Common pitfalls of effective integration/ transformation to ICBs/ICSs and how to avoid them

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The formation of Integrated Care Systems in July 2022 has given us as healthcare professionals an opportunity to improve and shape respiratory care in our area for patients with respiratory disease.

However, for many the focus has appeared to have been on protecting and improving secondary care – prompted by stories of 12 hour ambulance waits outside emergency departments and long surgery waiting lists.

It is imperative however that the role of primary and community care is raised to the forefront in the delivery of care to patients with respiratory disease (and other long term conditions); as set out in the Long Term Plan (https://www.longtermplan.nhs.uk/) and to meet the desire of patients to be treated locally.

Improving access to care closer to home for patients meets many needs:

- Reduce cost and time for the patient
- Reducing the greenhouse gas emissions associated with NHS transport (which in itself is responsible for 5% of traffic on our roads - https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf)
- Ensuring we start to reduce health inequalities and inequalities in access to treatment – often seen in more rural areas.

The transformation of services away from a secondary care led model to a more integrated model is key to achieving these aims. Services should be designed with the needs of the patient front and centre and we have asked some of our PCRS members to describe where their services have gone well, and in the interest of a balanced review, to describe some of the barriers to providing their services.

Daryl Freeman

CASE STUDIES

We asked two HCPs from across primary and secondary care to tell us about their experiences of transformation.

Carol Stonham *NHS Gloucestershire ICB*

What did you have in place before the transformation started?

We had an established community team consisting of nurses and respiratory physiotherapists dealing mostly with patients with COPD, an established specialist team in the acute trust and healthcare professionals in primary care who manage the majority of the patients. We have had an active respiratory work stream within the transformation directorate of what was then the CCG.

Was this a new project or building on existing work?

We started to look in depth at integration in 2016. We mapped our COPD pathway as a starting point, including a broad range of stakeholders including A&E staff, ambulance services, primary, community and secondary care, diagnostics and imaging etc.

It was clear from this exercise that there was replication and the potential to offer a better service to patients including admission avoidance with enhanced care at home. An integration

lead joined the team and was jointly employed between the community provider organisation and the CCG (this was complicated in itself). We worked on communication between secondary and community care, shared pathways, but hit a hurdle on staff rotation as the staff had different employers and contracts. Aligning working hours was also troublesome. The integration lead completed her contract just before COVID-19 hit and the view was that we could just continue with the programme but COVID stopped us in our tracks. There was a big part of the project still to do to integrate primary care.

If they did succeed - how ?

We picked this up again and worked to actively get things moving. It was in part the drive from one of the respiratory consultants, and the need to link things up. We have respiratory champions in place at PCN level which has broadened the original brief to include primary care. The move to digital also allowed us to hold regular virtual MDT meetings. This works to up-skill primary care and break down the barriers between primary, community and specialist care with attendees from different professional backgrounds and parts of the system collaborating regularly. This has led to a great improvement in communication and mutual understanding. One of the consultants, having been inspired by the MDT meetings, has started community clinics in the area working with primary care staff to see patients together which has also had a positive effect.

I think there was a combination of factors that moved this forward:-

- the ICB could see the benefit and were prepared to support the move
- the driving force of a consultant
- the improved communication
- having a very active, forward thinking respiratory clinical programme group

What advice would you give to others hoping to achieve the same.

Communication is key. The 'them and us' attitude across boundaries and across professional groups is very limiting. I would also suggest that finding the passionate people to drive with enthusiasm and a 'can do' attitude is vital, and a commissioning system (or people within it) that supports positive change which improves patient care. Getting everyone on board and seeing the shared vision is critical.

Joanne King *Respiratory Nurse Consultant – Frimley Health, covering predominantly Berkshire East. Working across Frimley ICS – Berkshire East, North East Hampshire and Farnham and Surrey Heath.*

What did you have in place before the transformation started?

We had a very tight network in the North of the ICS where we worked closely between secondary, community and primary care to deliver projects, education and priorities. The south of the ICS had private providers so engagement was limited. It was easier to achieve engagement and collaboration before the ICS was born as it was a smaller tight knit group who worked together for local provision of respiratory care. However, ensuring there is consistent care across the area is a positive impact of ICS working.

Was this a new project or building on existing work?

We are fortunate to be the smallest ICS which joined up North and South of the patch. We had already merged some years ago as one acute trust and so are privileged that we only have one acute trust to 'deal with'. The disparity of services at either end of the ICS was tricky to navigate as the South had private providers for their community respiratory services and no integration with community and acute services. Since the birth of Frimley ICS providing the community respiratory services, we are closer to integration with acute and community but primary care engagement is a challenge. In the North of the patch the services are more established and had always had CCG / PC involvement and the relationship was more solid but it has been difficult to engage the south of the patch as they are not used to strong leadership of respiratory services.

We have a fantastic respiratory network group who meet monthly and has representation from acute, primary care and community teams and we come together to discuss issues surrounding respiratory care in our ICS; it was a challenge to obtain commitment from an additional GP to the group. The focus of those discussions has been on restarting spirometry in primary care, development of local 'Hublets' and the community diagnostic hubs alongside development of sleep services and virtual wards. The challenges are predominantly around the differences between how secondary / community services are commissioned and delivered and how primary care deliver services.

One of the steepest learning curves for me, as a predominantly secondary care provider, is how the contracts work in primary care. For example, in secondary care there appears to be more 'scope' in leniency' on how services are delivered with patients being referred and accepted for services that don't really exist but can be funnelled into a clinic and reviewed. For example - secondary care in my area doesn't provide a spirometry service and during the height of pandemic we offered a limited amount of spirometry testing to primary care, this wasn't taken up to the maximum, but now things have returned to 'normal', primary care continue to refer to secondary care for spirometry. When these requests are rejected there are questions of what should happen when spirometry is needed. However, some primary care providers do not perform this as they are not contracted to do so but secondary are not 'contracted ' to provide this service either. As a consequence, patient access to this service can be delayed or is not available at all.

I was unaware of the nuances of primary care practitioners in terms of expectations for their attendance at meetings etc. This can have significant implications for the work of the practice where a team member is required at meetings but is also needed for clinical work within the practice. There needs to be consideration for the additional workload so that there can be effective cover at the practice. In secondary care we are expected to attend relevant meeting such as respiratory network meetings and any workload missed will need to be made up, however, our salaries are not dependant on the volume of workload and work is not measured in the way QOF does. This leads to disharmony between secondary and primary care providers as their way of working, pay and reward are very different. To me, this is one of the most challenging areas of trying to work between primary care and secondary care as we have conflicting interests.

If they did succeed - how ?

It has been slow to create a consistent group of health care practitioners who are committed to moving respiratory care forward in our ICS but I feel we are there now. The difficulty I see is that the GP's in our group are committed but they seem unable to persuade their colleagues to move care in the direction suggested, this makes me wonder 'how can we influence when their own colleagues can't?'

What advice would you give to others hoping to achieve the same.

Take some time at the beginning to learn about each other's structures and ways of working that may avoid misunderstanding and disharmony. Explore the best ways of collaborating within the limitations of the working structures. It is vital to have this understanding and build the network to support engagement from all parties.