Phase 2 Future Hospital development site

Central and south Manchester
# Central and South Manchester Future Hospital Development Site Final Report

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## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project overview</td>
<td>3</td>
</tr>
<tr>
<td>Aims/objectives</td>
<td>4</td>
</tr>
<tr>
<td>Initial steps</td>
<td>4</td>
</tr>
<tr>
<td>Alignment to the Future Hospital principles of patient care</td>
<td>5</td>
</tr>
<tr>
<td>Progress against project plan</td>
<td>5</td>
</tr>
<tr>
<td>Impact of the project on patient care</td>
<td>5</td>
</tr>
<tr>
<td>Impact on patient experience</td>
<td>9</td>
</tr>
<tr>
<td>Impact of a virtual clinic model</td>
<td>13</td>
</tr>
<tr>
<td>Hospital admission data analysis</td>
<td>14</td>
</tr>
<tr>
<td>Impact on workforce/staff/team</td>
<td>16</td>
</tr>
<tr>
<td>How the Future Hospital is influencing wider change</td>
<td>18</td>
</tr>
<tr>
<td>Barriers and challenges</td>
<td>18</td>
</tr>
</tbody>
</table>
Project overview

Manchester has two large acute teaching hospitals; Central Manchester Foundation Trust (CMFT) and University Hospital of South Manchester (UHSM) that are situated seven miles apart, with a population of around 300,000 people living in the area between the two Trusts. Historically, community respiratory services have been set up according to the Central and South Manchester Clinical Commissioning Groups (CMCCG and SMCCG) geographical boundaries. The services over time have developed in different ways and prior to the commencement of the partnership between the Trusts, CMFT had a well-established community respiratory model that offered community clinics co-located with GP surgeries, community oxygen services and a ‘hospital-at-home’ service. UHSM had a well-established hospital-at-home service but no community clinics and very little integrated working with GPs and the nursing team were undertaking many roles within the secondary/tertiary care services. Patients living close to one hospital but with a GP practice in a different CCG catchment area were unable to access their local hospital services. This resulted in significant inequalities for patients depending on postcode.

The political landscape in Manchester has transformed since 2016. Devolution for Greater Manchester aims to provide more sustainable healthcare through moving from organisational focus to more system-wide perspectives through integration of care. The Five Year Forward View outlines the need to develop integrated service models that span organisational boundaries and provide services through vertical integration and horizontal networks between acute hospitals. Manchester City Council’s Living Longer Living Better Programme aims for a 20% shift of services currently provided in secondary care into the community by 2020 through integrated working and more cost effective use of resources.

With this in mind, in September 2016, a group of respiratory clinicians and managers from CMFT and UHSM met informally and discussed how the Trusts could work more closely together to benefit patients. It was agreed that CMFT and UHSM would develop a joined-up approach to integrated respiratory care. The Trusts subsequently were successful in becoming a Royal College of Physicians (RCP) Future Hospital Programme (FHP) development site, a move that was fully supported by both executive boards.

An integrated steering group was established with representatives from all key stakeholders across central and south Manchester, front line clinicians and patient representatives. A constitution was developed outlining mission, vision, values and objectives. Services were subsequently developed on the principle of co-design with patients and stakeholders.

Project aims

Mission
To develop respiratory services across central and south Manchester that will allow healthcare professionals across primary, secondary and community care to work together with patients and carers, to understand their needs and bring services together to achieve outcomes that are important to patients.

Vision
To create a single, collaborative and integrated respiratory care service across CMFT, UHSM and Central and South Manchester CCGs, in order to; break down geographical and organisational boundaries for patients, provide high quality standardised respiratory services, enhance patient experience by reducing fragmentation in care and gain greater efficiency and value from current resources.
Values

- Patients are at the centre of everything we do.
- The Future Hospital will act as an equal partnership between the member organisations.
- Each individual’s contribution is valued and respected.
- We foster a culture of learning and improvement.
- We support and value staff and team development.

Realising the vision

In order to realise our vision, a number of major changes would need to take place:

1) Vertical integration at the front line

In south Manchester, there was a need to develop the community team and build relationships between frontline staff in primary and secondary care, the existing relationship being poor with very little joint-working.

2) Horizontal integration at the front line

The frontline teams needed to develop relationships with each other, having never even met, despite working within close proximity for approximately 10 years.

The frontline teams needed a new, unified team identity and to develop joint standards of working, shared protocols and pathways to improve accessibility.

There was a need to break down ‘geographical’ barriers so that all patients could access services of their choice close to their place of residence.

3) Patients would need to be involved in co-designing care to ensure that service developments were patient-centred

Initial steps

Both frontline teams were rebranded the ‘Community Respiratory Team’ (CRT) to ensure consistency across central and south Manchester. There was a recognition that achieving true integration across health and social care would take a number of years, and that many decisions were outside of the scope of the steering group and would be determined by Devolution Manchester and the formation of the Local Care Organisation.

Therefore, it was agreed that the steering group would work within its ‘circle of influence’ and set clearly defined objectives that could be achieved at ground level. Internal issues (such as team development at south Manchester) would be dealt with at individual trust level and were not discussed in any detail within the steering group.

The steering group agreed on the following key aims for the first year of the project.

1. To co-design a shared acute pathway for those with a known diagnosis of chronic obstructive pulmonary disease (COPD) across central and south Manchester.

2. To co-design a shared model for Community Respiratory clinics; to educate and empower people in the self-management of their condition, ensure accurate diagnosis and encourage shared decision-making and development of care plans for every patient.
3. To develop a regular joint meeting between CMFT and UHSM respiratory community teams for education, sharing experiences and reflective practice by September 2016.

4. To develop an education programme for the community respiratory team with shared learning objectives across CMFT and UHSM.

Alignment to the Future Hospital principles of patient care

The project aligns to 10 of the 11 Future Hospital Principles, the only standard not of direct relevance is ‘Patients do not move wards unless this is necessary for their clinical care’, as the project does not focus on inpatient care. However, direct admission to respiratory beds is an area of potential future development.

Progress against project plan

Vertical integration at South Manchester

A number of changes took place over 18 months to develop the CRT with primary care.

Horizontal integration between CMFT and UHSM at the front line

A process for integrating the community teams at CMFT and UHSM was undertaken.

Co-designing services

It was agreed that development of acute and chronic services as outlined in the year one objectives (see page 4) should be done in partnership with a wider stakeholder group including patients and carers. Two co-design days were held aimed at developing:

- the acute pathway
- the chronic disease management model.

Organising the co-design events

The steering group brainstormed the various stakeholders that would need to be involved; these included patients, carers, frontline staff and managers from secondary care, primary care GPs and practice nurses, community pharmacy, community nursing, charitable organisations, voluntary organisations and the CCG.

The venue and date were set early and funding was obtained from endowments funds. Frontline staff and patient representatives were asked to recruit patients and carers for the events from local patient groups and day-to-day patient interactions. Invitations to the wider stakeholder group were issued by email and also through word of mouth. The events were workshop-based and facilitated.

Event 1: Designing the acute exacerbation pathway

17 March 2016

Patient involvement

Around 30 delegates attended for the full day. Despite best efforts, only three patients attended from the approximate 25 invited. Feedback from the patient representatives/staff was that most people they had spoken to were not keen to get involved but happy to give their views informally to the patient representatives. Due to the predicted small number of patients attending, four in-depth interviews had been carried out in advance of the meeting with patients who had had an acute admission to gain a wider perspective. One patient who attended who had no previous experience of working with healthcare professionals fed back that the day felt overwhelming and that he was not able to contribute.
Key learning

- Acute pathways between central and south Manchester were similar, but both had notable gaps.
- Out-of-hours access to urgent care was a major source of difficulty for the patients. It was reported by patients and healthcare staff that 111 calls inevitably led to 999 transfers to the emergency department (ED) due to the risk-averse nature of the 111 pathway.
- Ambulatory pathways did not exist and were desirable (for patients seen urgently at home who did not need admission but may need tests such as a chest x-ray or blood gas).
- There are a large number of excellent services available but due to silo-working, even local teams did not know what was available or how to signpost to services.
- The CRTs were not responsive enough to acutely ill patients, and GPs fed back that there was a need for same-day/urgent referrals to the CRT.
- Information sharing between organisations was poor and needed to be improved.
- Patient engagement in this kind of work is challenging. By default, those that are able to meaningfully contribute to system redesign are not necessarily representative of the wider population.

Key outcomes

Both CMFT and UHSM developed an ambulatory pathway.

An urgent care workstream was developed and there is a planned pilot of sharing care plans across the whole urgent care system including; 111, North West Ambulance Service (NWAS), out-of-hours GP and acute Trusts.

A ‘special patient note’ added to the 111 system will empower 111 call handlers to deviate from the shortness of breath (SOB) algorithm and pass the call to clinical staff, who can then access the patient’s pre-determined crisis plan. This will allow a different potential outcome eg review by the out-of-hours GP instead of 999. It is the first pilot of its kind in Manchester. Analysis of ED attendances with COPD highlighted that most patients attend within working hours with a peak attendance around midday and lower numbers at the weekend. Data regarding details on the number of 111 calls converted to 999 for SOB out-of-hours has been requested but is not available at the time of writing.

The allocation of ‘patch leads’ in south Manchester arose as a result of this event as it was recognised that much closer joint-working was required between the CRT and general practice.

Both the central and south CRTs agreed to become more responsive. Subsequent measurement of response time across seven days showed that most patients were being seen within one-two hours, the longest wait being four hours.
Event 2: Designing the chronic disease management service
16 June 2016

Patient involvement

Around 40 delegates attended the event including four patients. Members of the hospitals’ patient experience team and the British Lung Foundation (BLF) attended as patient advocates. A wider group of patients (approximately 20) had been invited but declined attendance.

Key learning

- GPs and patients suggested that in-reach into practices, with secondary care professionals working alongside GPs and practice nurses would not only educate and upskill, but would facilitate care for patients who had more complex needs.

- Patient-led peer support networks such as Breathe Easy groups significantly reduce reliance on healthcare professionals and increase self-support in COPD.

- ‘Patient-centred outcome measures’ (PCOMs) are different from Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs) currently used in healthcare and better reflect person-centred goals.

Key outcomes

1. The Breathe Easy pilot with the BLF was established and subsequent work has resulted in development of local peer support and patient education initiatives

2. It was agreed that there would be a presentation to the CCG Board regarding PCOMs, and these are now under consideration as Citywide CCG key performance indicators for April 2018/19.

3. A number of potential ‘in-reach’ models were discussed and piloted. The most successful of these – the Virtual Clinic (VC) model - is discussed later in this report (see page 13).
Impact of the project on patient care

Data from January 2015 until June 2017 was analysed from local hospital databases, where each interaction with patients and source of referral are recorded by the CRT. The Future Hospital development started in January 2016.

Figure 1 shows the total number of weekly referrals taken by the UHSM CRT and also a breakdown of referrals by source. Changes that were made to team working and structure (A-D) are highlighted in the table below the graph. The X axis shows week and year (eg ‘1 2015’ refers to the first week in 2015). Patient self-referrals rose steadily in 2016 and primary care referrals started to grow from mid-2016. This data acts as an indirect marker of increased integration with primary care and a shift to more patients being seen in the community setting.

Figure 1

![UHSM Referrals by Source (2015 to 2017)](#)

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Decision for UHSM and SMFT to work together</td>
</tr>
<tr>
<td>B</td>
<td>Integrated steering group established</td>
</tr>
<tr>
<td></td>
<td>Change in leadership for community team</td>
</tr>
<tr>
<td></td>
<td>Community team roles reviewed and changes to become more community-focused</td>
</tr>
<tr>
<td>C</td>
<td>Barriers for primary care to refer to team reviewed and removed</td>
</tr>
<tr>
<td></td>
<td>Co-production days completed with system-wide engagement</td>
</tr>
<tr>
<td></td>
<td>Specialist nurses assigned to GP practise to in-reach and provide support</td>
</tr>
<tr>
<td>D</td>
<td>Virtual clinic pilot in primary care</td>
</tr>
</tbody>
</table>
Figure 2 shows that in a similar period, referral numbers to the CMFT CRT did not change significantly. As mentioned previously, CMFT already had a fully integrated model, therefore significant changes to working practices were not made.

It should be noted however, that prior to being appointed as a Future Hospital development site project, UHSM had lower numbers of weekly referrals, and that numbers are now comparable between the two services. Numbers tail off in the final two weeks, this is due to a backlog in entering data onto the database and normal variation during the summer months.

Impact on patient experience

A patient experience sub-group was established in 2016 comprised three patient representatives, a representative from the BLF 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. This was linked to objective 1.

Key issues

1. Patient representatives are not representative of ‘most’ patients and should be considered as providing a viewpoint rather than representing the whole patient population
2. 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
3. More should be done to support patients to provide honest feedback about their negative experiences of accessing care and treatment
4. Patients ‘don’t know what they don’t know’; therefore satisfaction surveys or measures such as ‘Friends and Family’ are of limited benefit
5. More needs to be done to engage BME, LGBTQ and other minority groups

Baseline data

A scoping exercise was undertaken in the shape of inpatient interviews to understand how patients currently use acute services. A scoping document was then developed in an effort to understand the function of the patient experience group and define clear goals and further information gathered until the formal questionnaire was finalised, which collects a mixture of quantitative and qualitative data.

This process took around 18 months, partly due to limited meetings between the group (meetings took place every 2 months), lack of resources to conduct patient interviews and the integral difficulty with measuring patient experience across a ‘system’. It also highlights that whilst ‘patient
involvement’ is widely advocated in healthcare, there is very little guidance on how patients should be involved and a clear understanding of their roles.

In May 2017, it was agreed that there would be one week of intensive data collection across both CMFT and UHSM community teams and a local GP practice. Patients were unselected and included anyone with COPD who agreed to complete the questionnaire and had come into contact with one of the healthcare professionals involved. In total, 57 responses were collected, with an age breakdown of:

- Age 41-65 30%
- Age 66-80 57%
- Age 80+ 13%

96% of the respondents to the questionnaire were British Caucasian.

The patients were asked how able they are to manage their condition on a day to day basis: only 16% felt they were able to be active and mobile on a daily basis and 39% reported that they have good days but on occasions have bad days too. 45% of the participants felt that their condition was difficult to manage. They were subsequently asked if they had a good understanding of how to self-manage exacerbations, and a majority said ‘always’ or ‘mostly’ (31% and 39% respectively). The outstanding 30% felt that they were unable to self-manage. Incidentally, over 40 of the participants provided explanations of the reasons why they could not manage their breathlessness and the reason cited for a large percentage was “panicking” although some of the reasons also related to; not knowing what inhalers to take to get the best relief, forgetting to take medication and wheezing/chestiness.

The patients were also asked what they did when they became unwell and these responses are reflected in Figure 3 on page 11.

Respondents were subsequently asked what they did next if they were still feeling unwell. The responses varied but the majority related to:

- Telephone my GP for advice: 25%
- Contact the community team: 28%
- Call an ambulance / visit A&E (not by ambulance): 24%

Patients were asked how they rated this support and 70% of these responses were positive. Approximately 18% stated they were left feeling anxious or concerned and that more support was required to help them manage their breathing. A subsequent question specifically addressed what kind of support was desirable. Answers varied between the GP and the COPD team, with a small number (four) identifying education about self-management, a further third said they did not know and others responses related to medication such as steroids, oxygen and nebulisers.

The patients were later asked, where they had contact with the community teams, how they rated this service. 42 of the 57 responses confirmed they did have contact, and the majority of ratings were good or excellent (80%).
When you become unwell what do you do first?

Answered: 51  Skipped: 6

<table>
<thead>
<tr>
<th>Answer Choices</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do nothing and see if I improve:</td>
<td>25.49%</td>
</tr>
<tr>
<td>Telephone my GP for advice:</td>
<td>23.53%</td>
</tr>
<tr>
<td>Use an emergency prescription / rescue pack:</td>
<td>21.57%</td>
</tr>
<tr>
<td>Visit my GP:</td>
<td>5.88%</td>
</tr>
<tr>
<td>Contact the Community team:</td>
<td>13.73%</td>
</tr>
<tr>
<td>Visit a Drop in clinic / Walk in Centre:</td>
<td>0.00%</td>
</tr>
<tr>
<td>Contact GP Out of Hours</td>
<td>1.96%</td>
</tr>
<tr>
<td>Call an ambulance (if I become breathless):</td>
<td>7.84%</td>
</tr>
<tr>
<td>Visit A and E (not by ambulance)</td>
<td>0.00%</td>
</tr>
<tr>
<td>Total</td>
<td>51</td>
</tr>
</tbody>
</table>

Comments (28)
**Key messages from the patient survey**

- There is an underrepresentation of BME patients within the CRT patient population when considering the demographics of the local area.

- A third of patients were between the ages of 41-65, the young age of some patients was surprising to the healthcare professionals involved. Consideration must be given to earlier intervention and different means of engaging patients eg through smart technology.

- Anxiety/panic when exacerbating was frequently reported and is currently undertreated.

- The majority of patients known to the CRT did not visit ED or dial 999 as a first step when exacerbating. However, ED data shows that a large majority of those who present to ED self-refer, which raises the question as to whether there is a significant cohort of patients with COPD that are not known to the community teams.

- Overall, the survey feedback represents a snapshot of patients’ experiences and will enable services to support and improve outcomes, but further work is required. This may need to include GP and postcode data to gain an insight into the support provided and the possible areas for improvement.

**Next steps**

1. Work with the BLF to engage with ethnic minorities in Manchester and continue developing peer-support networks.

2. Discuss funding for a clinical psychologist to work alongside the team to support management of anxiety and panic.

3. Explore use of smart technology.

4. Develop an ED quality improvement (QI) initiative to identify those who have been seen, treated and discharged and ensure that CRT follow-up is arranged promptly.

5. Continue providing self-management support and education.
Impact of a virtual clinic model

Virtual clinics (VC) were established in south Manchester based on an established London model. These are face-to-face meetings between a secondary care expert and primary care, where selected patients are discussed ‘virtually’ through their electronic records, with a view to optimising medicines and step-down from inappropriate therapies. Searches performed by the CCG pharmacist identified appropriate patients at each GP surgery, with numbers varying between 10 and 72 patients depending on GP practice.

At the time of writing, 14 VCs have been completed and outcomes fed back from five practices. The practices with the smallest number of patients identified for review were the most proactive in feeding back, whilst other practices have reported feeling overwhelmed by the task of reviewing so many patients. In total, 522 patients were identified and discussed as a result of the VCs. Of those subsequently reviewed, 50-75% had treatment stepped down, leading to a cost saving of £306/patient/year. Table 1 summarises the feedback data collected to date.

Table 1 Feedback from 5 out of 14 GP practices after VC

<table>
<thead>
<tr>
<th>Practice</th>
<th>Number of patients identified for discussion</th>
<th>Number of patients identified for review post VC</th>
<th>Number of patient reviewed and stepped down</th>
<th>% of patients reviewed that had medication changed</th>
<th>Cost savings on inhaler spend (£/annum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>10</td>
<td>10</td>
<td>5</td>
<td>50</td>
<td>3,190</td>
</tr>
<tr>
<td>2</td>
<td>28</td>
<td>10</td>
<td>5</td>
<td>50</td>
<td>1,536</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>13</td>
<td>7</td>
<td>54</td>
<td>1,732</td>
</tr>
<tr>
<td>4</td>
<td>14</td>
<td>24</td>
<td>18</td>
<td>75</td>
<td>4,745.81</td>
</tr>
<tr>
<td>5</td>
<td>20</td>
<td>20</td>
<td>14</td>
<td>70</td>
<td>2,572</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
<td>44</td>
<td>57</td>
<td></td>
<td>13,475</td>
</tr>
</tbody>
</table>

Other than cost savings, the benefits of the VCs include education and upskilling of primary care healthcare professionals, strengthening of relationships across the system, promotion of the Future Hospital work/integrated care services, pulmonary rehab, flu vaccination and smoking cessation. Based on evidence, optimisation of medicines should reduce severe COPD exacerbations and impact on hospital admissions. Feedback from practices has been incredibly positive.

A business case has now been submitted to the Greater Manchester Transformation Board for the roll-out of VCs to the whole of Greater Manchester (500 GP practices) with a projected potential gross annual cost saving of up to £4,895,567 on drug spend alone (Table 2 and 3).

This is based on recent clinician-led guidance produced by the Greater Manchester Medicines Management Group (GMMMG) regarding preferred inhaler therapy choices, estimated prevalence of ‘triple therapy’ prescribing across Greater Manchester CCGs and estimated potential step-down rate of 40%. This is a conservative estimate accounting for the potential difficulty in reviewing all patients identified for a possible change in therapy. Real-world experience in Lambeth and South Manchester identified a 63% and 57% step-down rate respectively. The cost of rolling out a Consultant-led VC model has been estimated as £642,586 per annum for Greater Manchester.
Table 2: Calculated potential savings based on full inhaler use annually across all Greater Manchester CCGs

<table>
<thead>
<tr>
<th>Numbers of Patients</th>
<th>Potential Population</th>
<th>% Meds Optimised</th>
<th>Potential population</th>
<th>Average saving</th>
<th>Gross Annual Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triple Therapy &gt; to LABA/LAMA inhaler</td>
<td>26,408</td>
<td>40%</td>
<td>10,563</td>
<td>£336.75</td>
<td>£3,557,158</td>
</tr>
<tr>
<td>Medicines optimised</td>
<td>32,241</td>
<td>40%</td>
<td>12,896</td>
<td>£103.78</td>
<td>£1,338,410</td>
</tr>
<tr>
<td>Total Potential Savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£4,895,567</td>
</tr>
</tbody>
</table>

Table 3: Potential savings based on mean use of 8 x 30 day inhalers annually

<table>
<thead>
<tr>
<th>Numbers of Patients</th>
<th>Potential Population</th>
<th>% Meds Optimised</th>
<th>Potential population</th>
<th>Average saving (Table 3)</th>
<th>Gross Annual Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triple Therapy &gt; to LABA/LAMA</td>
<td>26,408</td>
<td>40%</td>
<td>10,563</td>
<td>£221.43</td>
<td>£2,338,974</td>
</tr>
<tr>
<td>Medicines optimised</td>
<td>32,241</td>
<td>40%</td>
<td>12,896</td>
<td>£68.24</td>
<td>£880,050</td>
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<tr>
<td>Total Potential Savings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£3,219,024</td>
</tr>
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</table>

Hospital admission data analysis

**Detailed analysis of admission data to central and south Manchester**

There were 316 total admissions with a primary code of ‘exacerbation of COPD’ to UHSM from the South Manchester CCG between April and December 2016 and 340 to CMFT from Central Manchester CCG in the same period. Table 4 shows that only approximately 5% of patients had had four or more admissions, with the majority having one or two.

**Table 4 Admissions with a primary code of ‘exacerbation of COPD’ from Central and South Manchester CCGs to UHSM and CMFT respectively, between April and December 2016.**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>No of admissions</th>
<th>Total no of patients</th>
<th>No of patients ≥4 admissions</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHSM</td>
<td>316</td>
<td>204</td>
<td>11</td>
<td>5.4%</td>
</tr>
<tr>
<td>CMFT</td>
<td>340</td>
<td>177</td>
<td>7</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Review of patients with multiple admissions**

The 11 patients from UHSM with recurrent admissions were reviewed in detail:

- 10/11 were known to the CRT
- 4/11 had subsequently died

Of the seven patients still alive, the following themes/contributing factors were identified as reasons for admission, with most patients having a combination of factors, including: mental health/anxiety; dementia; frailty; multiple comorbidities; poor motivation or willingness to engage with team.
**Review of cost of recurrent admissions**

It was identified from the data above that a small cohort of patients had a very high number of admissions (defined as greater than eight). An additional analysis was performed to explore the potential impact of this financially.

Seven patients from south Manchester had greater than eight admissions ever were identified. The total cost of admissions was calculated based on length of stay and average cost of inpatient bed days. The cost would have been higher if patients required non-invasive ventilation, critical care admission or if cost to the healthcare system as a whole was considered. However, this level of information was not ascertained. Table 4 below summarises the estimated cost of the admissions.

![Table 4: Cost of recurrent COPD admissions](image)

<table>
<thead>
<tr>
<th>Patient</th>
<th>Notes</th>
<th>Total COPD admissions</th>
<th>Length of stay (days)</th>
<th>1st COPD admission</th>
<th>Total approximate cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RIP October 2016</td>
<td>9</td>
<td>50</td>
<td>1/5/14</td>
<td>£14,129</td>
</tr>
<tr>
<td>2</td>
<td>RIP Nov 16</td>
<td>13</td>
<td>161</td>
<td>24/4/15</td>
<td>£43,707</td>
</tr>
<tr>
<td>3</td>
<td>RIP Dec 16</td>
<td>10</td>
<td>80</td>
<td>26/10/13</td>
<td>£22,114</td>
</tr>
<tr>
<td>4</td>
<td></td>
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**Reflection**

As well as being costly, recurrent admissions result in poor experience for the patient. ‘Avoiding recurrent admissions’ is a constant theme that individual hospital teams are tasked with. This brief analysis highlights that a small minority of patients have recurrent COPD admissions, many of whom are entering a terminal phase of their illness or have complex co-morbidities or social issues. Some of these admissions will be necessary and aiming for zero admissions is probably unrealistic.

However, it may be possible to reduce admissions in this cohort by adopting a ‘whole-systems’ approach, including better access to mental health services, twenty-four hour support and palliative/end-of-life care at home. By re-distributing the cost across the healthcare system to better support patients in their own homes, quality of life and patient experience could be improved, whilst freeing up resource in hospitals.

**Next steps and opportunities**

- A palliative care co-production day was held (June 2017) to improve palliative/end-of-life care for respiratory patients across the system.

- Data analysed from individual GP practices will allow targeted intervention in primary care. High level data, analysed and drilled down to individual patient level data allows focused review of those with, for example, a single admission or multiple admissions.

- The FHP team is engaging in a systems leadership project to address some of the issues outlined above.
Impact on workforce/staff/team

**Integrating the front line community respiratory teams**
Historically the UHSM and CMFT frontline community respiratory teams have had a professional relationship, however there were perceptions of barriers to referral of patients between the services. The teams had never met face-to-face, as there was no previous incentive from the organisations or system to do so. The following steps were taken to start integrating the teams:

1. Initially, the idea of change was communicated to each team individually, allowing any concerns to be raised.

2. Joint team meetings were established on a monthly basis. These have focused on the following:
   - exploring the services each team offered and the patient access routes
   - joint education sessions and sharing of case studies
   - process-mapping different parts of the service and producing joint operating policies.

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

**Reflection**
In large, system-wide integration, decisions are often made at a strategic level with policy being driven in a top-down fashion. Frontline staff are often only briefed on changes many months after key decisions have been made. We believe that integration at the frontline, in parallel with high-level discussions, will enable more successful transformational change. Developing relationships across the system at all levels is key. Through cross-working at ground level, there is now a better understanding between the UHSM and CMFT community respiratory teams resulting in better communication and ease of referring patients. This indirectly impacts positively on the patient experience.

**Staff surveys**
Nine staff from the two teams responded to a questionnaire on their views of the integration of the two services. There were 4 responses from UHSM and 5 responses from CMFT.

Staff were asked what their initial feelings towards integration of the teams was (Figure 4). Concerns included cross-site working, potential increased commute to work and the practicalities of how the teams would work.

**Figure 5** shows feelings towards team integration after the change efforts, with a shift in responses to the right. 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’. **Figure 6** shows what factors influenced any changes in attitude.
Figure 4

Initially how did you feel about the idea of the teams integrating?

Answered: 9  Skipped: 0

Figure 5

How do you feel about the integration of the teams now?

Answered: 9  Skipped: 0

Figure 6

If your feelings have changed what has led to this change?

Answered: 9  Skipped: 0
How the Future Hospital is influencing and supporting wider change

1. Since the Future Hospital Development commenced, UHSM and CMFT have agreed to merge and become one Acute Trust in October 2017. The FHP has been hailed a ‘flagship’ for joint-working by both executive boards.

2. North, South and Central Manchester CCGs have merged into one Citywide Manchester CCG (April 2017). There is now an integrated respiratory steering group across the City, which the FHP clinical leads are integral to. It has been possible to bring the principles of the Future Hospital to this forum, ensuring that the principles have a much wider reach. The FHP team is helping to shape future respiratory care for the Greater Manchester at a strategic level.

3. It has been requested that the FHP patient experience group becomes a subgroup of the citywide integrated steering committee and it is hoped that this will be agreed.

4. The Manchester FHP team has received national recognition at EXPO 2016, the British Thoracic Conference (2016) and the RCP conference (2017). The Consultant lead for the FHP has joined the Primary Care Respiratory Society National Service Development Committee, taking Future Hospital principles to a strategic level in primary care.

5. The Greater Manchester Transformation Team has written a business case based on the FHP virtual clinic model aiming to roll out to 500 GP practices across Manchester, with a projected potential £4.8 million cost-saving on drug spend.

6. The quality improvement support provided by the RCP has had a profound influence on how the team considers data and metrics that will now influence at Manchester CCG level.

Barriers and challenges

1. The changing political landscape has been challenging due to the uncertainty created and turnover of staff. However, overall the merger of the Trusts and CCGs has acted as an enabler as the principles of the project reflected higher strategic aims.

2. Little additional resource was given to the project. Support with administration, project management and particularly data retrieval and analysis was hugely challenging throughout. The project was largely run on good will from those involved across the healthcare system, though some resource was given to the co-production days and backfilling GP or practice nurse time.

3. The biggest barriers to change were; ingrained historical ways of working, hierarchical process-driven culture in some departments and changing the mind-set of those on the frontline accustomed to working within single-disciplines. Time and effort to understand different perspectives, creating evidence for a new way of working and positive feedback has helped to slowly change attitudes.

4. Historically, there has been limited information-sharing across the system which has been a barrier to progress. However, we are working with the Manchester Care Record leads to address this, and CMFT and UHSM have both procured EMIS community software that will transform information sharing.
References

1. Since the inception of the project, the CCGs have merged with North Manchester CCG to create Manchester Health and Care Partnership.


3. British Lung Foundation Breathe Easy support groups https://www.blf.org.uk/support-for-you/breathe-easy


