Consultant-led, collaborative service for people suffering from respiratory conditions

This Future Hospital Programme case study from Dr Nawaid Ahmad of The Shrewsbury and Telford Hospital NHS Trust outlines the benefits of having a consultant-led service for respiratory medicine.

Authors: *Dr Nawaid Ahmad, consultant (respiratory), Princess Royal Hospital*

Key words: respiratory medicine, primary care, mental health, hospital admissions

Person-centred care

Key recommendations

- Establish a series of multidisciplinary team (MDT) meetings to discuss the needs of patients with long-term conditions. The MDT should incorporate primary care physicians, mental health, social services and palliative care services to provide a collaborative and exceptional level of care.

- Run community-based clinics to reduce hospital admissions as well as help with accurate diagnosis.

- Propose a long-term management plan for more patients with more complicated health needs and to help with advanced care planning for those patients who are especially ill.

The challenge

The Shrewsbury and Telford Hospital NHS Trust (SaTH) comprises of two hospital sites within Shropshire: the Royal Shrewsbury Hospital in Shrewsbury and the Princess Royal Hospital, Telford. Two clinical commissioning groups (CCGs) operate alongside our Trust but it is with Telford and Wrekin CCG that this project has a partnership with.

Our Trust has a catchment population of 160,000 which has an above average deprivation. Smoking rates are higher than the national average; current estimates suggesting that 3.4% of adults within the Trust's catchment, aged 16 and over, have chronic obstructive pulmonary disease (COPD).

Our solution

High admission rates of people with COPD, accounting for almost a third of acute admissions, led to the idea that preventing admissions, rather than achieving faster discharges, should be the core principle to improving patient care without compromising on quality.

CCG data shows that at least 30 patients in the local area accounted for 108 admissions from February 2013-February 2014. This is the cohort which we would specifically like to target as a part of the project, by providing educational and clinical assistance to the primary care team.

Outcomes

Community respiratory nurses required a clinical leadership. As such, a secondary care consultant was deemed necessary to support this project. Building on an agreement between the Shropshire Community Health NHS Trust and SaTH we developed a project that focuses on delivering a consultant led service for respiratory medicine.

This project commenced in November 2013 and has two parts:

1. A consultant-led multidisciplinary team (MDT) meeting

We devised a consultant led MDT meeting where we were able to discuss people with long-term conditions, particularly those with COPD. These meetings are held every other week and are comprised of the respiratory nurses, physiotherapists and the consultant. We also had, at one point, a community psychologist as part of the MDT.

Each MDT lasts on average 90 minutes. The number of cases varies depending on the season, with more in winter. The MDT discusses 3-4 new cases and 5-6 follow-ups from previous discussions. We have

found that by completing a proportion of the work beforehand (by completing an MDT proforma) helps to gain a thorough history and clearer picture.

2. Community 'one-stop' respiratory clinics

Every other week, alternating with the MDT meetings, we have set up community 'one-stop' respiratory clinics (also attended by patients from other GP surgeries). These are run at a local GP surgery. The main aim of these clinics is to help with accurate diagnosis, propose a long-term management plan for more complicated cases and to help with advanced care planning in those patients who are especially ill. We are encouraging primary care colleagues to initiate these discussions with patients and, where possible, we do it in hospitals. The Trust has an appointed end-of-life care nursing lead who has introduced a 'preferred priorities for care' document. It is a central part of the integration process and we are looking at adopting an end-of-life care decision making document for the region.

Our strategic plans are discussed by a dedicated local implementing team formed of CCG members, the Trust's operational team, a Trust respiratory physician, respiratory nurses, a lead respiratory nurse in the community and a patient representative. The management plans from the MDT/clinic are shared with the GPs through a letter. The community respiratory nurses also do weekly rotational shifts in acute hospital, acting as the link to share the plans with the hospital clinical team.

Project aims

- Provide person-centred care by achieving a seamless integration with all other stakeholders involved.
- Improve the quality of life of people with long-term respiratory conditions.
- Provide care closer to home by doing community respiratory clinics.
- Avoid admission by supporting people to stay at home, with the help of respiratory nurses, physiotherapists and psychologists. Every patient has a self-management plan and some have specific rescue packs. We are not keen on home nebulisers for COPD patients.
- Educate and empower people in the self-management of their conditions by spending more time at the community clinics with support from healthcare workers. We are working closely with the Telford & District Breathe Easy group, supported by the British Lung Foundation (BLF), to help spread information to patients and raise awareness of lung conditions.
- Further empower people by creating 'patient champions' who we work closely with. We also have current plans for creating patient champions in conjunction with BLF and the Breathe Easy group to help those patients who are reluctant to be a part of the Breathe Easy group sessions.

If there is exacerbation, it is self-reported to the GP who will then inform the respiratory team for making a phone call or a visit depending on the seriousness of the situation. Well known patients to the community service will ring directly and ask for help should they need it.

Patient champions

Our patient champions will narrate their own story and we think patients will relate to this more than what is written in a book. They can help visit patients at home; particularly the ones who do not want to join, cannot breathe easy or are unable to come to the group. We hope that this will help patients improve psychologically; as mental state affects these patients more than their disease can at an advanced stage. There will be posters and video stories exemplifying the patient champions.

We are in the process of discussions with the hospital and Breathe Easy groups to identify the role of patient champions. At the moment, we do not allow champions to see patients until we have gained permission from the patient and they will have no access to their data. Their role will only be to share their story and encourage people to attend rehabilitation and have more positive outlook towards things. This project is yet to reach its fruition so nothing has yet been implemented.

Person-centred care

Outcomes

A service evaluation carried out in 2014 showed that, between November 2013 and July 2014, 40% of people discussed at our MDT meetings (32 out of a cohort of 80) did not require admission to our hospitals.

At least three frequent service users have not had any further hospital admissions over a 12-month period:

- one was referred for lung transplant as her disease got stable and she got stronger mentally
- one patient had palliative care support in the community and learnt to cope with his disease better
- one had a peaceful death at home.
- When directly comparing hospital admissions between February 2013–October 2013 and February 2014–October 2014, there was a net saving of £50,000 for the CCG. We also saved 50 bed days over a 6-month period, with the average length of stay (LOS) being 5 days.

The community clinics are seen as an ideal opportunity to rationalise the treatment of patients with complicated health needs. Not only this, but they will prove to be effective at reducing the waiting list at our Trust hospitals, thus preventing the need to migrate people to neighbouring trusts.

Barriers and levers

Our major concerns came from funding for the project. We are lucky to have had funding provided by Telford and Wrekin CCG. Otherwise it was the technical aspects of the project that caused concern, particularly with the endeavour to ensure that there were no adverse reductions in clinical activity related to community clinics.

We found that the time saved from this project could be better utilised elsewhere. For example we were able to start an endobronchial ultrasound service and a pleural service, which brought in revenue to the Trust.

The CCG paid only for the consultant time, equivalent to 1.25 PAs. The nurse and physiotherapist funding was already there and existing before the consultant-led service was commissioned. It was “forward” investment into the consultant delivered service and I am not aware of any thing being affected by the funding. The nursing staff are all Band 6 with one team leader who is Band 7. The physiotherapist is Band 6 and there are two healthcare assistants who are Band 3.Efficiency post-delivery of service has been achieved by reducing costs on hospital admissions and reduction in the number of health care utilisations by some complicated patients.

Senior involvement in this process was vital to show respect to trainees, identify obstacles early on and give validity to projects. Supervising consultants were engaged and willing to input into the process, though in general we noticed that there was poor identification of the need for QI and knowledge of methodologies, realising how this new approach is a cultural shift from previous approaches. We would like to work with the health board in the future for QI training to be offered at all levels in a team approach.

Patient story

One person exemplifies the aims of the project. This person had underlying mental health issues and COPD. She was a frequent service user presenting with collapse, type-2 respiratory failure and aspiration pneumonia, needing high dependency unit admission as well as non-invasive ventilator support. When discussed at the MDT meeting we were able to identify that she was taking a combination of antidepressants and benzodiazepine. She was also still smoking.

Person-centred care

To help improve this person's health we organised a case conference with social services, family members and the mental health team at her last hospital admission. Her medications were reviewed, rationalised and reduced where appropriate. She self-referred herself for smoking cessation services. The outcome was very favourable for the patient. There were no further readmissions in the ensuing 12 months. She was found to be doing well now that she had stopped smoking and taking other unnecessary medications. She was seen initially in the community clinic before being transferred to a secondary care clinic, for more detailed assessments (eg pulmonary function tests, oxygen assessment, sleep studies and CT imaging) that could not be provided by the community clinic.

This person's story highlights how effective collaborative working can be. We were able to not only to help her to improve her quality of life but were also able to save an estimated 25 bed days (per patient per year) for the Trust.

> *The community clinics have proved effective at reducing the waiting list at our Trust hospitals.*
> Dr Nawaid Ahmad, The Shrewsbury and Telford Hospital NHS Trust

What next?

Current plans are to expand the MDT meetings to incorporate those primary care physicians who are responsible for the care of the people being discussed. This is to be done through IT innovations using teleconferencing platforms, eg Skype and FaceTime. Additionally we want to include mental health, social services and palliative care services as part of the overall MDT.

This project has the potential to achieve seamless collaboration between primary care and other stakeholders to focus on person-centred care. For respiratory medicine there is the clear capacity for a single plan of care to be developed, in the future, for all people suffering from long-term respiratory conditions.

The long-term plan to include other services, eg palliative care, will provide a more holistic management of patients. This can be further developed by having our patient champions incorporated to change the delivery of healthcare in our landscape.

This case study is not an endorsement of any individual or organisation. The material within is promotional only and we do not necessarily reflect the views of the author and the organisation they represent.

Future Hospital Programme

Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE

Tel: +44 (0)20 3075 1585
Email: futurehospital@rcplondon.ac.uk

www.rcplondon.ac.uk

Royal College of Physicians