PRIMARY AND SECONDARY CARE INTERFACE PARTNERSHIP

PROJECT AIM:

Explore and improve how Primary and Secondary care work and communicate together to alleviate unsustainable clinical pressures after COVID.
Improve Patient and Staff experience.

PROJECT ACHIEVEMENTS:

- Primary and Secondary Care Interface Partnership established.
- Identified common denominator clinical pressures
- Agreed joint objectives between Primary and Secondary Care.
- 70+ projects impacted positively by this change, better interface between services
- Better Patient Experience using services
- Better staff and clinician experience working within services

How we approached the issue:

- Establishing the Partnership enabled colleagues to meet, talk, listen and hear each other.
- Talking honestly let us recognise patterns and common issues.
- We started small - early adopter conversations.
- We committed to learning from each other.
- We listened and looked for ways to influence change.
- We built trust to drive change forward.

- We identified communication blockers.
- Created a shared language so we could enable effective communication and avoid misunderstanding.

"The single most important thing that made this work, has been the development of an open, honest dialogue"

Who was involved:

- The Interface Partnership - working at strategic, transformational and operational levels.
- Nottingham University Hospitals NHS Trust (NUH)
- Nottingham City Locality Team.
- South Nottinghamshire Locality Team.
- Clinical Design Authority.
- Integrated Care Board (ICB).
- Nottinghamshire's Local Medical Committee (LMC).

ICB Coproduction Resources

KEY ENABLERS TO SUCCESS:

Starting small meant we were able to make small changes initially, **we considered change in terms of days and weeks, not months and years**.

Small, yet tangible, changes gained the trust of staff.

We were open minded and **willing to try new things** and **learn from our mistakes.**

We **monitored the patient impact** and reflected on how changes we made affected the patient experience.

We resisted the instinct to work in silos, this was another enabler to developing trust between sectors.

Conversations were solution focused and didn't focus on money or contracts.

We **worked to establish a culture of trust.** We were honest with each other when we couldn't do something and we explained why.

Senior Management Support was important- **we needed key decision makers involved so we could enact change**.

"It is the patient that ultimately benefits from organisations working collaboratively to drive transformational change"

Effective onboarding for new members, ensuring that they understand the transformation journey we have been on.

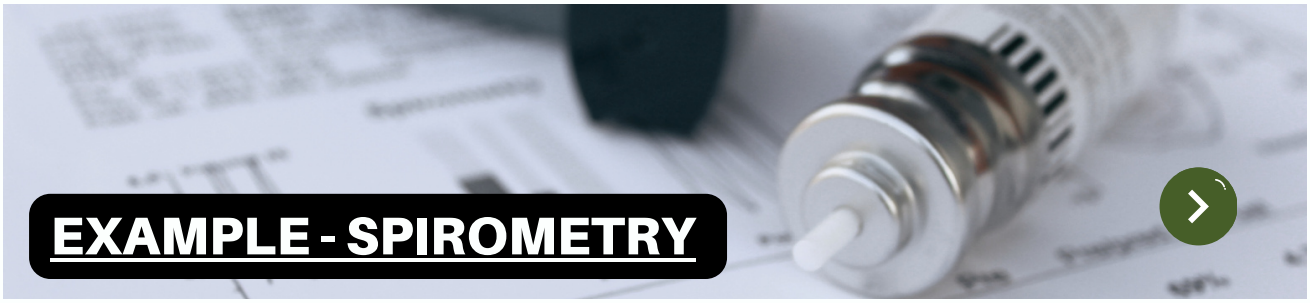
Prioritising our actions - we didn't act on every idea and weren't afraid to delay the development of some ideas.

Taking a **collective approach to prioritising proposed transformation schemes**, which contributes to all members feeling valued and included.

Seeking to **understand evolving challenges to each sector** and identifying how they can be alleviated through collaborative working.

Demonstrating value- this has encouraged other acute providers to collaborate on transformation projects.

Measuring value through qualitative, as well as quantitative data. Transformation on a large scale can be slow to generate quantifiable data. However positive feedback from practitioners and those resistant to change demonstrates that collaboration is driving impactful transformation.



EXAMPLE - SPIROMETRY

Defined as “a simple test used to help diagnose and monitor certain lung conditions by measuring how much air you can breathe out in one forced breath”.

PROJECT SUMMARY:

During the pandemic, the provision of spirometry in a primary care setting ceased due to infection prevention and control concerns. This meant that GPs were unable to assess a patients’ lung function or ascertain if a patient with a known lung condition had deteriorating lung function. This created a risk of patients developing undiagnosed lung conditions.

However, the infection prevention and control risk of performing spirometry during the pandemic could be mitigated if the test was performed in a secondary care setting, with superior infiltration.

WHO PRIMARY CARE WORKED WITH:

- The ICB Locality Team who analysed existing data and identified patients known to have poor lung function, including abnormalities in volume and airflow.
- ·Nottingham CityCare Partnership CIC, to identify vaccinated staff, trained in spirometry with appropriate Personal Protective Equipment.
- Nottingham University Hospitals (NUH) NHS Trust, to secure the use of rooms with adequate extraction and filtration, for delivery of weekend spirometry appointments.

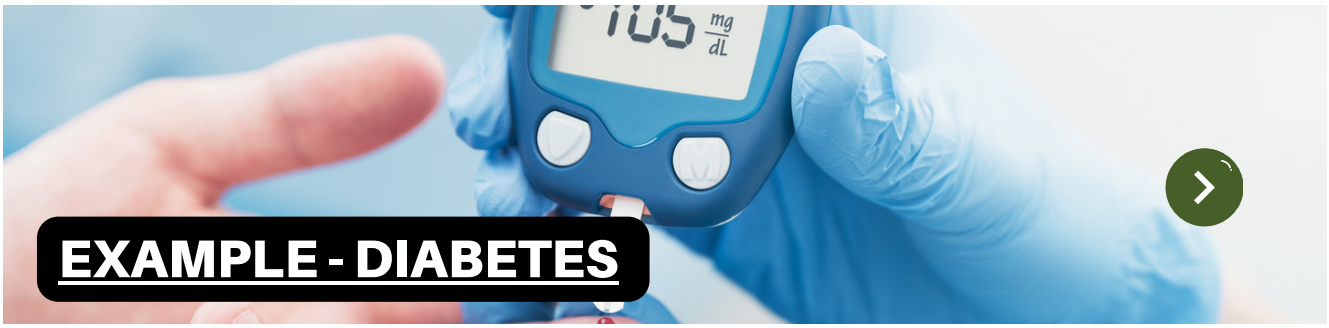
AN UNEXPECTED OUTCOME:

The successful pilot of delivering spirometry in a secondary care setting was halted by wave three of the pandemic. Whilst the pandemic had halted the pilot, it created a transformative shift in the interface between primary and secondary care.

Colleagues stopped deflecting workload on to each other, took joint ownership of resolution identification and worked collaboratively to release capacity in the system. The collective intention was to deliver a service that was mutually beneficial to patients, primary and secondary care colleagues.

WHAT HAPPENED NEXT:

When spirometry was allowed to resume in the community, colleagues took a collaborative approach to identifying more locations to hold clinics, to continue to alleviate pressure on primary care to deliver all testing.



Defined as “when the level of glucose (sugar) in your blood becomes too high. It happens when your body cannot produce enough of a hormone called insulin, which controls blood glucose”

PROJECT SUMMARY:

During the first year of the pandemic, patients with Type 2 diabetes, were unable to attend medical reviews to support the management of their condition. Diagnostic blood tests were unavailable to patients with suspected yet undiagnosed Type 2 diabetes. This created a risk of patients experiencing diabetes complications which would require treatment within a secondary care setting.

WHO WAS INVOLVED:

- Primary Care Colleagues
- NUH Diabetes Specialists
- CityCare Diabetes Specialists
- ICS Diabetes Transformation Group
- Locality Colleagues
- Patients with diverse diabetes needs

WHAT DID WE DO:

Colleagues from primary care worked with diabetes specialists at NUH and CityCare to identify patients with a fasting blood sugar of over 120 milligrams per decilitre (mg/dL).

We also worked with the ICS Diabetes transformation group ICS to identify Patients with multiple needs and to select the at risk cohort.

GP colleagues and Head of Service agreeing a definition using data figures held in GPRCC and through identifying records of patients who had recently had a diabetes level defined by a blood test that fell into a danger bracket.

The identified cohort of patients were invited into their GP practice to have a diabetes monitoring appointment, with CityCare nurses (overseen by NUH’s consultant body) to minimise the risk of their diabetes deteriorating into long term health problems.

Whilst this approach to Type 2 diabetes management has not yet concluded, it is felt that feeding the results into the Care Navigation System will support practitioners to deliver more personalised care to patients.