible for actioning on the e-Referral if declined
       - There is currently an issue identified where the internal e-Referral outcome is sent only to the referrer (e.g. House Officer). Current work is in process to incorporate responsible SMO within the internal referral form to ensure a closed loop communication. This will likely be addressed by end of 2023 or early 2024.
4. Limit **notifications** to GP only when referrals are graded or declined
   - Modify grading notifications to include reference to Health Pathways FSA realistic wait times for each district when table is updated to include average and 95th percentile numbers.
5. Standardization of subject line for all incoming **results, care summaries and notifications from both public and private secondary care providers**
   - Care summaries (e.g. discharge letters, clinic letters)
     - [Specialty] [Type of letter] [Organisation]
   - Radiology reports
     - [Imaging modality] [Body part imaged] [Organisation]
     - Use "Missed" (for DNAs) and "Cancelled" (for abandoned procedures)

6. **Each primary care practice** will need to ensure each patient's NES details includes a **primary care provider details** (even though it is not mandatory to do so)
    - **Rationale**
        - If there are no provider details included, current hospital practice is to randomly pick a clinician within that practice (if no generic proxy provider for that practice exists)
    - If a practice chooses to not have enrol patients under a practitioner's name, then they will need to create a **generic doctor EDI inbox**.
    - If technically possible, hospital PAS in the future will automatically pull patient's primary care details from NES
    - The hospital will direct patients to contact each practice if they wish to be enrolled under a different clinician (see Appendix B – NES patient pamphlet). Whether this will occur will be at the discretion of each general practice.
    - **Te Whatu Ora Northern Region** will rely on NES for the correct allocation of all **results, care summaries and notifications** to enrolled primary care providers.
7. Standardise HO/registrar education and orientation across the Northern Region e.g. discharge summary advice to GP, e-Referral acknowledgement
    - Electronic Discharge Summary (EDS) templates to add in prompts for RMOs when writing 'reason for amendment' and 'advice to GP'.
    - For example
        - *"Please do not ask a Primary Care to chase results without prior agreement. Ensure outstanding/outpatient investigations are ordered under the responsible inpatient consultant."*
        - *"You must state what has been changed and reason for change."* ← **mandatory field**
8. Delay sending **care summaries** to primary care up to 3-4 hours, so as to only send the most up to date copies in case of amendments.
9. Formalize a method of feedback from primary care to hospital regarding any **results, care summaries and notifications** of concern (e.g. GP to chase, incorrect medication lists on clinic letters, incorrect details on discharge summaries)
    - There will be an appropriate response from secondary care to primary care within a reasonable timeframe
    - Most likely this will be in the form of contacting each district's GP liaison to submit a record on the respective adverse event/risk management system
    - Vice versa, secondary care are encouraged to feedback through GP liaison regarding any communications from primary care of concern (e.g. inadequate e-Referrals)

2. Purpose

- Creating a safe and sustainable future work environment for primary care.
- Safeguard against Primary Care Physician burnout.
- Rationalize, modify, and/or eliminate selective medical and administrative **results, care summaries and notifications** sent from secondary to primary care inbox.

3. Background

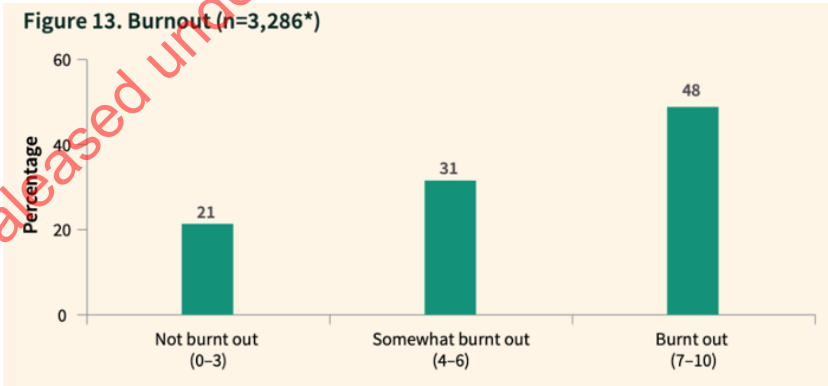
MACGF 2022 GP Survey Outcome

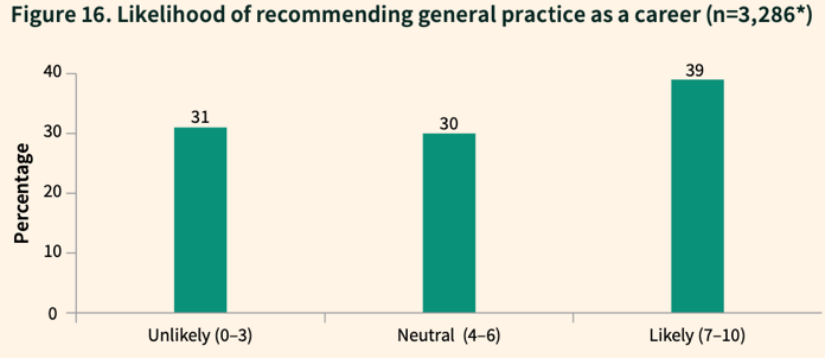
- Discrepancy between what results/notifications primary care would like to receive and the comments/feedbacks.
- Conclusion

- There is nuance with regards to results/notifications primary care wish to receive.
- Communication from secondary care needs to be
  - Relevant
  - Succinct without duplication
  - Professional with clear understanding of result responsibility

According to the 2022 GP workforce survey and 2021 GP Future Workforce Requirement report, general practice workforce is under immense pressure due to

1. Shortage of specialist general practitioners throughout the country, especially in rural and areas of high need, leading to increased workload.
   a. Ageing GP workforce, almost half of GPs work part-time
   b. Excluding registrars, 44% of GPs intend to retire in the next 5 years, and 64% in the next 10 years
   c. Number of GPs per 100,000 is projected to fall from 74 in 2021 to 70 in 2031.
   d. Average number of hours GPs spend consulting with patients is 24.4 hours/week
   e. Average number of hours spent on non-patient facing activities (e.g. paperwork, teaching, practice management etc.) is 11.5 hours/week
2. The increased complexity of patient care as care is shifted out of hospitals and into the community.
   a. More GPs would save the economy $139.6 million in health savings a year ($150 m per year in savings after deduction cost of $10.4m to train more GPs)
3. Lack of recognition within the health system of post-graduate specialist general practitioner training.
   a. GP training by RNZCGP needs to increase from 200 to 300/year to develop a sustainable workforce





4. Survey 2.0 outcomes (filtered only for those in the Northern Region)

According to clinical advisors from the Medical Protection Society (Dr. Samantha King) and the Health and Disability Commissioner's office (Dr. David Maplesden): "There is a responsibility for primary care to act on significant abnormal results when they arrive in your inbox or when you view it on Testsafe, regardless of who ordered the investigation in the first place." Are you aware of the above medicolegal opinion?
Yes 66%
No 34% ← this poses as a significant risk to primary care

If Yes, **how long have you been aware of this?**
<3 months 25% ← the recent Goodfellow webinars on this issue have helped brought this issue to the forefront again
>3 months 75%

"Filing patient related results and notifications (e.g. declined outpatient referrals) not initiated by you is therefore, equivalent to acknowledging the result and agreeing to take appropriate action in a timely manner." Are you aware of the above medicolegal opinion?
Yes 51%
No 49% ← significant medicolegal risk for primary care

Please indicate whether you would like to routinely receive the below inbox items requested by secondary care (both inpatient and outpatient).

Radiology reports (requested by secondary care)
Yes 35%
No 65%

Histology reports (requested by secondary care)
Yes 37%
No 63%

Endoscopy reports (requested by secondary care)
Yes 50%
No 50%

Cardiology investigations (requested by secondary care) [i.e. echocardiogram, exercise tolerance test, angiography etc.]
Yes 49%
No 51%

Microbiology reports (requested by secondary care)
Yes 20%
No 80%

Haematology and biochemistry reports (requested by secondary care)
Yes 18%
No 82%

Internal hospital referral to outpatient services (e.g. if an inpatient general medicine team requesting outpatient cardiology review is declined and you receive the declined notification in

your inbox, there is a potential responsibility for primary care to follow-up if the declined referral is significant/time critical).
Yes 20%
No 80%

Date of future outpatient clinic appointment (requested by secondary and primary care) (Note: you can view booked appointment date and time on Testsafe)
Yes 26%
No 74%

Hospital admission notification
Yes 62%
No 38%

Hospital discharge notification (Note: this is a brief notification and not the full discharge summary that follows)
Yes 38%
No 62%

Do you agree with the following proposed changes to communication between primary and secondary care?

Any results cc'd to primary care (including the associated responsibilities) need to be discussed with and accepted by a relevant clinician in primary care (e.g. GP, NP or a practice nurse).
Yes 80%
No 20%

Primary care should be able to see drafted copies of outpatient clinic letters on Testsafe (Note: it takes time for the clinic letters to be finalised, given they need to be dictated, transcribed and approved by the clinician).
Yes 82%
No 18%

All Northern Region communications (e.g. discharge summaries, clinic letters, radiology reports etc.) should have standardised headings that appear on your practice management system. [specialty] [type of letter] [organisation] e.g. Cardiology clinic letter Counties Manukau [imaging modality] [body part imaged] [organisation] e.g. MRI head Counties Manukau
Yes 99%
No 1%

Would you support using NES to identify the correct practice for all hospital communications?
Yes 98%
No 2%

Would you support using NES to identify the responsible primary care clinician for all hospital communications? Note: this will further aid your practice management system to allocate the correct inbox items to the correct clinician.

Yes 96%
No 4%

Would you like to have a formalised communication and feedback system between primary and secondary care with regards to any information or interactions of concerns? Note: there is currently no register/database on how frequent communication issues arise, hence it is difficult to drive any meaningful change.
Yes 96%
No 4%

Should medical schools in New Zealand include in their curriculum how to compose discharge summaries? Note: this extends beyond clinical communication skills and includes clinically coding training relevant for secondary care.
Yes 84%
No 16%

Should hospitals in New Zealand standardise House Officer education on composing discharge summaries? Note: this extends beyond clinical communication skills and includes clinically coding training relevant for secondary care.
Yes 96%
No 4%

Are you a Doctor or Nurse Practitioner?
Doctor 96%
Nurse Practitioner 4%

Participant role at main work site
General Practice 444
Urgent Care 15
Other Primary Care (e.g. Aged Residential Care, Skin Cancer, Student Health) 11

Do you currently have a set number of patients enrolled under your care?
Yes 60%
No 40% ← this highlights importance of how primary care can ensure continuity of care if a significant proportion of clinicians do not have specific patients enrolled under their care

Do you currently having support in your practice with managing your inbox? (e.g. practice nurse for routine cancer screening such as cervical or breast)
Yes 43%
No 57% ← not all practices have the capability to have support with managing inbox

If yes, who helps you with your inbox management?
Practice Nurse 77%
Nurse Practitioner 7%
Health care assistants/physician assistants/medical assistants 29%
Automated filing 11%
Other 15%

What information do you receive in your electronic inbox from secondary care?
All communication 91.9%

All communication excluding routine screening review by practice nurse e.g. cervical, breast screening 5.7% ← judging by the above stated 43% of practitioners saying they have support with manging their inbox, then this is likely under-represented. Possibly due to participants not understanding this question.
Abnormal reports only 1.1%
Other 1.3%

What best describes your current level of training/qualification?
1st year trainee/registrar 1.9%
2nd year and above trainee/registrar 11.9%
FRNZCGP/FRNZCUC/Nurse Practitioner 82.3%
Other (I do not hold a vocational scope in general practice/urgent care/NP) 3.8%

How many years have you been working in primary care? Please include your years spent in training.
Under 3 years 8.4%
3 to 5 years 9.4%
6 to 10 years 13.5%
Over 10 years 68.7%

What district is your main work site?
Te Tai Tokerau (Northland) 11.7%
Waitemata 33.6%
Te Toka Tumai Auckland 31.3%
Counties Manukau 23.4%

Is your practice Very Low Cost Access (VLCA)?
Yes 40%
No 60%

Is your practice Cornerstone accredited?
Yes 80%
No 20%

What is your gender?
Female 61%
Male 39%

What ethnic group do you belong to? (you may choose multiple)
Maori 6.4%
Pacific Island (Pasifika) 4.7%
Chinese 12.8%
Indian 9.8%
NZ European/Pakeha 53.2%
Other European 11.7%
Other Non-European 11.9%

What is your age cohort?
< 35 years 15.3%
35-44 years 25.1%
45-54 years 18.9%
55-64 years 31.5%
65+ 9.1%

Do you feel you are currently able to maintain a good work-life balance?
Yes 42%
No 58%

Have you decreased your patient facing hours in the past 5 years?
Yes 68%
No 32%

Has increased administrative burden from paperwork been one of the main reasons to reduce patient facing hours?
Yes 72%
No 28%

How would you rate yourself in terms of your well-being with regards to burnout?
Not burnt out 24.5%
Somewhat burnt out 54.3%
Burnt out 21.3%

How would you rate the satisfaction with your role at your main work site?
Very satisfied 12.8%
Moderately satisfied 45.3%
Unsure 17.4%
Moderately dissatisfied 17.0%
Very dissatisfied 7.4%

When do you intend to retire or leave primary care (i.e. switch to a different career pathway)?
Less than 3 years 26.4%
3 to 5 years 19.8% ← total 46.2% of clinicians intending to retire from primary care within 5 years
>5 years 53.8%

Has increased administrative burden from paperwork been one of the main reasons to move up retirement plans or leave primary care earlier?
Yes 62%
No 38%

Would you recommend primary care as a career in New Zealand?
Yes 28% ← less than 1 in 3 primary care clinicians would recommend their own specialty in NZ
Neutral 36%
No 36%

Additional information

1. Results cc'd to GP
    a. What we know
        i. Some blood test results ordered are cc'd to GP on regular basis (e.g. noted with dialysis and oncology patients)
        ii. Inpatient radiology (this is an automatic process, as there are no options to cc GP when doing an inpatient radiology request electronically)
        iii. Outpatient investigations when seen in outpatient clinics or post-discharge e.g. cancer staging radiology, histology
            - The check box for 'copy to GP' is currently automatically ticked and can be turned off (as per Stuart Barnard, Counties Manukau)
    b. Impact
        i. Unclear responsibility leads to medico-legal ramifications and duplication of work for the clinician who had not had any handover of clinical responsibility or context.
        ii. Receiving investigations ordered by specialist creates difficulty in filing (as will be visible on patient portal) and also informing of patients of next steps if primary care does not have the clinical expertise to interpret and advise.
    c. Recommendation
        i. Cease all routine cc'd to GP **results** ordered by secondary care
        ii. Any future **results** cc'd to GP will require, on a case-by-case basis, agreement from the primary care recipient (clear communication from the requestor whether the recipient is expected to act on the result, or if it is just for their information).
        iii. Rationalization and Transition plan
        iv. All **results** are and have always been available to view on Testsafe
            - We recognize this may not have been widely known and will develop dedicated PMS-specific video tutorials and manuals to ensure all primary care staff know how to access and use Testsafe
        v. **Patient admission to hospital notification** will still notify the primary care provider and it will be up to each individual practitioner to choose whether to follow their patient's admission.
            - **Discharge summary** will inform primary care of patient admission outcome (as it should include all relevant **results** and **notifications**)
        vi. **Laboratory, radiology** and **histology results** requested by a secondary care provider are to be interpreted by the requester themselves with responsibility to action on the results (this includes ordering follow-up tests e.g. abnormal TSH, chest x-rays)
            - Otherwise, **discharge summaries** and **clinic letters** will inform primary care of the action taken/planned by the secondary care provider
            - Requests for primary care involvement will require a phone call agreement handover of care
        vii. Notification of Primary Care in the Northern Region regarding above change
            - 2-4 weeks in advance of change through Medinz, RNZCGP newsletter, PHO newsletter, and New Zealand GP Facebook Group (notifying members of change).
    d. Limitation
        i. Obstacles would be buy-in from selected specialties in secondary care and a proportion of primary care providers as this is effectively removing a safety netting. However, there needs to be a consideration of reasonable responsibility and sustainability considerations for primary care.
        ii. There is a concern with regards to the volume of unaccepted radiology/histology at Counties Manukau

- Note: unaccepted results do not equate to unactioned results
- There is currently work on building Qliksense app at Counties Manukau to improve visibility of above. The goal is to provide data to action change of behavior.

2. "Subject" for incoming documents
    a. What we know
        i. Non-essential and outdated wording e.g. Rheumatology Service Clinic Letter CMDHB
        ii. Inaccurate description e.g. CMDHB-ClinicReportDoc-v3 [for haematology discharge summary], Referral [for notification of patient hospital admission]
        iii. Subject not in order of important e.g. CMDHB-General Medici-EDSDoc
        iv. Insufficient information e.g. Radiology CMDHB
    b. Impact
        i. When filed onto PMS, it is difficult for GPs to
            - Identify nature of a filed document
            - Search relevant documents by subject headings
        ii. This difficulty is further amplified when seeing patients not registered under your service
    c. Recommendation
        i. A standardised format for subject line with most important information in the forefront
        ii. Transfer of care letters (e.g. discharge letters, clinic letters)
            - Specialty
                a. Type of letter
                    i. Organisation
            - e.g. Cardiology Clinic Letter/Discharge Summary Counties Manukau
            - e.g. Respiratory admission notification Counties Manukau
        iii. Radiology is exception
            - Imaging modality
                a. Body part imaged
                    i. Organisation
            - e.g. MRI Head Counties Manukau
            - Suggest using terminology of "Missed" (for DNAs) and "Cancelled" (for abandoned procedures).
                a. e.g. Missed X-ray Chest, Cancelled Ultrasound KUB

5. Conclusion

The risks of ever-increasing information received by the primary care PMS inbox comes in the form of reduced patient-facing clinical hours due to increased paperwork, burn-out, and medico-legal risk all at the detriment of patient care. The above recommendations need to be promoted by a united effort and supported by like-minded secondary care advocates to ensure primary care achieves a sustainable future to provide quality service.

Appendix A: Result responsibility document

- **Currently**
  - **Approved by the national CMO group for sign-off**
  - **Afterwards, RNZCGP, MPS, HDC and MCNZ will all subsequently endorse this document**

Purpose:

Transfer of care and confusion around result handling is recognised by the Health and Disability Commissioner, Medical Protection Society, Royal New Zealand College of General Practitioners and others as a time of increased risk of harm to people. There have been a number of cases in NZ where people have been adversely affected by the current lack of clarity.

Definitions:

Responsible clinicians are registered clinicians capable of autonomous practice without direct supervision. Currently this includes:

- Senior Medical Officers (SMO)
- Specialist General Practitioners (GP)
- General Medical Registrants
- Advanced Practice Allied Health staff (AHP)
- Nurse Practitioners (NP) and Nurse Prescribers
- Dentists and Dental Specialists
- Pharmacist Prescribers
- Lead Maternity Carers (LMC) and DHB Midwives

Principles:

The following are high level principles which are intended to be applicable to all responsible clinicians who order investigations and are involved in a person's care.

Principle 1

The clinician who orders an investigation (the requestor) is responsible, either personally or delegated through defined team processes[1], for review and actioning of the results regardless of subsequent transfer of care, unless explicitly agreed to and documented, otherwise.

All pending tests at time of transfer of care will be clearly stated including subsequent responsibility for test result. This includes, within organisations, between organisations, between institutions as well as any services. Transfer of care letters and outpatient clinic letters should not include statements suggesting otherwise. If responsibility of pending tests has been agreed upon by the receiving service, this will be explicitly noted on the transfer of care document.

In those instances, where a health professional is copied into results, the responsibility for reviewing and actioning results lies with the requestor however the recipient health professional also has responsibility to ensure results of significant clinical importance[2] have been acted upon. Actioning includes ensuring that the person is aware of their results in a reasonable timeframe.

Principle 2

Where it is critical that (for effective continuity of care) information is shared with other clinical or service providers, separate clear communication is required if the recipient is expected to act on the result.

[1] Examples could include junior doctors working within a medical team or other clinicians and professionals in a multi-disciplinary team setting such as pre-operative assessment clinics.

[2] The boundary of what constitutes a clinically significant result is not defined but in practice is likely to refer to any result which could lead to mortality or significant morbidity if not acted upon.

This includes to clinicians outside of the requestor's organisation, including the person's GP. Any results copied require a clear communication from the requestor whether the recipient is expected to act on the result, or if it is just for their information. If action is required, a documented handover, with agreement from the receiving clinician to accept the responsibility, involving closed-loop communication is expected. This is essential if an investigation is particularly time sensitive or important.

Principle 3
Any clinician copied into result which is significantly abnormal needs to ensure appropriate action has been taken.

Clinicians have a duty of care to act on test results they are copied into which may have significant consequences for patients if not followed up despite the prime responsibility remaining with the requestor as per principle 1. The clinician must base their response on sound clinical judgement and the clinical context and information available to them to make that response.

Principle 4
Requirements for regular monitoring and follow up must be agreed between the referring and receiving clinicians.

Some people require regular monitoring once discharged back to Primary Care. A secondary care clinician may ask the primary care provider to be the requestor for repeat tests, providing the test is readily available in the community setting and the interpretation of the test is within the scope of the recipient professional. The recommended testing interval must be clearly stated, with management plan and agreed to by the accepting responsible clinician.

Context:
This document outlines principles which promote the safe transfer of responsibility for follow up of test results. This relates to medical investigations and tests that occur within hospital settings, are pending at the time of discharge from secondary care and are requested from outpatient appointments. It is important before copying a colleague into test results that these are meaningful and necessary for continuing care and that the colleague will have the understanding necessary to interpret the result. Copying test results should never be an automatic process but a carefully considered action, when the person ordering the test is intending that the recipient will need to act on the result, and that this has been made clear to them, in a separate communication.

It **cannot** be assumed that community-based clinicians (e.g., GPs) will follow up on outstanding test results. This requires either a discussion with them or their team to ensure they are prepared to accept responsibility or that explicitly agreed delegation for the responsibility is documented in the discharge summary.

Most community-based clinicians cannot 'acknowledge' results in the hospital system – a hospital clinician will still need to do this.

It is inappropriate to expect other clinicians to be responsible for results that require specialist knowledge or intervention.

The purpose of setting principles is to improve patient safety by reducing ambiguity of responsibility. It is also to ensure that the administrative burden related to viewing and actioning of medical investigations that are requested by clinicians outside of an organisation is reduced.

Every consumer has the right to co-operation among providers to ensure quality and continuity of services. Where the clinical care of a person is handed over to a different clinician or service all parties have responsibilities regarding following up investigation results. The clinician transferring the person is expected to have reviewed all test results to hand, and to document tests ordered and notify the accepting clinician of any pending results as well as the results to hand. Any clinician who accepts care of a person is expected to have some familiarity with the results of tests already performed.

It is expected practice that the requestor of a test should take responsibility for checking and acting on the result, however, in hospital settings, many tests will not be requested by the responsible clinician (e.g. consultant of a team). Nevertheless, the responsible clinician still has the responsibility for ensuring that the result is viewed and accepted or delegated.

Cole's Medical Practice in New Zealand state a number of principles for doctors, including:

- If you order investigations, it is your responsibility to review, interpret and act on the results.
- If you go off duty before the results are known, you should alert the incoming doctor that there are results outstanding.
- Furthermore, you should check the results when you are next on duty.
- It should be the responsibility of the clinician who has ordered the test to ensure that the results are reviewed, the person is informed, and any necessary action is taken.

The Royal New Zealand College of General Practitioners has produced guidance for general practitioners about what standards are expected and this includes: (RNZCGP, 2016) All incoming test results or other investigations are sighted and actioned by the practice team member who requested them or by a designated deputy.

The Medical Protection Society article 'Handling test results' also looked at the issue of doctors' responsibility for tests they did not order and notes that the primary responsibility for following up abnormal results rests with the clinician who ordered the tests. (MPS, 2019)

A clinician that requests a test has a duty of care towards the person to ensure that all test results are reviewed in a timely manner and that any appropriate action is taken. A requestor that is unable to do so must organise appropriate cover within their organisation. Organisations and clinical leads have a responsibility to ensure that the systems for handling results are fit for purpose and have sufficient safeguards. This will necessitate changes such as allocating sufficient time for staff to review results.

There can only be one responsible clinician during any episode of care. Laboratory and radiology systems must ensure results are only allocated to responsible clinicians. Every responsible clinician must have a 'results inbox' available to them when they sign in to their clinical portal that includes all outstanding unacknowledged results. Electronic results should only appear in the 'results inbox' of one responsible clinician. Registrar clinics must be associated with a named SMO who assumes responsibility for results. Responsibility may be delegated to another person.

Responsibility will be transferred when a person's care transfers to another team such as when people are admitted from ED. By acknowledging a result, a clinician is also taking responsibility for any action required. Simply reviewing a significantly abnormal result[3] without ensuring appropriate action occurs or that it is brought to the attention of an appropriate responsible clinician is not acceptable. If you view a report this action establishes a clinical relationship between yourself and the person — thus you are now partially responsible for ensuring that the clinical implications of the report that you have seen are dealt with, regardless of who requested the test/procedure. **This creates duplicate work for clinicians in who are copied into results without handover of clinical responsibility or context.** The copied doctor needs to make a reasonable effort to contact the requestor to ensure that they are aware of the result and that appropriate action is taken.

Copying of results is NOT a transfer of care and results should not be routinely copied to any other clinician at the time of request. This ensures that ongoing responsibility lies unambiguously with the requester. If handover

[3] The boundary of what constitutes a *clinically significant result* is not defined but in practice is likely to refer to any result which could lead to mortality or significant morbidity.

of responsibility is requested, this needs to be clearly communicated in writing and with closed loop communications – i.e. by phone call.

Significantly abnormal results are to be followed up by the requestor who also hold the primary responsibility of informing the patient in a timely manner (MPS Handling of Test Results, May 2015). ← this might need to be removed, as if it's significantly abnormal, all those who are sent the report will need to take timely action.

Appendix B: NES Patient Pamphlet content

When to use:
When a patient raises a query that the Primary Care provider displayed on hospital Patient Administration Systems (PAS) does not match the Primary Care provider on the National Enrolment Scheme (NES) database.

Pamphlet heading: Changing your GP details

Pamphlet content:
You have raised a question about your Primary Care provider details on our hospital system. **Please note that Middlemore hospital cannot alter as this can only be changed by your General Practice.**

When you are enrolled under a General Practice, the main benefits are

- **The choice to see any doctor in that practice.**
- Pay a lower cost for your appointments (in comparison to visitor rates).

However, each doctor/nurse practitioner can only enrol a limited number of patients under their name. Even though you may prefer to see doctor A, you may be enrolled under doctor B because doctor A already has the maximum number of patients enrolled under his/her name. **Please note that this does not stop you being able to see doctor A (subject to their appointment availability).**

If you wish to change your enrolment to doctor A, you will have to make this request to your General Practice.

Form for patients to bring to their preferred General Practice:

I, (patient name) would like to request to be enrolled under (Primary Care provider's name) at (General Practice clinic's name).

I understand that this request may be declined as my preferred doctor may not be enrolling new patients.

Signature:_____
Date:_____