

## Whole System Working

### The Interface in Scotland

#### Background

The “interface” as it relates to healthcare is the point at which two systems come together, be it primary and secondary care; in-hours, and out of hours care; health, and social care, or within primary care itself across the multiple interfaces of extended multidisciplinary teams. These systems are independently complex and do not always relate or communicate well with each other. Their different IT systems, cultures and priorities all contribute to this. Consequently, interfaces are points of high risk for patients accounting for 50% of all medical errors, with one third of those errors occurring at the primary-secondary care interface.

The Cabinet Secretary for Health and Sport requested in March 2016 that Scottish Government officials establish a Short Life Working Group (SLWG) with key stakeholders to better understand the pressures facing general practice. The main objectives of the multi-partner Working Group were to develop an understanding of the underlying issues contributing to practices getting into difficulty and to make recommendations on how general practices in Scotland could be supported to improve sustainability over the short, medium, and longer term. Membership included representation from Scottish General Practitioners Committee, Royal College of General Practitioners (Scotland) and both territorial and national NHS Boards including NHS24. The report from the SLWG emphasised effective interface and its effect on practice sustainability<sup>1</sup>. This work continued with the Improving Practice Sustainability Group and was incorporated into the 2018 General Medical Services Contract<sup>2</sup>.

Where Health Boards have introduced joint learning events involving primary and secondary care clinicians, they have been popular and effective in improving understanding and dialogue between the groups. The use of Problem Based Small Group learning (PBSGL) across the interface has been explored. The Scottish Online Appraisal Resource (SOAR) has a work shadowing template where clinicians who spend time shadowing a colleague from a different discipline can reflect on the experience and use this as evidence in their annual appraisal. Work is being done on significant event analysis and morbidity meetings that involve representatives from GP and hospital departments. RCGP Scotland has developed an *Effective Interface Module* and interface toolkit pulling together many of these resources<sup>3,4</sup>.

The Scottish Access Collaborative and Modern Outpatients Group have primary care representation on their secondary care groups to ensure that their guidance is applicable to both sectors. The Modern Outpatient: A Collaborative Approach 2017-2020 states that the programme *‘is not about adding to the burden on services or moving bottlenecks to a different part of the care continuum. We recognise the significant pressure that GPs and other community-based professionals are facing. So, this is not about a transfer of workload but is about working together across the primary/secondary care interface to provide the best care in the most appropriate setting for each patient at the point of need.’*<sup>5</sup>

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<sup>1</sup> <https://www2.gov.scot/Resource/0052/00527520.pdf>

<sup>2</sup> <https://www.gov.scot/publications/gms-contract-scotland/>

<sup>3</sup> <https://www.rcgp.org.uk/-/media/RCGP-Scotland-Effective-Interface-Module-2017.ashx?la=e>

<sup>4</sup> <https://www.rcgp.org.uk/rcgp-near-you/rcgp-nations/rcgp-scotland/primary-secondary-care-interface-working.aspx>

<sup>5</sup> The Modern Outpatient: A Collaborative Approach 2017-2020 Consultation Paper, Health Performance and Delivery Directorate, Scottish Government 2016

Both RCGP and BMA have committed to improve interface working particularly between Primary and Secondary care.

- Recommendations have been published in RCGP From the Frontline<sup>6</sup>
- BMA 2018 Scottish GP contract framework. “To ensure effective working between primary and secondary care, we will continue to implement the recommendations of the Improving General Practice Sustainability Advisory Group as set out in its report on November 2016”.

We must work to better understand and respect each other’s roles, remits, and challenges, work collaboratively to achieve common goals and rebuild relationships that have broken down. The Professional Behaviours and Communication Principles for working across Primary and Secondary Care Interfaces document, developed by RCGP Northern Ireland, and endorsed by the Academy of Medical Royal Colleges (AoMRC) should be promoted<sup>7</sup>.

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<sup>6</sup> <https://www.rcgp.org.uk/-/media/Files/RCGP-faculties-and-devolved-nations/Scotland/RCGP-Scotland/2019/RCGP-scotland-frontline-june-2019.ashx?la=en> Also see: <https://www.rcgp.org.uk/rcgp-near-you/rcgp-nations/rcgp-scotland/primary-secondary-care-interface-working.aspx>

<sup>7</sup> [https://www.aomrc.org.uk/wp-content/uploads/2019/07/20-0228\\_Behaviour\\_and\\_communication\\_principles\\_joint.pdf](https://www.aomrc.org.uk/wp-content/uploads/2019/07/20-0228_Behaviour_and_communication_principles_joint.pdf)

## Whole System Working Principles

This document recognises that effective whole systems working is based upon understanding roles and responsibilities, developing high trust relationships, adhering to agreed principles, and seeks to articulate these so that parties to interface working can jointly agree to work within these parameters.

Roles and relationships for interface working between primary and secondary care are developed by:

- Recognising the role of the GP as the Expert Medical Generalist in the community and clinical lead of the wider multidisciplinary team of community-based practitioners.
- Recognising need to focus Consultant resource on more complex patients undertaking activity that requires Consultant input.

For people to move seamlessly between different areas of care, the following principles will be helpful:

- 1) Patients:
  - A focus on the patient journey and effective delivery of individual care where this crosses interfaces of care, with systems designed to support this.
- 2) Information:
  - Effective sharing of information – IT systems must be developed which enable information to be shared which is relevant to a person's care, to reduce duplication, repetition and the risk of gaps and lack of access to relevant data.
  - Optimising digital opportunities to aid communication, develop relationships and enhance collaborative interface working.
- 3) Quality of care:
  - Effective review of quality of care from all sources including routine audit, significant events and patient feedback, to improve pathways of care.
  - Recognising that a poorly functioning interface poses a significant risk to patient safety. (Effective significant event analysis and recording where interface is an issue is an important step for quality improvement).
- 4) Learning:
  - Shared learning and training opportunities – staff can only work effectively together if they understand each other's situation and priorities.
  - Collaborative working and leadership to promote good practice based on the best available evidence and adopting the principles of realistic medicine.
- 5) Staff attitudes:
  - Mutual respect between clinicians working in different roles and in different areas of practice, whether community care, primary care, or secondary care
  - All parties undertaking to be informed about and have regard to demand and capacity
  - Respecting the time and resources of others, not presuming to use those up without discussion and agreement.
  - Adhering to The Professional Behaviours and Communication Principles for working across Primary and Secondary Care Interfaces. Developed by RCGP NI and endorsed by the AoMRC,
- 6) Staff engagement:
  - Clinicians must be supported to identify and address issues which occur at interfaces of care, and there must be mechanisms in place to enable resolution of issues.
  - Adherence to an agreed governance process with a transparent and published structure.

## Board Level Primary Secondary Care Interface Groups

Whole systems working can be greatly enhanced by development of Primary-Secondary Care Interface Groups and each Board should be strongly encouraged to develop such a group as recommended by the Interim Chief Executive NHS Scotland in May 2020<sup>8</sup>

Primary-Secondary Care Interface Groups should:

- Be clearly signposted
- Feed into the recognised structure of each Board
- Be sufficiently resourced and with a designated secretariat
- Have joint chairs accountable to primary and secondary care
- Have members who understand the decision making and planning structures within the NHS Board so that issues can be directed appropriately
- Work on across board as opposed to local pathways
- Commission short life subgroups, with additional specialist membership, for specific tasks.

The group **requires** to have as members:

### 1. Key clinical leaders

- Deputy Medical Director for Acute (or equivalent depending on the Board structure) who can make decisions and ensure action taken across acute services.
- Equivalent Director level for Primary Care/HSCPs able to make decisions and ensure action as above.
- Relevant advisory/representative bodies – GP subcommittee/LMC and Hospital subcommittee.

### 2. Senior Managers

- Include senior managers of sufficient seniority to be able to take forward actions across the system, equivalent to Chief Operating Officer for Acute or nominated Deputy who is able to make decisions and ensure action can be taken across acute services.
- Essential that representatives understand the decision making and planning structures within the NHS Board so that issues can be directed appropriately.

### 3. Clinicians and/or managers with IT expertise

- Many of the interface solutions offered require IT knowledge and influence within the local organisation.

### 4. Clinician members with a training and education role

- To facilitate collation of identified projects and linkage with existing development opportunities (e.g. clinical development fellows, PC Cancer Leads, quality improvement teams).

### 5. GPs in leadership roles with knowledge of in-hours and Out-of-Hours GP services

### 6. Lead Secondary Care Clinicians

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<sup>8</sup>John Connaghan, Interim CE. Letter to Boards, 14 May 2020

## Resources

The group should be sufficiently resourced with clinicians funded for their attendance or through recognition within job plans. Identified dedicated Project Management support should be available when required for formulation of project plans and onward delegation of identified work streams.

An interface group with such a structure, authority for decision making and enaction is essential as we move through the covid pandemic. Agile working between primary and secondary care with a clear pathway for decision making will improve remobilisation of services and enable a more rapid deployment of agreed new pathways to the benefit of patient care.

## Health and Social Care Interface Working

The focus of this suite of principles and structure of the interface group described is to address primary and secondary health care working. This can be easily adapted for the health and social care context, to aid whole system working across this important interface. We would be happy to be involved in such a piece of work which we suggest should be led by social care to ensure that language and systems are fully appropriate to social care colleagues.



Academy of Medical Royal Colleges and Faculties in Scotland

*This document is endorsed by the Academy of Medical Royal Colleges and Faculties in Scotland (Scottish Academy). Enhancing experience of patient care between the community and hospitals continues to be a key priority of the Scottish Academy.*