



Phase 2: Integrated care

Central and south Manchester

Aim

To develop integrated respiratory services across central and south Manchester in partnerships with patients and carers, that will allow healthcare professionals across primary, secondary and community care to work coherently together.

Outline

Historically, central and south Manchester had separate community respiratory services that operated within different clinical commissioning group (CCG) boundaries. The team set out to create a single, collaborative and integrated respiratory care service across Central Manchester Foundation Trust (CMFT), University Hospital South Manchester (UHSM) and central and south Manchester CCGs. The team's objectives were to:

- 1 break down geographical and organisational boundaries for patients
- 2 reduce variation in care and provide high-quality, standardised respiratory services
- 3 enhance patient experience by reducing fragmentation of care
- 4 gain greater efficiencies and value from current resources.

Key messages

- Encourage and nurture **self-care skills** among patients with long-term conditions.
- Developing **peer support networks** can help people with respiratory disease feel more knowledgeable about their condition, confident and less isolated.
- **Building relationships** and trust between individuals in different organisations at ground level is the foundation to integrating care.
- A **systems approach** is required to address the issue of recurrent hospital admissions.
- Measurement of change and organisational performance needs to reflect **what is important to patients**.
- **Data, data, data.** Prove the value of what you do.

Methods

1. Vertical integration in south Manchester

In order to align services with central Manchester who had a well-established community model, south Manchester made a number of changes and developments to the community team over 18 months, including: recruitment, re-defining roles, establishing regular team meetings with a respiratory consultant, an education programme, commencing a 'virtual clinic' model in primary care and a review of services provided.

2. Horizontal integration between CMFT and UHSM at the front line

Historically the UHSM and CMFT front-line community respiratory teams had a professional relationship but had never met face-to-face as there was no previous incentive from the organisations/system to do so. Joint team meetings between CMFT and UHSM were established on a monthly basis. Teams:

- explored the services each team offered
- identified the patient access routes
- established joint education sessions, including sharing of case studies
- used process mapping to identify different parts of the service and produce joint operating policies.

A shadowing programme was undertaken where staff within the teams gained experience of how the other team operates. This enhanced development of personal relationships and helped with the alignment of team policies.

3. Patient involvement

Patients were involved in the integrated steering group and in co-design events to ensure that service developments were patient-centred.

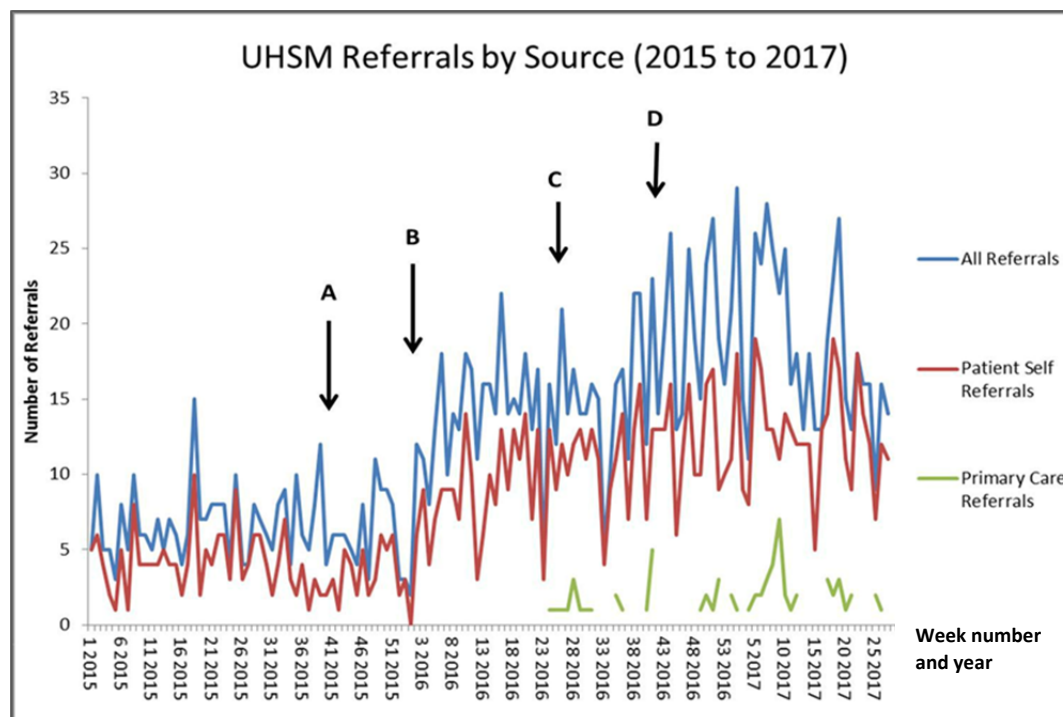
Milestones

- Jan 2016: Appointed as an FHP development site.
- Mar 2016: Multiple stakeholder co-design event: developing a pathway for the acutely unwell.
- Jun 2016: Multiple stakeholder co-design event: developing services to support chronic disease management.
- Dec 2016: Hosts of phase 2 learning event on the theme: commissioning.
- Apr 2017: North, south and central Manchester CCGs merge into one city-wide CCG.
- Jun 2017: Palliative care co-design event.
- Oct 2017: UHSM and CMFT merge into one acute trust.

Outcomes

1. Impact on patient care

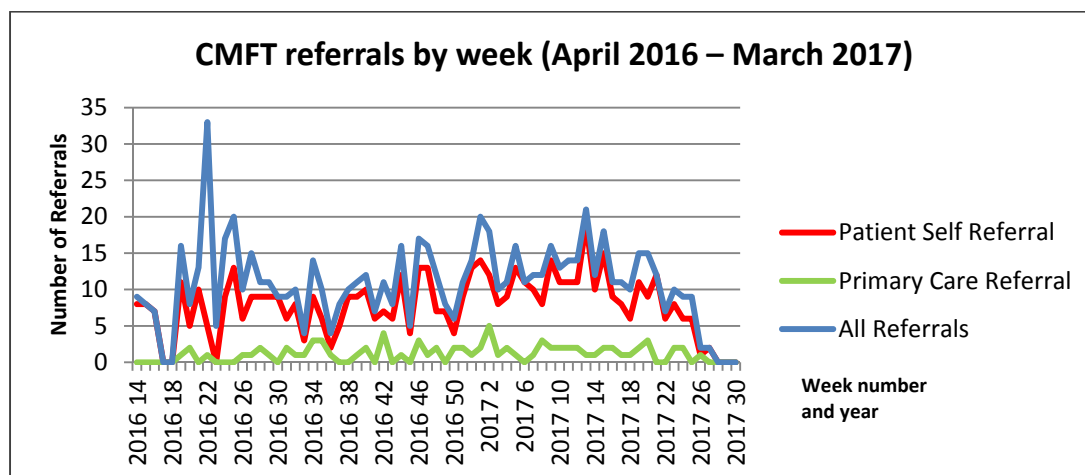
In south Manchester, patient self-referrals rose steadily in 2016 and primary care referrals started to grow from mid-2016. These data act as an indirect marker of **increased integration with primary care** and a shift to **more patients being seen in the community setting**.



Phased changes that were made to team working and structure

A	Decision for UHSM and CMFT to work together
B	Integrated steering group established Change in leadership for community team Community team roles reviewed and changed to become more community-focused Regular community team meeting established
C	Barriers for primary care to refer to team reviewed and removed Co-production days completed with system-wide engagement Specialist nurses assigned to GP practices to i-reach and provide support
D	Virtual clinic pilot in primary care

The graph below shows that in a similar period, referral numbers to the CMFT community respiratory team (CRT) did not change significantly. As mentioned previously, CMFT already had a fully integrated model, therefore significant changes to working practices were not made.



2. Impact on patient experience

A patient experience sub-group was established in 2016. It comprised three patient representatives, a representative from the British Lung Foundation and two members of clinical

staff. A specific objective was set to develop a set of measures for the 'acute' pathway (ie when a person with COPD becomes unwell) and to explore their experience of getting appropriate help and care. The following key issues and concerns were raised and discussed by the group:

- Patient representatives are not representative of 'most' patients and their contribution should be considered as a 'patient view' rather than representing the whole patient population.
- Metrics should reflect what is important to patients, such as 'living the life they want to live', rather than simply reflecting experience of a particular service or process.
- More should be done to support patients to provide honest feedback about their negative experiences of accessing care and treatment.
- Patients 'don't know what they don't know'; therefore satisfaction surveys or measures such as 'Friends and Family' are of limited benefit.
- More needs to be done to engage BME, LGBTQ and other minority groups.

3. Impact on workforce

Nine staff from the two teams (UHSM and CMFT) responded to a questionnaire on their views of the integration of the two services. There were four responses from UHSM and five responses from CMFT. Concerns included cross-site working, potential increased commute to work and the practicalities of how the teams would work.

A quote from the survey captured the positive effects: *'The joint working sessions have helped us to get to know the other team and experience a different way of working. Communication has definitely improved and it is easier to refer patients between us'*.

Successes and challenges

Successes

- ✓ The FHP was hailed a 'flagship' for joint-working by both executive boards, when UHSM and CMFT became one acute trust in October 2017.
- ✓ FHP clinical leads are integral to the citywide Manchester CCG Integrated Respiratory Steering Group, which is now shaping the future respiratory care for the city.
- ✓ The quality improvement support provided by the RCP has had a profound impact on how the team considers data and metrics that will now have influence at Manchester CCG level.
- ✓ The virtual clinic model is being considered by the Greater Manchester Transformation Team for roll-out across 500 Manchester GP practices.

Challenges

- Limited information-sharing across the system, which has been a barrier to progress.
- Enabling effective and diverse patient representation was challenging.
- The hierarchical process-driven culture in some departments and changing the mindset of those on the front line accustomed to working within single disciplines.
- The changing political landscape and turnover of staff across the system created uncertainty.
- Few additional resources were given to the project.
- Administrative support, project management, data retrieval and analysis were hugely challenging throughout.

Read the full report from central and south Manchester's development site team at www.rcplondon.ac.uk/delivering-the-future-hospital

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