



Royal College of
General Practitioners

Effective Interface

A module to assist GPs and consultant colleagues to identify and provide solutions to problems that exist at the primary/secondary care interface.

Foreword

Chairing my health board's Area Medical Committee brought home to me the gulf that can exist between GPs and Hospital doctors. Where relationships and communication are good, job satisfaction was high and medical staff felt empowered to improve the care of their patients, but this was only patchy. As a result of this experience I was very keen to see what could be done to improve things and was delighted to have the entire team agree this as a priority for RCGP Scotland.

The term "interface" has now become established to talk about the current challenges in providing sustainable and safe healthcare. The interface is the point of interaction between different systems. In healthcare, interfaces exist where a patient journey crosses from one area of care into another such as moving between primary and secondary care, between health and social care and between scheduled and unscheduled care. It is probably most usefully considered in a healthcare context in terms of the relationships, both organisational and interpersonal, that exist between these different systems.

Due to the individual complexity of these different systems, with their differences in aspects such as culture, professional boundaries, governance systems, performance targets and IT systems the interface can be a dangerous place for the patient to navigate. It is estimated from national patient safety data that around 50% of errors occur at the interface. There are many lessons to be learned and improvements to be made by better understanding of and investment in the interface between primary and secondary care. Investment and energy has traditionally been focused on specific quality and safety initiatives that improve component parts of the healthcare system but fundamental challenges remain around how the wider NHS in Scotland could function more effectively.

RCGP Scotland recognises this key aspect of inter-professional working in the modern NHS and has pursued a series of approaches to bring about improvement in the interface. The Effective Interface quality improvement module is one outcome from this work. It is important to state that though RCGP Scotland has been leading on the development of this module it has backing from the Scottish Academy of Royal Colleges as no one sector can bring about change in the way the interface works.

We earnestly hope that it will be used widely across Scotland, building relationships, mutual understanding and making changes for the ultimate benefit of our patients.

Dr Miles Mack
Chair RCGP Scotland

Introduction

This module is designed to help GPs and consultant colleagues identify and provide solutions to problems that exist at the primary/secondary care interface. It provides a quality improvement method of approaching these problems which should provide a means of improving the care our shared patients experience. The improvements should also make the participants' work more efficient so that benefit is gained for all. Potential benefits may ensue in areas such as patient safety, patient satisfaction and time to diagnosis and treatment. Interpersonal relationships and mutual understanding of roles should certainly improve.

The module is divided into the following sections:

- 1. Preparatory work**
- 2. Effective Interface Meeting**
- 3. Implementing change**
- 4. Review Effective Interface meeting**
- 5. Continuing relationship**
- 6. Tips and tools**

It is important that someone takes on the responsibility for ensuring that the processes in the module are followed. It is suggested that the practice manager is the person best placed to do this. The meetings require someone to take on the role of facilitator as well as being a participant. It is expected that either the GP or practice manager take on this role. In some Health Boards there may be an opportunity for external facilitation.

Though the actual module work is carried out by a single practice and one speciality, it is expected that the learning gained is shared widely throughout the local health care system using channels such as GP clusters, secondary care and Health Boards.

This module is based on the RCGP Guide to Quality Improvement which can be found at <http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement.aspx>. Further explanation of the tools described in the Effective Interface module can be found there.

RCGP Scotland is keen to get feedback on the effectiveness or otherwise of the module. Please send any comments on this to Euan.Bailey@rcgp.org.uk.

1 Preparatory Work

Getting started

The Effective Interface module will usually be initiated by a Primary Care Team, probably a GP Practice. The Practice will nominate an Effective Interface Lead GP. This may be, for example, the Practice Quality Lead or a GP with an interest in the chosen specialty. The GP Lead will be expected to work closely with the Practice Manager or another identified senior administrative staff member. The Effective Interface GP Lead and Practice Manager will read through the whole module early in the process so that they are aware of what to expect at each stage. First they will need to identify the secondary care team they most wish to engage. A significant event or series of incidents at the interface may have highlighted a theme, or perhaps a quality improvement need may have been raised by the Cluster or Practice Quality Leads.

The Effective Interface GP Lead will approach a Consultant in the secondary care team to invite them to be involved in the module. A personal connection or introduction through a third party can facilitate engagement but is not essential. Initial communication may be by telephone, particularly if a prior relationship exists, or by letter or email. An information sheet to send to Consultants is available in the appendix. (See also Chapter 7 of the 'Quality Improvement for General Practice toolkit' on Engaging Stakeholders).

In the event that the invitation is turned down, the Effective Interface lead GP may wish to consider an alternative Consultant in the same department or it may be necessary to switch to another specialty altogether. If the practice goes through the module with a second choice secondary care team and there is a successful outcome it may be possible to return to the first specialty at a later date with examples of mutual benefit that have been gained through the process.

After agreement to participate in the module has been reached, a date should be set for the Effective Interface Meeting. This should take place around 12 weeks later to allow for preparatory work to take place. For clarity in describing the timeline, the date of agreement will be called week 0 and the Effective Interface Module Meeting will be at week 12.

The preparatory work for both teams will be similar and running in parallel.

A suggested timeline for the project is shown below and an interactive project plan is available when the practice registers its interest in carrying out the Effective Interface project with RCGP Scotland.

Timeline

Week number	Date	Action
		Read Effective Interface module and engage with practice team Identify practice lead Choose secondary care team to collaborate with
0		Secondary care team agree to participate and nominate a lead Agree date for Effective Interface meeting Register with RCGP Scotland
2		Leads agree with wider teams to identify interface issues. Agree within teams which two priorities to share
4		Priorities shared between primary and secondary care teams
4-6		Primary and secondary care teams choose which of the two priorities they wish to address
6		Primary and secondary care teams feed back to each other which priority they have chosen Re-confirm date of Effective Interface meeting
6-9		GP practice identifies suitable patient representative Primary and secondary care teams collect data on the priorities chosen
10		Data is shared with the other team The other team looks at this data GP practice prepares information pack for the patient
12		Effective interface meeting Jointly, <ul style="list-style-type: none"> • diagnose problems • agree changes and actions • agree timescale for measuring outcomes • agree date for review Effective Interface meeting
		Complete questionnaire and send to RCGP Scotland
		Primary and secondary care teams implement changes agreed
		Primary and secondary care teams measure outcomes of changes
		Primary and secondary care teams share information on outcome measures following change
By week 26		Review Effective Interface meeting Outcome data fed back to RCGP Scotland
		Continuing relationship

Effective Interface team preparatory meeting

The Effective Interface leads in both primary and secondary care should independently set a date within their own organisations to meet with their respective teams to prepare the background work for the module. This meeting should take place at week 2.

This meeting will probably require about an hour of discussion facilitated by the Effective Interface Leads in primary/secondary care or selected alternative, for example the Practice Manager or Service Manager. It should involve as many different team members as possible. At this meeting the team will discuss their relationship with the other team (in either primary or secondary care) including

- 1) What works well at the interface
- 2) What issues there are at the interface
- 3) Which **two** priorities they wish to address

The choice of what priority to address is key to the whole process. Several factors should be taken into account: -

- potential impact of changes
- practicalities of change
- scope of influence of the participants over the issue

The priorities chosen should be quite specific issues, but generalised across patient/staff experience. Whilst the learning points from Significant Events can be very useful resources for the process, they are by nature usually multifactorial. Focussing on a single Significant Event occurring to an individual patient can confuse the process, has potential for conflict and will be problematic for confidentiality, as a patient representative will be present at the Interface Meeting.

Chapters One and Two of the Quality Improvement for General Practice toolkit gives an excellent background on Context and Culture and Diagnosis, which may be helpful (although this will be covered more fully at the Effective Interface Meeting).

Sharing Effective Interface priorities

By week 4 the primary and secondary care Effective Interface Leads should email the two priorities identified by their teams to their counterpart. Once the priorities have been exchanged, the primary and secondary care teams should choose which one of the two priorities provided by the other team they would like to address as part of the module.

By week 6 the Effective Interface Leads from the GP Practice and the secondary care team should both have communicated their single top priority to their counterpart. These two issues, one from primary care and one from secondary care, will be the focus of discussion at the Effective Interface meeting (and share this with the RCGP Scotland Trainer for the pilot sites).

Patient involvement

The GP practice will identify and engage a willing patient participant between week 6 and 10. Advice on choosing a suitable patient is in the Tips and Tools section at the end of the module.

Information gathering

Between weeks 6 and 10, the Effective Interface leads will gather evidence and information relevant to the two priorities which have been identified. The success of the Effective Interface meeting depends on good preparation at this stage. The leads will consider what questions need answering before the meeting. There may be some communication required between the GP lead and the secondary care lead about what information they are looking for from each other.

There are many different sources of information including:

- Patient feedback e.g. patient satisfaction questionnaires, complaints, significant event analysis (SEA) or incident reporting
- Outcomes of clinical meetings e.g. morbidity/mortality meetings, Gold Standards, community mental health team meetings, multi-disciplinary team meetings
- Audits
- Health board statistics e.g. Scottish Patients at Risk of Admission and Re-admission (SPARRA) data
- Data sets e.g. tableau
- Examples of letters from secondary care to primary care and referral letters from primary care to secondary care
- Referral numbers and outcomes
- Discharge letters
- Discussion with team members e.g. reception/secretaries/nurses particularly about systems in the practice or department to inform process mapping

Some work may be required to assemble this information e.g. completing a SEA or the first round of an audit. The Effective Interface Leads may wish to enquire further afield if the issue affects other organisations such as other GP practices in the cluster or local area or other departments in the hospital or statistics from the Health Board.

By week 10 the Effective Interface leads will share all the information they have assembled (also with the RCGP Scotland Trainer for the pilot sites). It may be helpful for full details of SEA's, including the identities of patients, to be shared between secondary and primary care in order for a full investigation to be undertaken. Recent advice from the GMC on completion of Significant Events should be adhered to. Each lead should familiarise themselves with the information shared by their counterpart.

The GP Effective Interface lead will prepare a specific information pack for the patient who will be attending the meeting. This will include information around the issues to be addressed, which might include statistics. Care must be taken to ensure patient confidentiality as anonymous patient information could still easily identify the patient. If an SEA is to be discussed it is important that only the learning points from the SEA in general terms are shared with the patient rather than the full SEA that the health care professionals will have considered. It would be advisable for the patient information pack to be shared with the Effective Interface secondary care lead, so they are aware of exactly what the patient representative knows.

2 The Interface Meeting

This next section covers the actual face to face discussion of the agreed priorities. The aim of the meeting is to diagnose the problem and to propose some solutions. It is anticipated this meeting should last approximately three hours. Equal time should be allowed for each priority and it is important to factor in some time at the start for introductions and at the end to summarise what has been achieved and agreed. A suggested outline and times are offered below. Following this outline will help foster a collaborative approach throughout the meeting.

Consider any equipment that may be required such as flip charts, pens, post-it notes of a number of different colours, a computer with internet access and any notes or data you have collected.

Meeting outline

After the welcome and introductions, it may help for everyone to say one or two sentences about why they got involved with the Effective Interface Module.

As a group, ground rules for the meeting should be agreed. These should include maintaining patient confidentiality but also that mobile phones are switched off. Consider using the group rules template, which is In the Tips and Tools appendix.

Next allocate tasks such as someone to keep time and someone to take minutes or action notes.

(15 minutes)

This is a good point for everyone to watch Dr Mike Evans YouTube video on Quality Improvement in Healthcare which explains why quality improvement is both important and sometimes difficult. <https://www.youtube.com/watch?v=jg52ZjMzqyI>

After the video is a good opportunity for everyone to share something positive about the other service or how you have worked well together. It might be good to display these, for example on a flip chart or with post it notes. Reflect back as to why these examples worked and how they can help with the current priorities. This technique is called Appreciative Inquiry.

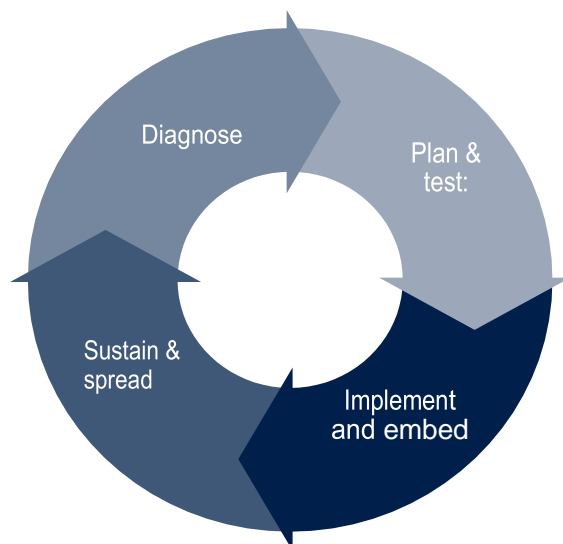
(15 minutes)

Having established a positive working atmosphere it is now time to move on to the two priorities one from primary care and one from secondary care.

Allow one person to outline the priority. It is important to make sure everyone has a thorough understanding of the priority and it may be helpful to encourage open questions. Once everyone is comfortable they understand the priority you can move on to **diagnosing** the problem. Below is a simple four step Quality Improvement cycle and some suggested Quality Improvements tools for each step, copied from the RCGP Quality Improvement for General Practice.

It can be tempting to assume everyone knows and agrees what the problem is but failure to accurately diagnose is why many quality improvement projects fail. Allow one hour to work through the four steps for each priority.

(Two hours)



This diagram summarises the steps of a Quality Improvement cycle and sets out a menu of tools that you can choose from for each step. Later in the cycle some of the tools will be reused.

Diagnose

In preparing for the Effective Interface meeting both primary and secondary care teams will have already carried out some data collection and interpretation. These may include Significant Event Analysis (SEA), clinical audits or surveys. There are some additional methods that can be employed during the meeting to fully diagnose the problem.

Process mapping

This creates a visual representation of all the steps in a process.

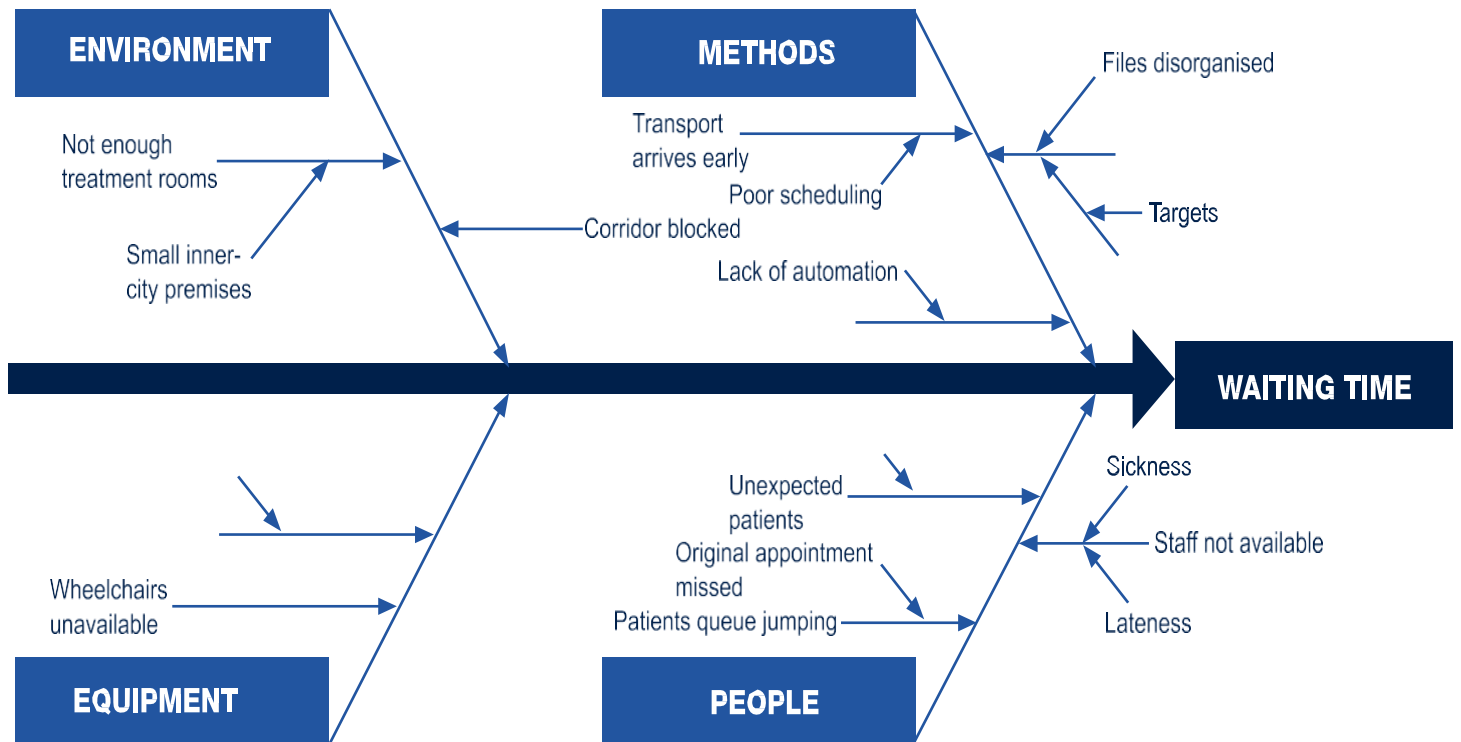
- Firstly agree on the start and end point of the process, which in healthcare is not always as easy as it sounds. Ideally everyone who has a part to play in the process should be involved in generating the process map to ensure all steps are captured. Each step is recorded by writing on a post-it note and putting it down on a long table.
- Add on different coloured post-it notes at appropriate steps to identify both opportunities and barriers at each step in the process. This can then help design a more efficient process for the future. There are three viewpoints of a process; the way we think a process is running, the way it actually is running and the way it ought to run.
- Looking at a process can be a non-threatening way to build engagement. For example consider the process of making a cup of tea. First find a clean mug, then the box of teabags. Next you might choose to fill the kettle, but where is the nearest tap? Do you put milk in before or after the hot water? Does everyone make a cup of tea in the same order?
- Capture your process map as a permanent record of the discussion. It can be useful to use the panorama function on a smart phone for this. In the process map below, the steps in carrying out the Effective Interface are in yellow, possible problems in pink and opportunities in orange.



Fishbone diagram

Also sometimes known as cause and effect analysis this is a useful tool to identify the root causes of a complex problem. The identified problem is located at the head of the fish whilst potential causes or influencing categories form the spine. Consider making the cup of tea again, what factors influence how long it takes to make that cup of tea? Consider the delays under the headings of environment, methods, equipment and people.

Below is a fishbone diagram of why patients are kept waiting at out-patients.



Appreciative inquiry

This differs from the problem solving approach of other methods in that it builds on good practice.

One of the most commonly used models consists of the four elements

- | | |
|-------------|---|
| 1. Discover | Identify what works well |
| 2. Dream | What could work better in the future? |
| 3. Design | Prioritise the processes that would work well |
| 4. Deploy | Implement the design. |

So for our cup of tea example what might currently work well is that the cups are in one cupboard which is labelled. The dream might be for all cupboards to be labelled. A design of how the cupboards would be organised should then be drawn up and agreed before deploying the labels and re organising the cupboard spaces.

Let's try it!

Part one of the face to face meeting is intended to allow both interface teams to contribute towards a deeper understanding of the nature of the issue under discussion and to use quality improvement tools to diagnose and elucidate the systems and processes from which the issue arises. It is commonly found that as discussion progresses both sides begin to form a picture of the underlying problem and possible solutions.

Together, the two interface teams should formulate a clear statement of what the group is trying to accomplish. Grand statements of lofty goals are all very well, but you will need to hone or translate this into a specific goal which you are going to be able to practically address and measure.

Think:

- “How will we practically achieve this goal?”
- “How will we know we have achieved the goal?”
- “How will we measure achievement of the goal?”

There are tools available to help you hone down a high level improvement goal into specific actions

Driver diagrams

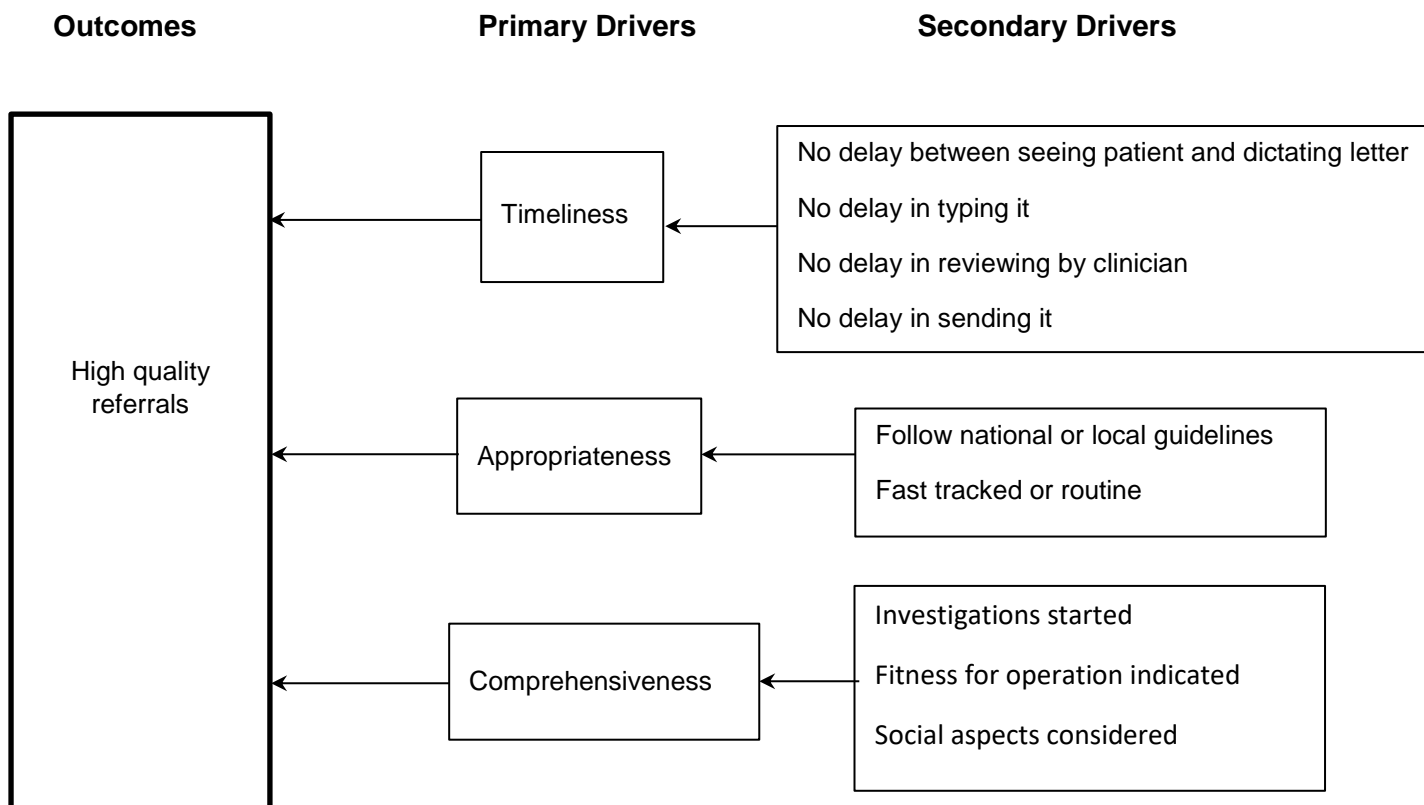
A fishbone diagram has at its end point a problem and then identifies the factors. A driver diagram looks at issues in the opposite way by firstly deciding what would be a desirable outcome and then identifying the factors that create that outcome.

1. Decide your outcome
2. Identify the key things that would increase the likelihood of you reaching your desired outcome. These can include attitudes, behaviours as well as practical or physical attributes.
3. Taking each of these ‘change drivers’ in turn think about what action you could take to bring these change drivers to bear.

This process can be particularly useful dealing with interface issues because it recognises that there is more than one influencing factor. It can be helpful to get both sides of the interface to think about what part they could play in making the desired improvement.

The example on page 12 might be a result from a driver diagram discussion around the quality of referrals to the specialty.

Driver Diagram for High Quality Referrals



It is then possible to define the actions needed to improve each of the secondary drivers. Once you have identified the change you can move on to the Plan Do Study Act cycle (PDSA).

The Plan and Test of Quality Improvement cycle

The plan do study act (PDSA) approach is best understood as more than a series of phases representing the implementation of the change. It is actually a model which walks us through the whole process of planning, implementing and evaluating the change.

The pre-meeting phase and the Effective Interface meeting form the backbone of the first element of the cycle:

'Plan'

By this point of the day you should be well into the 'plan' phase having used data supplied at the pre-meeting phase and the day's discussions to identify and agreed on a change to make. The next step is to actually go ahead and plan in detail the rest of the PDSA cycle.

'Do'

This is the phase where you implement your change, but it is important to plan the 'doing' phase carefully. Plan who is going to do what as part of the change, who else might be affected by the change, how the fact that a change is occurring is going to be disseminated. A communication matrix can be used to do this dissemination of information in a structured way. A template of a communications matrix is in the Tips and Tools.

Consider how long to let the change run for before entering the 'Study' phase and set realistic timeframes. A Gantt chart could be used to plot out visually the timescale for different activities associated with implementing and monitoring the change. One benefit of doing this is that it becomes more transparent to the person overseeing the project whether the project is running to time.

Lastly, when planning the 'doing' phase – consider how and why the project might become derailed. What circumstances might threaten the implementation of the project. Identifying these potential constraints at this stage can allow you to put in place sufficient mitigation to eliminate or reduce the potential constraint. A template to help identify constraints is in the Tips and Tools.

'Study'

This is the phase where you are going to study the measurable effect of the intervention. The two interface teams will already have looked at methods of measuring the status quo at the outset of the planning process, but it is important to plan what data you may need to collect and/or analyse in order to gauge the success or otherwise of your intervention. This may be quantitative or qualitative data and may relate to outcomes, measures of the process itself or a proxy measure. Whatever method you choose, you will need to use the measure to form a benchmark against which the change can be evaluated.

There are many tools used for assessing quantitative data. Statistical Process Control charts or run charts are examples which are found in the RCGP guide to Quality Improvement for General Practice at <http://www.rcgp.org.uk/clinical-and-research/our-programmes/quality-improvement.aspx>

'Act'

Looking into the future you are going to want to meet as a group to discuss the outcome of the change implementation and discuss what modifications might be required or whether a new approach is needed. The two teams should set a provisional date for a second meeting to do this.

3 Implementing change

The purpose of the second meeting is to check and see the effect of the changes that were agreed at the end of the first meeting. It is thus important that data measures after implementing change are made before the second meeting and shared so that the participants can reflect on the data before that meeting. This is the 'Study' phase of the PDSA cycle

It may be helpful for the data to be measured more than once in between the two meetings but that will depend on how easily it can be obtained.

Data should be obtained for both sets of changes, the primary and the secondary care ones.

4 Review interface meeting

This will allow you to complete the study phase and take actions forward.

This is the 'Act' phase of PDSA.

The timing of this meeting is variable. It may be that three months will be enough time to allow a change to take effect but often the effects are not seen for six months. The length of the meeting is much shorter than the first meeting, perhaps one and a half hours.

The participants should ideally again be the GP, practice manager, consultant, hospital service manager and the same patient as attended the first meeting. Their task is to decide if the changes instituted have led to an improvement. If so, their initial work is over but they may wish to continue monitoring the data to check that the improvement is maintained.

If there has been no improvement in either or both of the areas chosen then ideas for different changes should be sought. These changes should then be implemented and a further meeting arranged for a few months later to see if improvement has occurred on this occasion. Thus the cycle can continue.

It is important that the outcomes of the work, both positive and negative, are shared widely. The communication matrix shown in the first meeting guide should be completed again. This will help you to decide who needs to know the outcomes of your work and what each person needs to know.

Please complete the questionnaire found at <http://www.rcgp.org.uk/rcgp-nations/rcgp-scotland.aspx> (for the pilot sites the questionnaire will come to the practice separately) and send it to the most appropriate people in your local health care system. These are likely to include your local Health Board interface lead, the Practice Quality Leads and Cluster Quality Lead in your cluster, Assistant Medical Directors or the equivalent. Please also send the questionnaire to RCGP Scotland at Euan.Bailey@rcgp.org.uk

5 Continuing relationship

Though not part of this specific quality improvement module, there may be advantages for both the practice and the specialty to maintain a relationship. This might mean sharing issues over a lunch occasionally. Perhaps work shadowing could be arranged. Each party can then become a critical friend of the other.

6 Tips and Tools

Group rules template

These are some suggestions for group rules. Some may not be relevant to your group or there may be others that you wish to add.

- Maintain patient confidentiality at all times
- Treat each other with respect
- Mobile phones on silent
- The timing of a comfort break
- One person to speak at a time
- Meeting will start and finish on time
- Suspend judgement until an idea has been heard out
- Avoid using jargon or acronyms
- If unable to reach agreement on any point use “park it”

Choosing a suitable patient

As part of the preparation, you will need to identify a patient representative to attend your meeting. This is not as simple as it sounds but you might like to bear in mind the following advice from the RCGP patient group, P3.

Attributes of a “Perfect Patient Representative” for the module include aspects such as being prepared and willing to participate at the meetings; being able to look beyond a personal perspective but yet have some experience of the interface; having softer attributes such as integrity, respect and probity. An ability to move on from the problem being discussed and focus on the solution is also important.

The patient would be required to understand the importance of maintaining confidentiality throughout as well as being open and honest and not be afraid to articulate the patient perspective amongst professionals.

Ideally, a patient should be selected from a Patient Participation Group associated with the practice or from the Public Partnership Forum. This would ensure that the patient selected would have knowledge of and be familiar with the need for confidentiality especially if significant events at the interface are being discussed. However these groups may not exist. It may then be that a local officer of the Scottish Health Council will be in a position to help you nominate such a person. If it is not possible to select such an “expert” patient then choose someone with most of the attributes in the second paragraph.

A copy of the letter sent to consultant colleagues

December 2016

To our consultant colleagues

The term “interface” has crept into our everyday vocabulary when talking about some of the current challenges in providing sustainable and safe healthcare. The interface is the point of interaction between different systems. In healthcare, interfaces exist where a patient journey crosses from one area of care into another such as moving between primary and secondary care, between health and social care and between scheduled and unscheduled care.

Due to the individual complexity of these different systems, with their differences in aspects such as culture, professional boundaries, governance systems, performance targets and IT systems the interface can be a dangerous place for the patient to navigate. In fact, it is estimated from national patient safety data that around 50% of errors occur at the interface. There are many lessons to be learned and improvements to be made by better understanding of and investment in the interface between primary and secondary care

The Royal College of General Practitioners (RCGP) Scotland recognises this key aspect of inter-professional working in the modern NHS and has pursued a series of approaches to bring about improvement in the interface. The Effective Interface quality improvement module is one outcome from this work.

The Effective Interface module is centred on a half day meeting in a general practice between a GP, practice manager, specialty consultant, hospital service manager and a patient. The practice and the specialty will each bring an interface priority to the meeting. Backed up by previously gathered evidence, the delegates will use the quality improvement tools provided to decide on appropriate changes for improvement. They are likely to use tools such as process mapping and the Plan Do Study Act cycle. Subsequent measurement to assess the impact of change will be carried out and assessed at a meeting three to six months later. Importantly, lessons learnt from this activity will be widely shared both locally and nationally so that change can occur outside the walls of the practice. Opportunities for personal interaction between GPs and consultants have lessened significantly in recent years and it is hoped that this exercise can help reverse this unfortunate trend. We would encourage you to engage in this process.

When you participate your work would form an important part of your CPD learning, especially if you require some of your credits to be from learning external to your own department.

It is important to state that though RCGP Scotland has been leading on the development of this module it has backing from the Scottish Academy of Royal Colleges as no one sector can bring about change in the way the interface works.

Ken McLean
RCGP Scotland Clinical Lead for Effective Interface

Communication matrix template

The idea behind an effective communication matrix is that not everyone needs to know everything when a change is made. Rather, each person or group receives information relevant to them. It is a balancing act to ensure that people know enough about a change to have some ownership of it without being swamped with details that are not pertinent to them.

Many staff rooms will experience the “dirty coffee cup” problem. Imagine a meeting takes place to discuss it and changes are suggested. The table below describes the subsequent actions and who needs to know what about them.

Task / item	GP	Practice Nurse	Admin	Cleaner
Washing liquid	May need instruction in use	Reinforce not to be hand maiden	To order if need more	To check if need more
Rota for clean up	In GP rooms		Review in 1 month	
Penalty system	Where do profits go?			
Named cups	To decide name on cup			Leave dirty cups on shelf

Work on dealing with interface issues may require a number of people needing to know about the proposed changes so the communication matrix may look like below.

Task / Item	Practice GPs	Specialty consultants	Service manager	Cluster practices
[Enter the specific change element here – this may be practical or behavioural]	[Enter here the details of the communication required]			

Task / Item	RCGP	Health Board Interface lead	Service manager	
Enter the specific change element here – this may be practical or behavioural]	[Enter here the details of the communication required]			



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The Royal College of General Practitioners (Scotland) is a network of over 50,000 family doctors working to improve care for patients. We work to encourage and maintain the highest standards of general medical practice and act as the voice of GPs on education, training, research and clinical standards.

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