Norfolk and Waveney
Clinical Commissioning Group

Agenda item: 12

Subject:	**Primary and Secondary Care Interface**
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Submitted to:	**PCCC**
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Purpose of paper:

To update PCCC on progress made by the Interface Group.

Executive Summary:

Since the previous update provided to PCCC in October 2021, interface discussions have remained positive with good engagement from all parties, however progress has been slow.

The key achievement of the group to date has been agreement of the interface policy (appendix 1) which was created to clarify contractual roles and responsibilities for secondary care colleagues. Patients are at risk of falling through the net when there is no clarity regarding roles and responsibilities at the interface. To note, secondary care providers should have already had mechanisms in place to ensure contractual compliance. Successful implementation of the policy will be critical to ensuring improved adherence to the contract. The policy will require updating in accordance with national contractual changes.

The policy was approved in December and was then taken through provider governance processes for sign off in January/February. All providers have either finished disseminating the document with colleagues or are in the process of completing this.

Many other issues have also been raised at the Interface Group; key areas are covered in section two. Many of the issues raised are complex and require time and resource to work through and resolve.

Engagement at the Interface Group to date remains constructive and progress is being made. However, as highlighted in the previous October update, the ability to deliver change at pace remains a challenge in light of the significant operational pressure felt by all parts of the system and the complexity of many issues raised.

Recommendation to PCCC

To note the update.

1. Background

1.1 There has been increasing concern from general practice regarding unfunded workload passing from secondary to general practice. This is often resulting from a lack of adherence to the trust contractual interface requirements. When patient level issues are investigated, it is often apparent that colleagues in secondary care are not aware of these contractual requirements.

1.2 In addition to existing secondary care contractual requirements, the 2021/22 contract was updated to include the following schedules.

> *"3.17 The Co-ordinating Commissioner (in consultation with the other Commissioners) and the Provider must jointly assess, by no later than 30 September 2021 (and annually thereafter), the effectiveness of their arrangements for managing the interface between the Services and local primary medical services, including the Provider's compliance with SC6.7, SC8.2-5, SC11.5-7, SC11.9- 10, SC11.12 and SC12.2 of this Contract.*
>
> *3.18 Following the assessment undertaken under SC3.17, the Co-ordinating Commissioner and the Provider must then:*
> *3.18.1 agree, at the earliest opportunity, an action plan to address any deficiencies their assessment identifies, ensuring that this action plan is informed by discussion with and feedback from the relevant Local Medical Committees;*
> *3.18.2 arrange for the action plan to be approved in public by each of their Governing Bodies and to be shared with the relevant Local Medical Committees; and*
> *3.18.3 in conjunction with the relevant Commissioners, implement the action plan diligently, keeping the relevant Local Medical Committees informed of progress with its implementation."*

Work was started by the acutes to review adherence to the contractual requirements and it soon became clear that the internal view of adherence did not reflect the reality seen in general practice. It was decided that all contractual requirements needed improving and therefore agreement to move forward with development and implementation of the interface policy was supported by the CCG.

1.3 It was agreed to establish a new Interface Group with representation from CCG GPs, secondary care and the LMC* to work through the most pressing issues at the interface. The group started meeting monthly in October 2021. At the first meeting it was agreed to focus on the lack of adherence to the trust contractual requirements.

1.4 There are of course issues for all system partners at the interface, all members of the group can raise priorities for discussion and action at the interface group.

1.5 A key principle of the interface group is that all system partners are equal and as such, issues from all parties will be worked through in order of priority as agreed by the group.

*The LMC wish it to be noted that the LMC is the GP representative organisation at this meeting and the LMC is the only body able to independently represent GPs and their practices.

2. Initial areas of focus at the interface group

2.1 Secondary care adherence to interface contractual requirements

At the first meeting the group committed to moving forward with the development of an interface policy to cover areas of frequent confusion at the interface between primary and secondary care.

The policy clarifies contractual roles and responsibilities for secondary care colleagues at the interface in a simple format which providers can share widely. Patients are at risk of falling through the net when there is not clarity regarding roles and responsibilities at the interface.

The policy was approved in December and was then taken through provider governance processes for sign off in January/February. All providers have either finished disseminating the document with colleagues or are in the process of completing this.

The CCG communications team are capturing details on how each provider has shared this policy with colleagues. Feedback from practices regarding interface contractual issues will continue to be captured via the PID inbox.

2.2 Development of collaborative, supportive relationships across the system

One of the underlying principles of the interface group was recognition that all system partners are equals and that all providers are able to raise issues for discussion and action.

Despite the huge challenges all parts of the system continue to face day to day, attendance and engagement with this group remains positive. Discussion is constructive, challenging, respectful and puts the patient at the centre.

Despite many of the items being incredibly complex with no quick fix available the group is providing the right forum for the discussion to begin, however progress to resolve issues is slow.

2.3 NSFT ECG requests

There remain ongoing issues with NSFT not always undertaking ECGs before initiating a medication, for example, and instead requesting general practice do this.

The trust interface contractual requirements are clear when it is the responsibility of secondary care to undertake investigations, this issue continues to be worked through with NSFT and the CCG mental health team with updates provided at the group. This issue has been ongoing for some time, the LMC wishes it to be noted that the enablement by the CCG of secondary care providers to breach their contracts is unacceptable.

2.4 NSFT Attention Deficit Hyperactivity Disorder (ADHD) annual reviews

During the pandemic annual ADHD reviews were paused, in September it was agreed that whilst they remained paused, some GPs may have concerns

about continuing to prescribe medication, and that if this was the case, they could refer in to NSFT to ask for a review under shared care.

Concerns were raised regarding the backlog of annual reviews and the potential impact on patients. The ADHD Clinical Lead is now prioritising the ADHD pathway and finalising reviews. There is currently a backlog of 235 reviews, this will take 40 weeks to complete if six are being completed a week. Progress against the recovery trajectory is being reported to the group.

2.5 Trust wide access policy

Concerns have been raised regarding the current requirement for private providers to request NHS referrals for patients via their GP. There is a view from secondary care that the GPs act as gatekeepers for referrals into the NHS. This is not the case; GPs end up with additional administrative burden and potentially carrying the risk of any delay in onward referral.

There is also a view that by allowing private providers to refer directly into the NHS some patients will be queue jumping. At best, the current process is inefficient from a patient perspective, at worst is causing unnecessary delays for urgent treatment. This issue has been discussed with no resolution so far, the April interface meeting will be dedicated to agreeing a pragmatic way forward for all parties.

2.6 Emergency Department (ED) follow up X-rays/tests

Some patients who have been discharged from ED require a follow up for test results and may also need follow up tests to be booked. Given the pressures on ED, secondary care has requested that consideration is given to general practice carrying out ED requested follow ups.

The General Practitioners Committee (GPC) do not support this approach as it represents a breach of the NHS Standard Contract. Discussions are ongoing and will continue at the April meeting where an agreed position needs to be agreed and then communicated to relevant parties.

3. Challenges and risks

3.1 Ongoing confusion regarding roles and responsibilities at the interface can result in patients falling through the net and not receiving the care and follow up they should be getting. Successful adherence to contractual requirements is crucial in supporting good patient care across the interface.

3.2 The volume of issues occurring at the interface is significant and there is a need to prioritise those issues that are being presented at the group for resolution.

3.3 Progress of the Interface Group is slow in resolving and moving forward many of the issues raised due to.

- staff involved not having time to dedicate to this work
- many other competing priorities

- the complexity of some of the issues
- multiple steps needed to resolve
- differing views from providers
- lack of time to discuss some of the very complex issues in detail

3.4 Slow progress, particularly regarding adherence to the interface contractual requirements remains frustrating for general practice and does not help to improve relationships.

3.5 There are also areas of frustration in secondary care as a result of poor-quality referrals (in some cases) from general practice, the group has not had time to focus on these as yet.

3.6 Lack of appropriate, dedicated resource available to support managing the CCG PID inbox and lack of resource providers have to investigate matters raised is resulting in slow and sometimes incomplete investigations.

4. Next steps

4.1 The April meeting will focus on agreeing next steps for items 2.5 and 2.6.

4.2 Consideration will be given to what additional workforce is required to support the interface work.

4.3 A focused discussion will be had in May (the April meeting will be specifically for secondary care, LMC and CCG GPs to discuss items 2.5 and 2.6) regarding concern about the pace of progress.

4.4 Consider extending the duration of the meeting to 1.5hrs each month, seek views from the group.

5. Recommendation

5.1 A further update will be provided to PCCC in July.

Key Risks	
Clinical and Quality:	Patients at risk as a result of interface issues not being addressed and confusion not being resolved to clarify each parties role and responsibilities.
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	Not applicable
Reputation:	There is a reputational risk to the CCG if significant interface issues are not addressed.
Legal:	Not applicable
Information Governance:	Not applicable
Resource Required:	Not applicable
Reference document(s):	Not applicable
NHS Constitution:	N/A
Conflicts of Interest:	Practice partners and staff will have direct experience of interface issues.
Reference to relevant risk on the Governing Body Assurance Framework	N/A

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	