#

**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 HB AUTHORISING MEETING/ GROUP] |
| **Date:** | [DATE] |
| **Submitted By:** | [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.

Evidence suggests that around 50% of medical errors can occur at interfaces, with up to one third of these happening at the interface between primary and secondary care.

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.

That every Board have a ‘well functioning primary-secondary care interface group’ was a key recommendation of the Scottish Government Improving GP Practice Sustainability Group (recommendation R25), and the Royal College of General Practitioners (Scotland) has received Scottish Government funding to support the establishment or development of Interface Groups and share the learning across the country.

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

Research by the Royal College of General Practitioners (Scotland) has identified a number of key factors as having 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

The Frances Report made it clear that ‘GPs undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services’.

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 HB AREA] 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 will be important new 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 a number of key principles are adopted:

* Clinical lead co-chairs from both primary and secondary care will support and promote local ownership and accountability
* These clinical leads should have a role in shaping the membership of the group
* Membership should include clinicians representing a broad range of areas, different hospital sites and Integration Authorities
* Membership should reflect both in and out of hours care
* The existing formal advisory structures such as area medical committee/LNC, GP Subcommittee/LMC are recognised
* The input of clinicians with roles in areas such as IT and training and education are recognised
* Non-clinical managers can enable linkage across work streams within the wider organisation
* Boards should identify dedicated project management to provide administrative support, project planning functions and onward delegation of identified workstreams
* The group should have visible support and enablement from senior clinical leaders
* Adequate resource to support effective and productive membership

In addition:

* When any new substantive protocol or process is proposed by any NHS [INSERT BOARD NAME] 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 BOARD NAME]
* Recurrent themes or significant events with organisational learning should be identified and escalated via the existing clinical governance structures of NHS [INSERT BOARD NAME].
* 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 – X sessions(s) per week/month
	+ A Lead from Secondary Care – X sessions(s) per week/month

The two leads will meet on a xxx[insert frequency]xxx basis.

 A [insert frequency of meetings] meeting which will involve [insert membership]

Please add if you require any administrative support or if this will be used from existing resources, please advise).

 It is recommended that the funding be allocated for an initial period of [insert term] 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 session/week for X years) |  |
| GP x 4 to attend meetings (1 ad-hoc session per meeting £XX) |  |
| Consultant x 4 to attend meetings (1 session per meeting) |  |
| Admin support |  |
| **Total** |  |