# 

**Developing a Primary-Secondary Care**

**Interface Group**

**SECTION 1: REPORT CONTENT**

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| --- | --- |
| **Title/Subject:** | Developing a Primary-Secondary Care Interface Group |
| **Meeting:** | [INSERT HEALTH BOARD AUTHORISING MEETING/ GROUP] |
| **Date:** | [INSERT DATE] |
| **Submitted By:** | [INSERT NAME] |
| **Action:** | For Approval |

**Introduction**

This report sets out the rationale for the creation of a high profile and fully-supported Primary-Secondary Interface Group and asks the [INSERT NAME of AUTHORISING MEETING/GROUP/BOARD] to support the report’s recommendations that the creation of such a group be viewed as a strategic priority.

**Background**

A poorly functioning clinical interface not only adversely impacts on patient safety, but also on the efficiency and effectiveness of the whole of the healthcare system.

In addition, it can adversely affect patients’ experience, leading to poorer outcomes, an increase in patient complaints and damage to inter-professional relationships and morale.

This not only has implications for patient safety but can be a major source of frustration and anxiety for patients, carers and professionals.

The Royal College of General Practitioners (Scotland) has been working to develop support to prioritise interface working as a key strategic priority.

**Business Case for resource to support Primary-Secondary Care Interface Group**

Research by the Royal College of General Practitioners (Scotland) has identified key factors which can have an adverse impact on interface working. These include:

* No formal structures or support to encourage two-way learning/information sharing, which could bring about wider systems improvements.
* No routine use of data available, such as significant events, between primary and secondary care to inform improvements to processes/services.
* Loss of inter-personal relationships resulting in less functional communication between primary-secondary care.
* Incompatible and unreliable IT systems with limited functionality adversely impact the ability to share clinical data effectively and safely.
* No formal groups to collaboratively scope improvements to services/processes which would result in better patient care and fewer errors.

Despite barriers to adverse event reporting, the incidence of such reporting is increasing. Thematic analysis of DATIX reports shows evidence of interface issues which have adversely affected patient care and experience. They also demonstrate adverse outcomes across many of the interfaces patients must navigate – including the ambulance service, dealing with multiple conditions, mental health and the failure of communications across multiple complex interfaces.

Additionally, when an adverse event is reported in primary care, feedback may not be routinely shared, and for many clinicians there is a feeling that there is no apparent organisational approach to sharing learning outwith their own area (which would in turn encourage the reporting of adverse events).

The changing demographic and national, regional and local drivers supporting new recommendations, guidelines and pathways of care has resulted in a complicated landscape and can be confusing for clinicians and patients alike. The ability to have a single Interface Group, where such guidelines could be discussed, agreed and then supported to implement as part of a whole system approach to safe, person-centred and effective care would support better outcomes for patients, and provide a level of reassurance to the Health Board and Integration Authority partners that [INSERT HEALTH BOARD] has a strong and visible priority to support locally owned evidence based pathways of care – with a focus on reducing waste, unwarranted variation and harm.

GP clusters are important structures which will facilitate communication across the Primary-Secondary interface, and it is recommended that the ongoing redesign of the acute structures also takes this proposal into account.

Building on knowledge and experience gained from other NHS Board areas, and the work progressed to date by the Royal College of General Practitioners (Scotland), it is recommended that the following key principles are adopted:

* The aim of an Interface Group should be clear: to improve the patient journey.
* Each Interface Group must have organisational recognition by the Health Board. It should be embedded within existing Health Board governance structures and should be the recognised place where to bring operational issues at the interface.
* Interface Groups should have a culture that is collaborative and focused on outcomes.
* Interface Groups should have senior representation from primary and secondary care and from Health Board management. Exact group make-up should be determined at a Health Board level.
* If the Interface Group is unable to reach consensus on a particular issue, the route for escalation of this issue should be clear. This should fit into existing organisational and governance structures.
* The mechanisms by which the group operates should be clear and transparent. For example, there should be clear pathways to raise issues with the Interface Group, recording of Interface Group outcomes, and communication of Interface Group decisions.
* Interface Groups should be visible with colleagues from across primary and secondary care with transparent information on who is on the group, how others can feed in, and where they can find information about outputs.
* Interface Group roles should be resourced to reduce turnover and to ensure that there is funded or supported time for groups to meet and action any research/improvements.
* The groups should encourage innovation which is likely to improve patient care at the interface.

In addition:

* When any new substantive protocol or process is proposed by any NHS [INSERT HEALTH BOARD] body that will affect the interface then the primary-secondary care interface group should be consulted.
* The remit of the proposed group will be to ensure that any changes have been subject to consultation across the interface and that patient safety implications have been properly considered.
* The group should work within the existing clinical governance structures of NHS [INSERT HEALTH BOARD]
* Recurrent themes or significant events with organisational learning should be identified and escalated via the existing clinical governance structures of NHS [INSERT HEALTH BOARD].
* A well functioning interface group will allow the transmission of approved guidelines to individual practices via their clusters and to relevant directorates.

In terms of resource to support the Interface Group, the following will be required:

* + A Lead GP – [INSERT NUMBER] sessions(s) per week/month
  + A Lead from Secondary Care – [INSERT NUMBER] programmed activity per week/month

The two leads will meet on a [INSERT FREQUENCY] basis.

A [INSERT FREQUENCY] meeting which will involve [INSERT MEMBERSHIP].

[ADD IF YOU REQUIRE ANY ADMNISTRATIVE SUPPORT OR IF THIS WILL BE USED FROM EXISTING RESOURCES].

It is recommended that the funding be allocated for an initial period of [INSERT NUMBER] of months.

The additional costs identified are summarised in the table below:

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| --- | --- |
| **Grade** | **Cost** |
| GP Lead (X session/week for X years) |  |
| Secondary Care Consultant (X programmed activity/week for X years) |  |
| GP x 4 to attend meetings (1 ad-hoc session per meeting £XX) |  |
| Consultant x 4 to attend meetings (1 programmed activity per meeting) |  |
| Admin support |  |
| **Total** |  |