Over £4,000,000 Per Year: Exploring the Burden of Interface Difficulties for General Practice in Humberside

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1. Over £4,000,000 Per Year

It will take you roughly 30 minutes to read this report and, in that time, GPs in Humberside will have spent more than £1,500 on resolving interface difficulties - activity that has little or no clinical value. Time and money that could have been used to resource much needed GP appointments. By the time you go home on Friday evening, the money general practice in Humberside spend resolving interface difficulties would be sufficient to fund the treatment of 10 breast cancer patients for a whole year[1]. Over the course of 12 months, this cost adds up to more than £4,000,000 of NHS funding that could be better spent on patient care in the Humberside region. This is the equivalent of over £223 million across England each year.

“Good organisation of care across the interface between general practice and secondary care providers is crucial in ensuring that patients receive high-quality care and in making the best use of clinical time and NHS resources in both settings.”

NHS England - July 2017[2]

2. Executive Summary

Humberside Local Medical Committees (LMCs) represent general practice in East Yorkshire, Hull, North East Lincolnshire, and North Lincolnshire. In 2023, Humberside LMCs surveyed staff working in general practice to determine the source, nature, and prevalence of interface difficulties affecting general practice. Here, we report our findings and quantify the administrative, clinical, and economic burden of interface difficulties in general practice. We refer to this as the 'interface burden' because it is un-resourced, unnecessary, and avoidable activity that, as this report shows, drains clinical capacity within general practice and the wider healthcare system.

Interface difficulties in Humberside are likely to cost more than £4,076,800 per year. Acute providers account for the single largest source of interface difficulties but other sources including mental health, community, and out of area providers which collectively account for nearly two-thirds of the monthly interface burden. Poor communication and inappropriate work requests are common sources of interface difficulties. With system-wide engagement, interface difficulties can be prevented. Where they occur, effective mechanisms that deal with individual difficulties, fully, are needed. Eliminating interface difficulties could create up to 97,084 GP appointments per year in Humberside. By recognising and quantifying the problem, we believe that stakeholders will be better placed to work together to optimise system processes and eliminate interface difficulties.

MAP OF THE HUMBERSIDE REGION

3. Introduction

In 2021 to 2022, the budget for health and social care in England was £186.9 billion[3]. Primary care, including general practice, dentistry, pharmacy, and ophthalmology, received £14.9 billion[4]. With less than 8% of overall healthcare funding, general practice in the UK delivered 300 million appointments[5] at £42 per appointment[6]. For context, providers received £114.1 billion (61% of healthcare funding)[3] which funded 122 million outpatient appointments[7] and 23 million emergency department attendances[5]. However, sustaining the high demand for GP appointments is challenging. The number of full-time GPs has not increased since the most recent peak in 2015 with workload demand leading to an increase in portfolio and part-time working[7].

The Organisation for Economic Co-operation and Development (OECD) provide health care quality indicators for primary care[8]. To ensure safe and effective care, the OECD recommends that 10.8 GPs are available for every 10,000 patients. Currently, the UK has an average of 7.8 GPs per 10,000 patients[7]. Humberside has as few as 4.3 GPs per 10,000 patients[9]. With high demand for GP appointments[10], too few GPs, and uncertainties about whether significant further funding will be awarded to general practice, healthcare systems need to optimise the limited resources they have.

3.1 The Primary Secondary Care Interface

In 2021, Humberside LMCs published their report on the interface between primary and secondary care[11]. The report highlighted that general practice regularly received instructions to undertake the contractual work of secondary care[12]. This included requests to make onward referrals, arrange tests and investigations, and issue medications. The time associated with addressing these requests was equivalent to 270 clinical appointments per week. In May 2023, NHS England (NHSE) published their "Delivery plan for recovering access to primary care" which noted that up to 20% of GP time was spent resolving interface difficulties[13]. Consequently, the report placed significant emphasis on improving the interface between general practice and secondary care organisations[13]. NHS England outlined an ambition to reduce interface difficulties and create additional clinical capacity. In doing so, four priority areas were identified. These were reducing the number of requests made for GPs to initiate onward referrals from secondary care, complete care being provided by secondary care (including fit notes), establishing

call/recall of patients within Trusts, and establishing clear routes for GPs and secondary care to communicate, rapidly. Acknowledging the challenges that the interface between healthcare organisations presents is an important step. However, whilst the scope of this document refers to secondary care, secondary care is not a single entity. It is made up of an increasingly large list of providers. Therefore, to improve the interface between primary and secondary care, it is important to understand the source of interface difficulties at a regional level. Unpublished data from Humberside LMCs, collected between April 1st and October 26th 2023, shows that general practice experienced interface difficulties with 39 organisations. Thus, whilst it is convenient to suggest that acute care may be the source of most interface difficulties, it is not a certainty. Furthermore, it is also unclear whether the priorities for improving the interface, outlined in the “Delivery plan for recovering access to primary care”, should be the priorities in Humberside. If Humber and North Yorkshire Integrated Care System is to effectively increase clinical capacity by reducing interface difficulties, local interface priorities need to be established.

> *“Left as it is, primary care as we know it will become unsustainable in a relatively short period of time.”*

Dr Claire Fuller – Author of the Fuller Stocktake Report - May 2022[14]

4. Survey Aim

The aim of this survey was to determine which organisations general practice experience interface difficulties with the type of interface difficulties they experience, the amount of time they spend on resolving these difficulties and the cost of doing so. We explored the difference in responses between professional roles, and between practices located in different Place areas and/or regions of Humberside. This information will be used to inform the interface strategy of Humberside LMCs and will be shared with stakeholders across the Humber and North Yorkshire Integrated Care System area to assist them in creating their own interface strategy.

5. Methods

For interested readers, the full methods used to collect and analyse data in this report are at the end of this document. Briefly, data were collected using a 21-item survey. The survey was provided to GP practices in the East Riding, Hull, North East Lincolnshire, and North Lincolnshire. The survey was open to all clinical and non-clinical staff working in general practice, as well as colleagues working for the Humber and North Yorkshire Integrated Care System. All participants provided informed consent. Response validation was used on all questions where appropriate. The survey was available for completion between September 5th and September 25th 2023.

6. Results

“the findings can be considered to represent the experience of general practice in Humberside.”

6.1 Response Rate

Every Primary Care Network (PCN) in the East Riding, Hull, North East Lincolnshire, and North Lincolnshire were represented in the survey with the exception of one PCN in the Hull Place area (Medicas). Nearly half of responses were from people working in the East Riding Place area (44%). A similar number of responses were received from Hull (24%) and North East Lincolnshire (20%). Fewest responses were received from the North Lincolnshire Place area (12%). Because our survey received responses from all Place areas, and all but one PCN, the findings can be considered to represent the experience of general practice in Humberside. Ninety-four people accessed the Humberside LMCs survey between September 5th and September 25th 2023. Of these, 95% provided consent and completed the survey. Therefore, results are expressed as a percentage of 89 respondents.

6.2 Respondent Characteristics

Humberside LMCs first and foremost represent GPs. Therefore, it is unsurprising that more than half of survey responses were from GPs (52%). The largest number of respondents were from GP partners (36%). Salaried GPs (12%), sessional GPs (3%), and trainee GPs (1%) also responded. Four in 10 responses were from people working in non-GP roles (41%). These included practice managers (23%), other non-clinical staff (11%), other clinical staff (2%) and staff at the Humber and North Yorkshire Integrated Care System (5%). Six percent of respondents did not state what their job role was. Having a larger number of responses from partner GPs than salaried GPs reflects the GP workforce at a national level[7]. Having strong representation from people working in non-GP roles strengthens the findings of our survey because they provide insights into the experience of the wider general practice workforce. This is important because the pressures facing general practice are not only experienced by GPs, but their clinical and non-clinical colleagues alike. The same is true of interface difficulties. The findings of our survey therefore capture the interface burden experienced by the entire general practice workforce.

6.3 The Cost of Interface Difficulties

> “*Approximately 6,600 interface difficulties are dealt with in general practice every month.*”

Each individual respondent resolved 11 interface difficulties per month. Based on the Humberside GP workforce, this means approximately 6,600 interface difficulties are dealt with in general practice every month. We do not know how many staff work in the wider general practice workforce across Humberside so we cannot estimate how many interface difficulties affect the wider workforce. However, the workforce is substantially larger than the GP work force and the total number of interface difficulties affecting general practice will be *significantly* underreported. It is concerning that interacting with other healthcare organisations is unnecessarily onerous and inefficient. It is likely to contribute to low morale amongst the general practice workforce. Indeed, one respondent

reported experiencing "poor treatment of GPs by secondary care colleagues". Interactions between healthcare professionals should be appropriate, professional, easy, quick, and accurate.

6.4 Time Spent Resolving Interface Difficulties

> *"The annual equivalent cost of wasted GPs appointments in Humberside is £4,076,800."*

The time spent resolving interface difficulties by each profession are shown below. More than half of respondents (56%) spent in excess of 30 minutes resolving interface difficulties every week. A further one in five respondents (19%) spent 20-30 minutes resolving interface difficulties each week.

	Time Spent Resolving Interface Difficulties by Respondents			
Job Role	**<10 Minutes**	**10-20 Minutes**	**20-30 Minutes**	**>30 Minutes**
Any General Practitioner Role	3%	10%	13%	38%
Other Clinical Staff	0%	0%	0%	2%
Practice Manager	6%	2%	5%	14%
Other Non-Clinical Staff	3%	2%	0%	2%
ICS Staff	0%	0%	2%	0%

ICS = Integrated Care System

Of all the professions, GPs were the most likely to spend more than 30 minutes per week resolving interface difficulties (60%) and typically spent *at least* 28 minutes per week doing so. In Humberside, this means that GPs spend up to **16,800 minutes every week** resolving interface difficulties (280 hours). That is the equivalent of 1,867 clinical appointments per week, or **97,084 GP appointments per year**, being wasted due to interface difficulties. This **is *significantly*** more than the 270 appointments per week that we estimated in our previous interface survey[11]. At £42 per appointment, the equivalent annual cost of wasted GPs appointments in Humberside is £4,076,800. **This does not include the additional costs associated with staff in non-GP roles addressing interface**

difficulties. For context, creating an additional 97,084 GP appointments would be sufficient to provide an annual appointment to more than 1 in 10 people in Humberside. At a national level, it would create 12% of the additional 50,000,000 annual appointments NHSE aimed to create by employing 26,000 additional healthcare professionals,[13] but at no cost. The UK Government concludes that it has already met this target because "in the 12 months to October 2023, 358 million general practice appointments, including COVID-19 vaccinations, were delivered" - an increase of 50.9 million compared to 2019[15]. However, in 2022, prior to the launch of the "Delivery plan for recovering access to primary care", data from NHS digital reported that 342 million appointments were delivered[16]. Thus, the target of creating an additional 50 million appointments is unlikely to have been met.

Across Humberside, practice managers spent between 2,400 and 2,964 minutes (40 to 49 hours) resolving interface difficulties each week, taking them away from supporting staff and patients in their key role within each general practice.

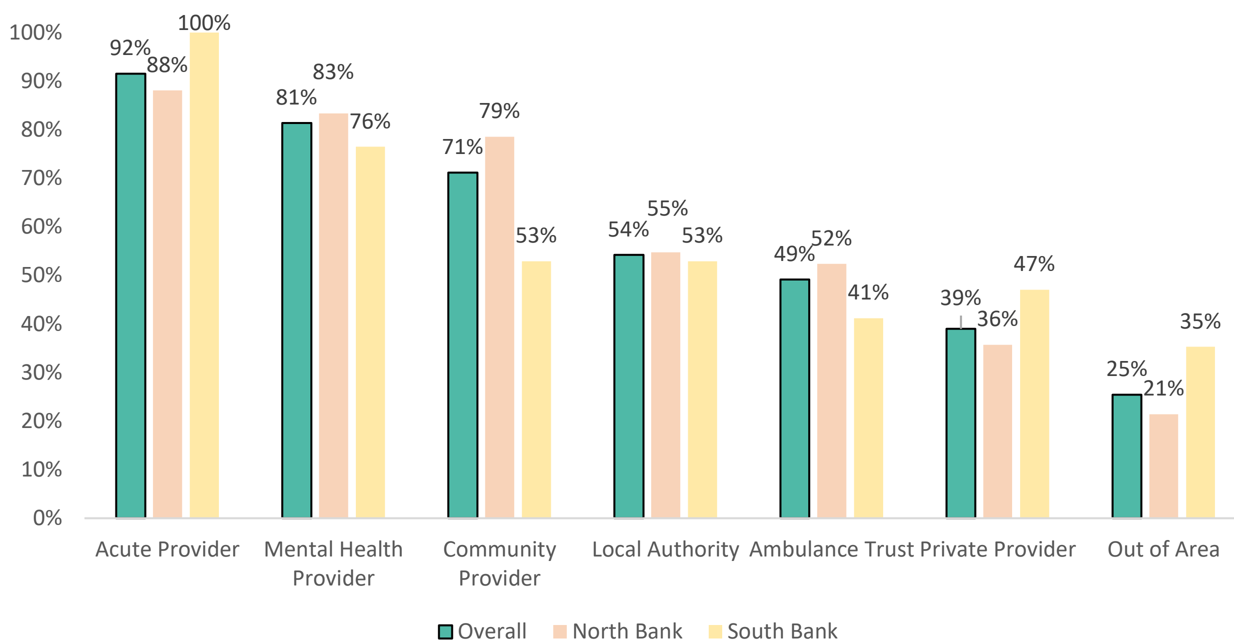
Interface difficulties have a pernicious, profound, and widespread impact on healthcare provision. They avoidably drain clinical capacity from a healthcare system that is already financially strained.

Improving the interface between general practice and healthcare systems should be intelligence led. The following section provides information about which provider types are associated with interface difficulties in Humberside.

6.5 Frequency of Interface Difficulties by Provider Type

"Mental health providers are almost as likely as acute trusts to be the source of interface difficulties."

Participants were asked to select provider organisations they had encountered difficulties with. This allowed us to quantify which organisations were most commonly the source of interface difficulties. Responses are shown in the figure below.



Overall, acute trusts were selected most frequently (92%). This was mirrored across the North and South Bank in the Humberside region. However, all (100%) South Bank practices selected acute providers compared to 88% of North Bank practices suggesting that practices on the South Bank experience interface difficulties with acute providers more often than practices on the North Bank. With the Hull University Teaching Hospitals (HUTH) and North Lincolnshire and Goole (NLAG) hospitals under a new clinical group structure from late 2023, it is likely that pathways and processes within those organisations will undergo a period of change and will continue to do so for some time. It is vital that acute providers observe their contractual requirement to consult with General Practice when they consider developing or redesigning services[12].

Mental health providers were selected as a source of interface difficulties by four out of five GPs (81%) making them the second most common source of interface difficulties. This indicates that mental health providers are almost as likely as acute trusts to be the source of interface difficulties affecting general practice.

Although more than two thirds of respondents said that community providers were associated with interface difficulties (71%), this affected North Bank practices (79%) more often than South Bank practices (53%) who experienced similar levels of difficulties with community providers (53%) and local authorities (53%).

As community providers continue to play an important role in patient care, it is logical that the number of interactions between general practice and community providers, and local authorities, will increase. With

increased interactions, interface difficulties will almost certainly increase too. Decision makers should consider how community and local authority providers interface with general practice whilst designing services, rather than retrofitting interface solutions once difficulties arise.

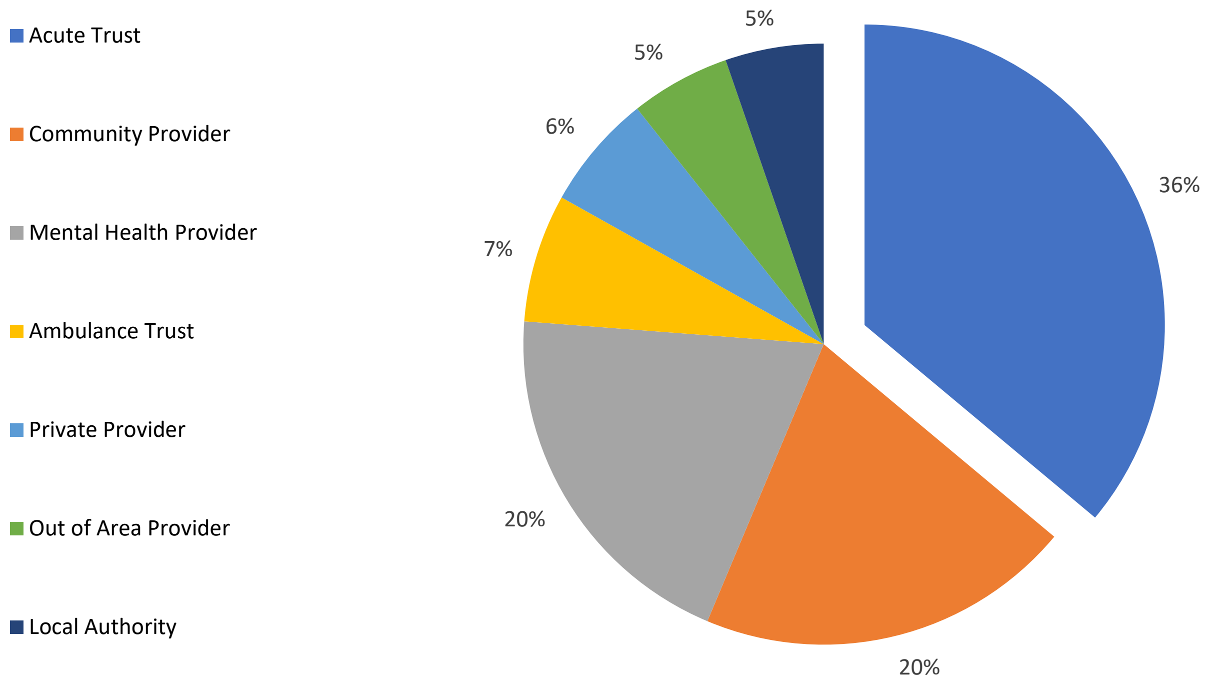
By reporting which organisations are the source of interface difficulties in general practice, we can recommend that resources are primarily focused on improving the interface between general practice and acute trusts, as well as general practice and mental health providers. However, this metric doesn't account for the volume of interface work associated with each organisation. In the next section, we report the interface burden on general practice by estimating the volume of work associated with each provider type.

6.6 Interface Burden by Provider Type

> *“Whilst acute trusts were associated with the single biggest monthly interface burden, the combined monthly interface burden of other organisations was significantly larger.”*

Respondents were asked how frequently they encountered interface difficulties with each type of provider. Using this data, we estimated and ranked the volume of monthly interface difficulties, or the “interface burden”, associated with each provider type.

Acute providers accounted for over one third of the total monthly interface burden (36%). Community providers (20%) and mental health providers (20%) each accounted for one fifth of the total monthly interface burden. Other providers, including local authorities, accounted for smaller volumes of interface difficulties (see below).



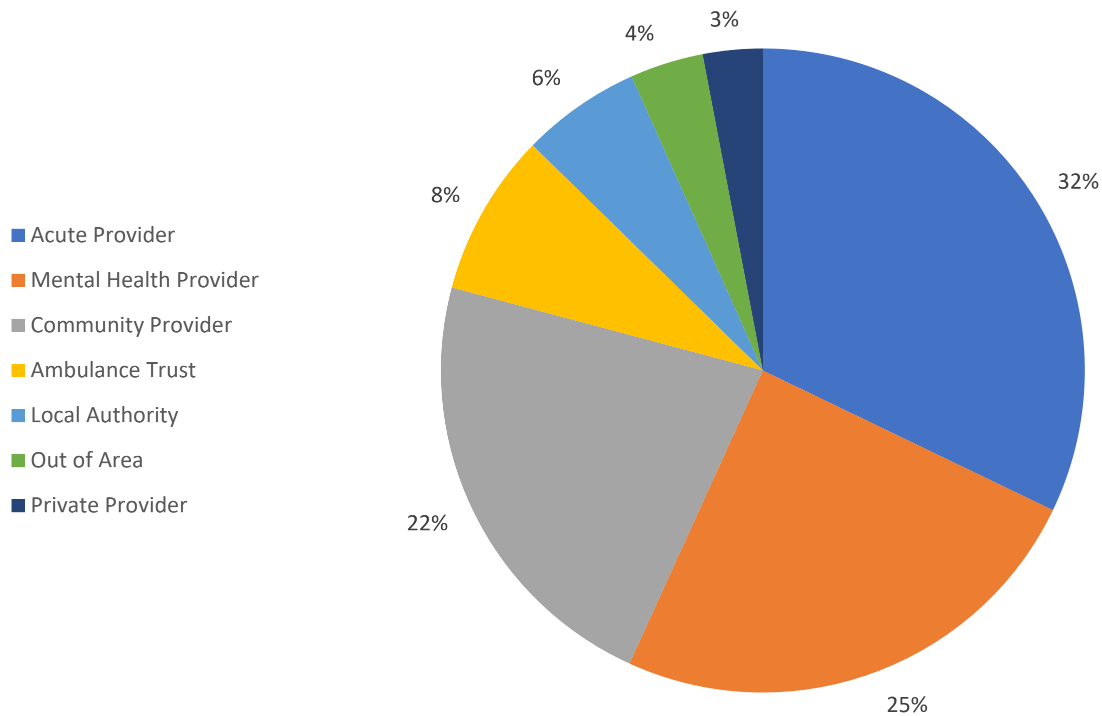
Interface burden by provider type across the Humberside region

It is important to highlight that even though acute trusts were the single biggest source of interface difficulties, the combined monthly interface burden of other organisations was substantially larger (64%). Undoubtedly, there is much to gain from improving the interface between general practice and acute trusts. However, we recommend system resources do not disproportionately focus on improving the interface between general practice and acute trusts but ensure that the interface with other providers is appropriately addressed. To help local healthcare decision makers assign resources appropriately, the following section of the report explores the interface burden on the North and South Bank in the Humber region.

6.7 Regional Interface Burden Differences

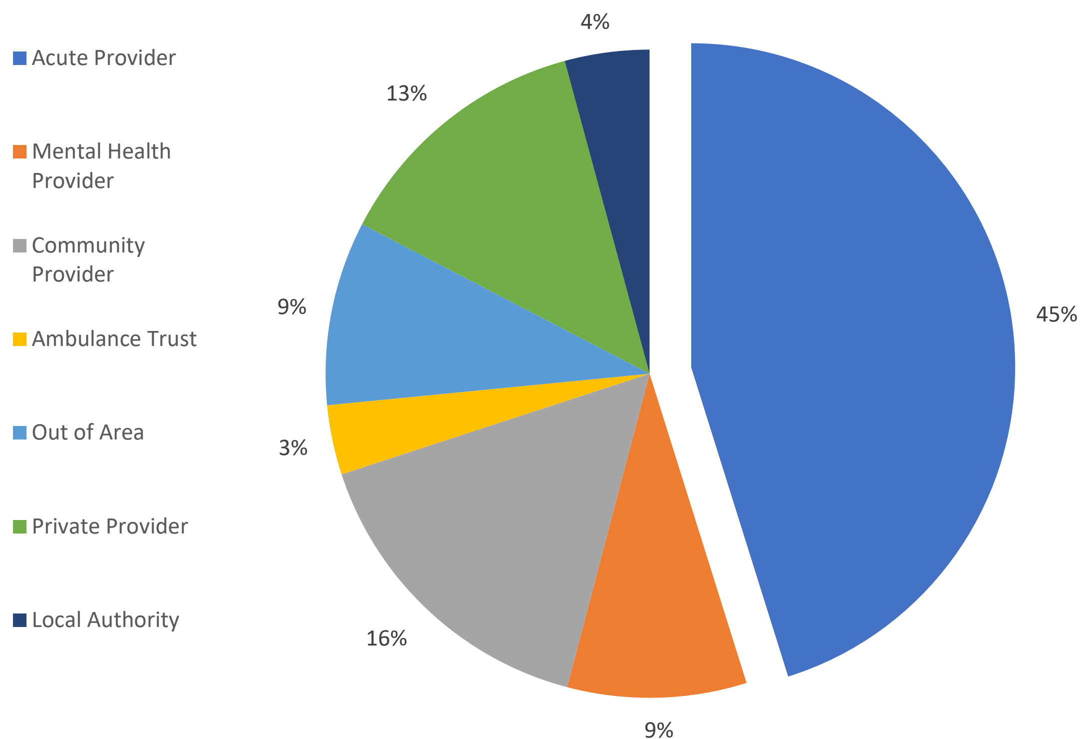
When separated by region, it was clear that acute providers accounted for a bigger proportion of the interface difficulties experienced by South Bank practices than by North Bank practices. On the South Bank, acute trusts accounted for 45% of the monthly interface burden whereas on the north bank they accounted for 32% of the monthly interface burden.

North Bank practices experienced similar monthly interface burdens with mental health providers (25%) and community providers (22%). Ambulance trusts, local authorities, out of area providers and private providers each accounted for smaller proportions of the total interface burden. Collectively, for North Bank practices, providers of non-acute care accounted for 68% of the total interface burden (See below).



Interface burden by provider type in Hull and the East Riding

On the South Bank community providers (16%), and private providers (13%) were associated with the second and third largest monthly interface burden, respectively. Mental health providers and private providers each accounted for around one tenth of the total interface burden (9%). Local authority and ambulance trusts accounted for fewest interface difficulties.



Interface burden by provider type in North and North East Lincolnshire

Acute trusts are the single largest source if interface difficulties for general practice. In Humberside, this fact does not differ by region. However, South Bank practices experience more difficuilties with acute trusts than North Bank Practices (13% more difficulties). Collectively, regardless of region, **interface difficulties associated with providers that are *not* acute trusts represent the the biggest interface burden**. What this data also tells us is that the organisations that are the source of interface difficulties differ by region. We recommend that local health decision makers consider this when developing their interface stratgey.

6.8 Types of Interface Difficulty Reported

> *“…We have had to employ a whole new workforce as GP administrators to help us cope.”*

Respondents reported the types of interface difficulty they had experienced. We collated their responses and created themes to simplify the report.

6.8.1 Communication

Communication, including patients not being made aware of test results, was most frequently reported (85%). Respondents said that there was a lack of “joined up” working with secondary care. There is a clear need to cultivate a sense of comradery between providers and general practice. A shared understanding of the pressures, roles, and responsibilities is likely to lead to improved ‘joined up’ working and mutual professional respect.

Timely arrival of clinical information is pivotal to maintaining good quality and safe patient care and maintaining the trust and support of the public. For this reason, providers are contractually required to send discharge information within 24 hours and clinic letters within seven days[12]. It is therefore unsurprising that late arrival of clinic letters was a frustration for our respondents. Late arrival of clinical letters made managing patients who had been prescribed new medication difficult, and the management of complex patients reportedly took a long time to “unravel”. Poor quality discharge communication, being unable to access services including crisis teams, and being asked “pointless” questions by hospital admission lines were highlighted as areas of poor communication leading to inefficient working.

6.8.2 Investigations and Referrals

Difficulties relating to clinical investigations (80%) were reported by four out of five respondents. These difficulties were often characterised as a ‘transfer of work’ from other providers. GPs were asked to initiate onward referrals, follow-up blood tests and other investigations, action results, and provide MED3 certificates. These activities had

a significant time cost. Some respondents reported "directly or indirectly" spending 30% to 40% of their working day resolving difficulties:

> "*We spend 40% of our daily time directly or indirectly resolving problems created by other providers.*"

These data suggest that there is a lack of awareness about the clinical and contractual responsibility within provider organisations, or a failure to prioritise this as a contractual requirement. Of equal importance, by transferring work, providers are not consistently acting in their patient's best interest. One respondent felt very strongly that little was being done to address these difficulties:

> "*There is no consistent meaningful interface worthy of the name.*"

This reflects a disappointing level of disenfranchisement that is likely to be felt by other colleagues in general practice. It is vital that healthcare decision makers prioritise the interface and **effectively** communicate their work to general practice.

6.8.3 Referrals, Advice, and Guidance

Finally, referrals/advice and guidance were a common sources of interface difficulties (72%). Some respondents reported that referrals from out of area providers were being inappropriately rejected. Referrals from GPs to providers is often a point of contention. There is no contractual basis for requiring a GP to use a referral form so these cannot be imposed. Any referral form adopted, or amended, must have systemwide agreement. Otherwise, GPs are free to use whichever referral method they see fit. Equally, if a referral process changes as part of service development or redesign, there is a contractual responsibility to consult with stakeholders first[12]. This includes general practice, with LMCs having a statutory duty to represent GPs at local level[18]. Finally, there needs to be an appreciation that it is not the role of general practice to undertake an exhaustive assessment of a patient prior to referral to a provider. The information requested prior to referral should be the *minimum* that is reasonably required to assess the eligibility to the service.

Shared care agreements (50%) and difficulties with IT systems (43%) were less common but were still cited as a difficulty by approximately half of respondents. Expectations from gender identity clinics that GPs prescribe medication, even when shared care has been declined, were specifically reported. Shared care is a simple concept. There is no requirement for general practice to agree to shared care. Pressure should never be exerted for a GP to accept shared care. Shared care protocols should be clear, and escalation/communication with providers should be quick and simple.

7. Interpretation and Recommendations

Our survey aimed to determine which organisations general practice experiences interface difficulties with, the type of interface difficulties they experience, and the amount of time they spend resolving interface difficulties. We also explored differences in responses between professional roles, and between practices located in different Place areas and/or regions of Humberside. This enabled us to assess the amount of patient contact time that the NHS loses due to interface difficulties. Our survey included responses from all but one Primary Care Network in Humberside. Thus, our findings are representative of the experience of general practice across Humberside.

General practitioners in Humberside spend up to 280 hours per week trying to resolve interface difficulties at a cost of £4,076,800. This does not include the cost to wider general practice workforce. As a single organisation, practices experienced most interface difficulties when interacting with acute providers. However, the combined monthly interface burden from other providers was substantially higher than for acute providers alone (64%). This was most notable for practices on the North Bank where acute providers accounted for a third of interface difficulties (32%). In contrast, almost half (45%) of the monthly interface burden experienced by South Bank practices was associated with acute providers. Despite the difference in the source of interface burden, there was commonality between the types of interface difficulties reported by North and South Bank practices. Communication was a common concern, but investigations and referrals/advice and guidance were also frequently reported as a source of interface difficulties. It was noteworthy that practices on the South Bank were more likely to report difficulties with every aspect of interface, compared to North Bank practices.

7.1 Interface Difficulties

- Our respondents resolved 11 interface difficulties per month with a time cost of approximately 30 minutes per week. GPs were most likely to spend time resolving interface difficulties, compared to other professions.

- The average GP appointment is 9 minutes[6]. Thus, 1,867 clinical appointments per week, or 97,084 GP appointments per year, are wasted due to interface difficulties. Based on a model contract, this is the equivalent of losing 7.5 WTE GPs each year, in the Humberside region.

- GPs in Humberside spend around 280 hours resolving interface difficulties each week. This is significantly more than the 270 appointments per week that we estimated in our previous interface survey[11]. This is most likely due to a more detailed data collection than in our previous survey. However, anecdotally, GPs regularly report to the LMC that they are experiencing more interface difficulties than ever. This increase is when pressure on the NHS is higher overall. Therefore, a greater volume of interface difficulties is also likely to have contributed to the apparent increase in time spent resolving interface difficulties. The increase in interface difficulties may also be attributed to a hiatus in governance whilst Clinical Commissioning Groups transitioned into Integrated Care Systems. Changes in pathways, processes, and staffing which have occurred since HUTH and NLAG began their closer working alignment may also be a factor. Finally, the proliferation of community providers who are not involved in the wider interface activity across the Integrated Care System, and who are unaware of their contractual obligations, or simply don't adhere to them, may be a factor.

- At £42 per appointment[6], the equivalent cost of wasted GPs appointments in Humberside is £4,076,800 per year. In the time it has taken you to read this report, GPs in Humberside will have spent more than £1,500 on resolving interface difficulties. By the time you go home on Friday evening, the money general practice in Humberside spend resolving interface difficulties this week would have funded the breast cancer treatment of 10 patients for a whole year[1]. This clearly demonstrates significant inefficiencies at the interface between general practice and other providers.

- The impact of interface difficulties on the morale of General Practice staff was clearly articulated by survey respondents, reflecting published papers and research including from the British Medical Association, Kings

Fund and in the BMJ Open[17]. Within two years, 18% of GPs now plan on retiring – an increase of 5% since 2014. Further, 48.5% of GPs have brought forward their plans to retire[17]. Lower job satisfaction, and 'job intensity', are key factors driving the desire for staff to leave general practice[17]. Reducing the needless burden of interface difficulties is one way that the job satisfaction of general practice staff could be increased, and 'job intensity' reduced.

- The National Audit Office publish commissioning guidance on "Assessing Value for Money"[18]. A commissioning inefficiency of £4,076,800 that also impacts on the quality of service experienced by patients suggests that Integrated Care Board investment in provider organisations could be far more cost-effective. Whilst every provider has a contractual requirement to *"ensure that Staff work effectively and efficiently together, across professional and Service boundaries"* [12], it is clear that this is not happening as uniformly as it should be.

- Integrated Care Boards are required to publicly report on their progress towards improving the interface between primary and secondary care, by cutting bureaucracy and workload[13]. Whether this reporting will drive improvements in interface performance and adherence to provider contractual obligations is unknown.

- System-wide engagement with interface activity represents a substantial opportunity to create additional clinical capacity at little or no cost. Compared to other initiatives, such additional funding for winter pressures, improving the interface between general practice and secondary care can be viewed as a "quick win" for Integrated Care Systems as many problems are simple to solve. They also cost very little, if anything to solve.

- Most interface difficulties were not from acute providers. Nearly two-thirds (64%) of interface difficulties were from other provider organisations. Thus, we conclude that interface difficulties are a "pan Humber and North Yorkshire Integrated Care System issue" in need of broad engagement. The potential to create up to 1,867 additional clinical appointments each week relies on strong interface mechanisms between general practice and other providers. If such capacity were created, it would substantially contribute towards the NHSE plan to *"build capacity so practices can offer more appointments from more staff than ever before"*[13]

- Overall, community providers and mental health providers accounted for a significant proportion of the combined monthly interface burden (40%). Thus, developing better interface mechanisms with community

and mental health providers is needed. However, for the South Bank in the Humber area, developing interface mechanisms with 'private' providers should be prioritised over mental health providers.

- Although community and mental health providers represented a larger combined monthly interface burden, acute trusts were the single biggest source of interface difficulties (36%) across Humberside.

- Structured mechanisms to resolve interface difficulties with acute trusts are clearly still required. In Humberside, two similar primary/secondary care interface groups (PSCIG) exist – one on the North Bank and one on the South Bank. (In the strictest sense, these groups do not interface with secondary care – they interface with acute trusts).

- Across Humberside, general practice can report interface difficulties in Primary Secondary Care Interface Group (PSCIG) meetings, or via online portals direct to Place teams. The success of this approach is unclear as quantitative data on progress to date are not yet available. However, the interface themes identified in our survey, such as transfer of work and poor communication, reflect age-old interface difficulties, and suggest that further work is required. This was particularly the case for providers on the South Bank. The high volume of interface difficulties reported in this survey indisputably highlights that previous approaches to preventing interface difficulties are, at best, incomplete solutions. At worst, they do not work. Further work is needed to improve the interface between general practice and providers. This will require all stakeholders, and all employees within those stakeholders, to understand their role and obligations. It will also require innovative approaches.

- The most common interface difficulties respondents across Humberside experienced were in relation to communication (85%). Qualitative data indicated that this was commonly related to poor quality or untimely communication from providers. Similarly, requests for GPs to arrange investigations/blood tests (80%), and onward referrals (72%) were highlighted. Thus, interface issues affecting general practice in Humberside broadly reflect those highlighted by NHSE[13].

- Whilst structured interface mechanisms and "joined up" working are clearly needed to improve the interface between general practice and provider organisations, these are difficulties that can be prevented through

effective communication and engagement with staff, training, sufficiently allocated staff time, and appropriate line manager support.

- Mechanisms to initiate referrals and arrange investigations should be established where no mechanism currently exists. Thus, our recommendation is that healthcare stakeholders collaborate to create a package of support, and an implementation plan, to eliminate low level (but time consuming) interface difficulties so that more time can be spent resolving more complex interface challenges. Whilst this is implemented, a concerted effort to resolve any interface difficulties, and openly report the outcome, should be implemented.

7.2 Conclusion

The demand for GP appointments will likely continue to rise. With the number of GPs available, compared to demand, continuing to decline[7] the NHS cannot afford to waste clinical capacity. Regionally, the weekly loss of 1,867 GP appointments alone is significant, costs £4,076,800 per year, but is preventable. With Integrated Care Systems reaching maturity over the coming months, the possibility of cohesive working is more achievable than ever. Thus, the potential to eliminate interface difficulties by working with ICS stakeholders is also possible. Improving the interface between general practice and other healthcare organisations is in the interest of all stakeholders as it will creating additional clinical capacity. Additional capacity in general practice will benefit the wider healthcare system by, for example, enabling better patient access to primary care and therefore reducing admissions.

There is a national mandate for improving the interface between primary and secondary care[13]. This must include the entire health and social care system if the full benefits of improved interface are to be obtained. Nationally, interface priorities include reducing the number of requests made for GPs to initiate onward referrals from secondary care, complete care being provided by secondary care (including fit notes), establishing call/recall of patients within Trusts, and establishing clear routes for GPs and secondary care to communicate, rapidly. The findings of our survey broadly recognise these priorities as local priorities. However, of these, specific local priorities should be reducing onward referrals, providing complete care including requests for further investigations, and improving the quality of communication. Progress towards achieving these priorities should be

measured and reported on. Doing so will demonstrate how integrated care can work for the benefit of all stakeholders.

8. Moving Forward

The next steps proposed below are divided into those directed towards our own organisation, Humberside LMC, and those constructively suggested to Place and ICS colleagues who hold responsibility for the provision of patient care within our area. The LMC has no direct remit over the Humber and North Yorkshire ICS, or its ICB executive, but we hope these suggestions are taken in the spirit of collaborative working to improve the lives of our colleagues and patients.

8.1 LMC Actions

- Practices on the South Bank, in particular North Lincolnshire, were less well represented in this survey. South Bank Practices were also more likely to report difficulties with every type of interface difficulty. We will therefore undertake targeted engagement with practices in North Lincolnshire.

- Salaried GPs were also less well represented in this survey. Salaried GPs may not be aware of the interface support available to them through the LMC. We will therefore undertake targeted engagement with all sessional GP colleagues.

- To continue to support practices, and achieve our ambition of eliminating interface difficulties, we will promote our interface services to increase the number of constituents that report interface difficulties to Humberside LMCs and/or Place teams.

- Preventing and resolving interface difficulties relies on strong and effective relationships with all stakeholders. We will continue to establish and refine interface networks with acute, community, mental health, and out of area providers.

- Humberside LMCs exist to support general practice. One of the services we offer is to resolve interface queries for any member of staff working in general practice. To demonstrate that Humberside LMCs are proactively trying to reduce the interface burden, and improve the morale of general practice, we will keep constituents updated about their interface difficulty.

- Rather than relying on reactive reporting of interface difficulties, we will lobby healthcare stakeholders to create a package of support, and an implementation plan, to eliminate low level but time-consuming interface difficulties.

- To work collaboratively, and to enable interface difficulties to be resolved more effectively, we will explore opportunities to share information about interface difficulties with Place colleagues.

- Demonstrating the benefits of improving the interface between general practice and secondary care is vital for system-wide engagement. Where appropriate, we will work with ICS colleagues to refine estimated costs of resolving interface difficulties to make a financial case for investing in regional interface staff and infrastructure.

- To encourage every providers' involvement in improving the interface we will lobby Integrated Care Boards to implement an 'interface' key performance indicator.

- It will require dedicated staff to resolve the high volume of interface difficulties currently reported by general practice and prevent future difficulties from arising. Tokenism will not work. We will therefore advocate for the employment of more staff who improve the interface between general practice and providers.

8.2 Suggested Actions for Integrated Care Board and System

Improving the interface between general practice and other health and social care organisations requires an understanding of the impact that a poor interface has. We therefore request that the Integrated Care Board and System colleagues take time to digest the contents of this report and acknowledge the financial and clinical resources that are lost because of interface difficulties, and the impact that a poor interface has on staff retention. With a clinical cost in excess of £4,000,000, and the wider cost to general practice likely to be substantially larger, healthcare decisionmakers should prioritise the eradication of interface difficulties. Integrated Care Systems should give the same prioritisation, if not higher, to improving the interface as they do to other projects.

While this report is based on data from the Humberside region, it is highly likely the themes will be replicated across all ICS footprints and these suggestions could be applied to support existing work across England.

- Previous initiatives to improve the interface between general practice and other health and social care organisations have not prevented interface difficulties from arising. Integrated Care Systems should develop new and innovative approaches to tackling the interface burden.

- Audits on the impact of reducing the interface burden to demonstrate reduced financial wastage, increased clinical capacity, and increased morale should take place at regular intervals.
- In our survey, we have provided metrics that could inform local strategy and policy. Integrated Care Systems should create a local evidence-based interface strategy using these data and/or other data at their disposal. Progress towards achieving this strategy should be reported on. This will help characterise ongoing challenges but also demonstrate a commitment to improving the interface.

- Integrated Care Systems should prioritise and commit to the elimination of common interface difficulties including:
    - Inappropriate request for GPs to make onward referrals
    - Inappropriate requests for GPs to arrange further investigations
    - Poor quality communication

- Our survey demonstrates widespread, regular contract breaches by providers. It is vital that contract breaches, such as delayed clinic letters, are not trivialised as 'minor breaches'. The collective impact of such 'minor breaches' is clearly a significant problem. Integrated Care Boards must ensure the providers adhere to their contractual obligations and address every breach in full. To achieve this, we recommend creating a package of support for providers, accompanied by an implementation plan.

- Respondents often believed that their interface difficulties went without investigation. To address this, and avoid disenfranchisement, regular updates should be provided to people who report interface difficulties.

- As services, pathways, and processes are created or developed, it is easy to overlook the contractual requirements (or absence of) of general practice. Often, non-contractual requirements are built into the design of new services. It is therefore important that all relevant Integrated Care Board, System, Place, and provider colleagues have awareness of provider and GP contracts.

- In the era of Key Performance Indicators, we suggest the introduction of 'interface' indicators for providers. This would incentivise every providers' engagement with interface activity whilst also providing Integrated Care Systems with metrics to measure and report on their progress towards improving the interface between primary and secondary care.

- To prevent interface difficulties from arising, consultation must take place when any services are designed, re-designed, or improved. All Integrated Care system staff, and provider staff, should be aware of those requirements. Doing so will foster system-wide trust and collaboration.

- Based on potential cost savings and the creation of additional clinical capacity, additional staff should be employed to support the improvement of the interface. A full-time staff member, whose remit is to improve the interface between general practice and other healthcare organisations, employed on an NHS band 5 salary, would cost just 2% of the annual cost of interface difficulties in Humberside. There is a clear financial case for making such an investment.

9. Appendix

A. Survey Design

This voluntary, cross-sectional, open survey was targeted at a convenience sample of GPs and other general practice staff working in Humberside. The broad topic of questions related to:

- Respondent information e.g., job role
- Organisations associated with interface difficulties
- The nature of interface difficulties
- The time cost of interface difficulties
- Satisfaction with Humberside LMCs support

Simon Nichols, Dr Zoe Norris, and Jonathan Appleton designed the 21-item survey. All participants provided informed consent using a yes/no option. After this, there were eighteen tick/select choices boxes, two yes/no questions, and three free text responses. Four of the closed questions also allowed a “other” response with the opportunity to provide a free text answer. Participants did not have a survey completeness check/review option at the end of the survey but were able to navigate the previous pages to review and amend their responses if needed. Response validation was used on all questions, where appropriate. The functionality of the survey was tested by all staff at Humberside LMCs. The final version of the survey is available on request.

B. Survey Dissemination

The survey was uploaded to SurveyMonkey™ (SurveyMonkey Europe UC, Dublin, Ireland) and was available for completion between September 5th and September 25th 2023. SurveyMonkey has ISO/IEC 27001 security certification. The automated database was password-protected, and data was stored on secure SurveyMonkey and N3i servers. The survey was promoted in the September 2023 Humberside LMCs newsletter. An e-mail with a link to the survey was sent to all practices across Humberside too. The survey was promoted ad-hoc in meetings,

and through direct e-mail communication with constituents, and was also promoted on the Humberside LMCs website. Access to the survey was not restricted and was available for anyone to complete.

C. Data Analysis

Quantitative data were analysed using SPSS Version 29 (Chicago, IL, USA). Categorical data are reported as a percentage (%) of the respondents to each question. Continuous data are reported as mean (or median where appropriate), or as a total.. Hypothesis testing was not conducted. Responses were analysed by Place area (East Riding, Hull, North East Lincolnshire, and North Lincolnshire). Locally, Place areas are often referred to by broader geography. Thus, we pooled and analysed responses from the East Riding and Hull (North Bank), and North East Lincolnshire and North Lincolnshire (South Bank).

D. Estimating the Interface Burden

Respondents were asked the frequency that they encountered interface difficulties with each provider. The options were “daily”, “weekly”, “monthly”, and “never”. These were reported categorically. However, we converted responses into a single numerical value as follows. We assumed 260 working days (Monday to Friday) per year and thus, 21.7 working days per month (260 divided by 12). Therefore, a response of “daily” was assigned a weighted value of 21.7. Using the same principle, 52 weeks were divided into 12 months and a response of “weekly” was given a value of 4.3. ‘Monthly’ was given a value of one. Values provided by a respondent were added together to create a total monthly interface burden for each provider. The average number of interface difficulties each respondent had to resolve each month was also calculated.

To estimate the amount of time taken to resolve interface difficulties, we converted responses to the question “Overall, how many minutes do you think you spend resolving interface issues each week?” into a numerical response. Original responses included:

- <10 Minutes
- 10 to 20 minutes

- 20 to 30 minutes
- >30 Minutes

To estimate the time spent resolving interface difficulties, we converted each category into the highest corresponding duration. For example, 10 to 20 minutes was denoted as '20 minutes'. The subsequent duration for each respondent was added together to determine the total weekly time spent resolving interface difficulties for our survey cohort. We also used these data to calculate the average weekly time spent resolving interface difficulties. The mean weekly time spent resolving interface difficulties was multiplied by the number of GPs in Humberside (600 GPs) to estimate the weekly time spent resolving interface difficulties across Humberside. Finally, we converted the time spent resolving interface difficulties into nine minute appointments – the average length of a GP appointment[6]. Each appointment was assigned a value of £42[6]. A total cost of resolving interface difficulties, by GPs, was then calculated. This was not calculated for any other profession.

E. Qualitative Data Analysis

Free-text answers were exported into NVivo V.11 software (Lumivero, Denver, CO, USA) for thematic analysis by Simon Nichols. Answers were coded inductively. The resulting coding framework was then reviewed to identify patterns and themes in the data. Similar codes were grouped to form lower order themes, which were then grouped into higher order themes. Illustrative quotes are provided where appropriate.