LEADERSHIP IN PRACTICE | MODULE 05

Patients, teams and communication

Turn communication into shared understanding, clearer decisions and meaningful patient partnership.

- ✓ 15 min reading
- ✓ Full teaching, practical next steps and reflection
- ✓ Six practice questions with answers and explanations
- ✓ Complete source list and jurisdiction notes

Prepared for SAS, locally employed and other UK doctors

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Using this module

Independent education

This is general professional information, not individual clinical, legal, employment, immigration, regulatory, tax or pensions advice. Current official instructions and the circumstances of the individual case remain controlling. Practice scores do not establish professional competence or accreditation.

The short answer

Communication is not complete when information has been sent. Check what people understood, what matters to them, who owns the next action and how the decision will be reviewed.

Three next actions

- Begin one discussion by asking what matters most to the patient or colleague.
- End the meeting by naming the decision, owner and review date.
- Check understanding in plain language rather than asking only “Any questions?”

Learning objectives

- Distinguish informing or consulting people from genuine partnership.
- Create role clarity and closed-loop communication in changing teams.
- Use patient, staff and cross-boundary knowledge to improve decisions.

Why this matters

Healthcare decisions are often technically correct but operationally weak because the people who must live with or implement them were not meaningfully involved. A patient may understand a risk differently from the service. A nurse may see a practical failure that is invisible in a meeting. A therapist may know that the proposed discharge plan cannot work in the person's home. Leadership turns these perspectives into better judgement rather than treating them as communication tasks after the decision.

Teams are also less stable than organisational charts suggest. Doctors work across shifts, sites, professions, agencies and digital channels. The relevant team may form for one patient and dissolve hours later. Purpose, role clarity and closed loops must therefore be created deliberately.

Put the patient in the purpose

Beginning a proposal with 'for patients' is not the same as understanding what patients value. The purpose should identify the patient or population, the problem experienced and the outcome that matters. This may include safety, function, continuity, dignity, access or the burden placed on families, not only organisational activity.

Patient knowledge can change the representation of the problem. A clinic may measure waiting time while patients describe uncertainty, repeated travel or inability to contact the service. These are not secondary experiences. They may reveal that the chosen measure does not capture the harm.

Information, consultation and partnership

Information tells people what has been decided. Consultation asks for views while authority remains elsewhere. Partnership allows patient or staff knowledge to change the problem, options or decision. Each can be appropriate, but they should be named honestly. An urgent safety instruction may require information rather than co-design; a long-term service redesign usually needs earlier involvement.

Avoid tokenism by involving people while options are still open, explaining what is and is not negotiable, providing accessible information and reporting what changed. One patient representative cannot speak for every community. Combine lived experience with wider evidence and avoid selecting only the person most likely to agree.

Lead the team that actually exists

A team is more than a list of professions. It needs a shared purpose, enough role clarity to coordinate, usable communication and some capacity to learn. In modern NHS care, the team may include acute and community staff, primary care, social care, ambulance services, patients and families. Interfaces are therefore part of the team, not external complications.

When a team changes rapidly, create minimum conditions early: what are we trying to achieve now, who is coordinating, what does each person own, what information is missing and when will we regroup? This is particularly important during transfer, deterioration or a complex discharge.

Role clarity without rigidity

Role clarity means people understand who is doing what and where responsibility changes. It should not prevent appropriate adaptation. A colleague may help outside a usual boundary, but the team should still know who retains accountability and when senior support is required.

Titles can mislead across organisations. A locally employed 'clinical fellow' may have very different experience in two services. A community role may carry autonomy unfamiliar to an acute colleague. Clarify capability and expected task in the present context rather than assuming that everyone interprets the title in the same way.

Communication must produce understanding

Sending a message is only the beginning. Important communication moves through purpose, expression, receipt, interpretation, action and feedback. Failure can occur at each stage. A clear email may reach the wrong person; a verbal plan may be heard but understood differently; an agreed action may have no owner.

Use closed-loop communication for material decisions. Name the recipient, ask for confirmation, summarise what has been understood and establish ownership and review. Structured tools can help under pressure, but a template does not guarantee understanding. The receiver should have a route to question the plan.

Language, disability and access

Plain language is a safety intervention. Avoid unexplained abbreviations, organisational jargon and expressions that rely on shared cultural knowledge. Use professional interpretation where required rather than placing responsibility on children or untrained relatives. Check hearing, vision, cognition, literacy and communication needs.

For staff, accent or fluency should not be confused with competence. At the same time, leaders must address communication that creates risk. Describe the specific event and effect, arrange appropriate support and apply standards consistently. Vague comments about style or fit are neither fair nor educational.

Partnership when the answer cannot be yes

Partnership does not mean every preference can be met. Clinical evidence, law, resource constraints and competing needs may limit options. Explain the boundary, acknowledge its effect and involve the person in the choices that remain. Do not present a decision as shared if the material option was never available.

When professional and patient knowledge conflict, slow the reasoning down. Check understanding, explore the values beneath the preference, consider capacity and consent where relevant, and seek further advice if the consequences are significant. Record the decision and how the person's perspective influenced it.

A practical handover test

Choose one cross-boundary handover. Ask whether the receiving team receives a live model of the situation: current condition, uncertainty, pending decisions, likely deterioration, patient priorities and the action required. A long history without a clear purpose can be less useful than a concise, prioritised transfer of responsibility.

After the handover, verify whether the receiver understood the decision and had the capability and capacity to act. If the same interface repeatedly fails, treat it as a system design problem rather than reminding individuals to communicate better.

- Purpose and present risk are explicit.

- Patient priorities and communication needs are included.
- Responsibility and escalation transfer clearly.
- The receiver confirms understanding and capacity.

Common mistake

Avoid this	Mistaking attendance, consultation or information-sharing for genuine involvement in the decision.

Pause and reflect

Whose priorities or knowledge are missing from the decision you are about to make?

Takeaways

- Understanding matters more than transmission.
- Close important communication loops.
- Patient and team perspectives improve decisions.

Knowledge check

Choose one best answer. These practice questions support reflection; they do not assess a real case or confer accreditation. Answer positions match the browser edition.

1. When does consultation become genuine partnership?

A. When the meeting includes a patient representative

B. When people receive a detailed leaflet

C. When patient or staff knowledge can change the problem, options or decision

D. When the organisation explains a completed decision

2. A rapidly formed team is managing deterioration across two sites. What is the most important early leadership action?

A. Avoid role clarification so people remain flexible

B. Ask the most senior doctor to do every task

C. Wait for the formal team structure

D. Establish purpose, coordinator, roles, missing information and review point

3. What does closed-loop communication add to sending a message?

A. More organisational jargon

B. Removal of the receiver's right to question

C. Confirmation of receipt, understanding, ownership and review

D. A longer email

4. A patient's preferred option is not clinically available. What supports genuine partnership?

A. Avoid discussing the constraint

B. Ask the family to persuade the patient

C. Describe the decision as shared anyway

D. Explain the boundary and involve the patient in the choices that remain

5. A colleague's communication has created a specific safety risk. What is the fairest response?

A. Assume accent proves lack of competence

B. Describe the event and effect, arrange support and apply the same standard consistently

C. Describe them as a poor cultural fit

D. Ignore the problem to avoid discrimination

6. Which handover is most useful?

A. A list of tasks with no escalation route

B. The longest possible medical history

C. A message sent without confirmation

D. A live model of condition, uncertainty, priorities, responsibility and required action

Answers and explanations

1. C — When patient or staff knowledge can change the problem, options or decision

Partnership provides a real route for relevant knowledge to shape the work while making decision limits clear.

Review the difference between information, consultation and partnership.

2. D — Establish purpose, coordinator, roles, missing information and review point

Dynamic teams need minimum coordination conditions even when membership changes quickly.

Return to 'Lead the team that actually exists' and use the five minimum conditions.

3. C — Confirmation of receipt, understanding, ownership and review

The loop is closed when the message becomes shared understanding and accountable action.

Review the six stages from purpose to feedback and apply them to one material message.

4. D — Explain the boundary and involve the patient in the choices that remain

Partnership includes honest limits and meaningful choice within those limits.

Revisit 'Partnership when the answer cannot be yes'.

5. B — Describe the event and effect, arrange support and apply the same standard consistently

Specific evidence and relevant support address safety without relying on vague or biased judgements.

Review 'Language, disability and access' and separate communication effect from identity assumptions.

6. D — A live model of condition, uncertainty, priorities, responsibility and required action

A useful handover transfers an actionable understanding of the current situation and responsibility.

Return to 'A practical handover test' and assess one current interface.

Official and professional sources

Confirm the current source version and applicable nation, contract, scheme or specialty. A source list is not a statement that every rule applies to every reader.

GMC: Leadership and management guidance
UK · https://www.gmc-uk.org/professional-standards/the-professional-standards/leadership-and-management/about-this-guidance

NHS Leadership and Management Framework
England and Wales · https://www.england.nhs.uk/leaders/nhs-leadership-and-management-framework/

NICE: Shared decision making
England and Wales · https://www.nice.org.uk/guidance/ng197

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