



## Phase 2: Integrated care

### Sandwell and West Birmingham

#### Aim

To develop a patient-centred respiratory service by integrating primary, acute and community services.

#### Objectives

Sandwell and West Birmingham's care model centres around a multidisciplinary respiratory team, including primary care doctors, acute clinicians, consultants, nurses and allied health professionals. The team identified the following objectives:

- 1 to provide patients, carers and clinical staff easy and swift access to care, services and specialist advice at each point in the care pathway, incorporating modern methods of access
- 2 to establish 'joined up' care records, alleviating burden on patients to repeatedly relay their condition and history and enable quicker correct diagnosis and treatment
- 3 to provide consistently high standards of care and reduce variations in quality of care
- 4 to empower patients to manage their own condition with full understanding as to where and how support can be accessed.

#### Key messages

- To ensure the sustainability of objectives, design a model which addresses **all aspects of care** requirements of the respiratory patient.
- Identify the gap between what is expected and the resource available in order to produce **persuasive business cases**.
- Effective, **collaborative engagement** of clinicians, commissioners and the executives working in the primary and secondary care setting is paramount.
- A **well-constructed team** is key – involving hospital clinicians and managers, patient representatives, GPs, commissioners, nursing staff, community clinicians and, importantly, a data analyst and project manager.
- Bringing **specialist input** to the primary care setting improves patient care, patient experience, skills and knowledge of GP and practice nurses.
- Additional resources and different ways of working are needed not just for consultants but also the **wider multidisciplinary team (MDT)**.

## Methods

The team led three workstreams to reflect patients' experience before, during and after a hospital visit.

### 1. Pre hospital

- Primary and secondary care: a respiratory consultant visited a GP practice for one morning session to work alongside GPs.
- Frequent attenders: patients were identified by cross-referencing those with frequent attendances and admissions across the emergency department, secondary care and a GP practice.

### 2. In hospital

- 'In Reach' care model: Patients attending the emergency department were promptly reviewed and diagnosed to allow a safe deflection or admission to the wards. This was led by the acute specialty clinical lead, in conjunction with the respiratory team and clinical nurse specialists.
- Back fill: to support a 7-day working pilot, all work was backfilled to ensure all clinicians and nurses were able to carry out daily ward rounds on the respiratory wards.
- Assessment: impact on length of stay, midnight free beds, junior doctor training opportunities and feedback from nursing staff were studied, along with other qualitative measures.

### 3. Post hospital

- Discharge from hospital: discharge plans were developed in combination with community respiratory services to decrease the frequency of admissions and reduce the length of stay for any necessary admissions to hospital.
- Integrated discharge: this workstream is jointly led by a clinical nurse specialist (CNS) and respiratory physician with input from the community respiratory services, a psychologist, GP and social worker as required.
- Virtual MDT: a virtual MDT was initially set up to adopt a holistic approach to frequent attending patients with long-term conditions.

## Key milestones

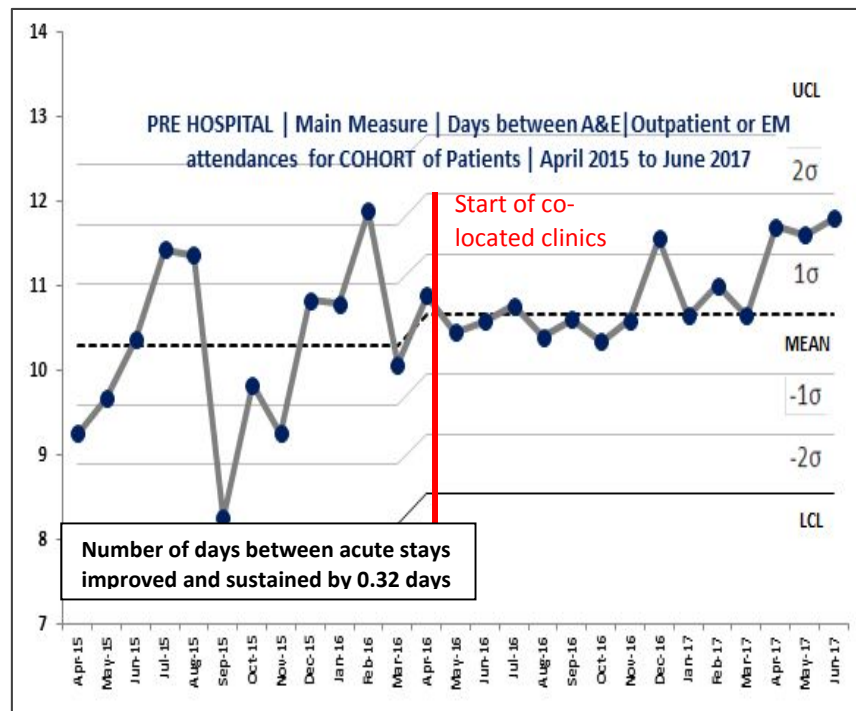
- Jan 2016: Appointed as an FHP development site.
- Mar 2016: Project launched to Sandwell and West Birmingham staff, patients and managers.
- Jun 2016: Organisational restructure resulting in redeployment of head of team, project manager and data analyst.
- Sep 2016: New project manager and divisional general manager appointed. Three workstreams defined.
- Jan 2017: Pilot model of reviewing referrals from assessment unit daily commences. Co-located respiratory clinics start.
- Feb 2017: Patient representative steps down from project.
- Jun 2017: New patient representative joins the project.

## Outcomes

### 1. Patient outcomes

#### Pre hospital

Outcomes were measured for the workstream’s ability to prevent unnecessary hospital visits for the cohort of patients seen within the pre-hospital clinics. **The number of days between acute stays improved by 0.32 days** balanced against **no discernible change in length of stay** for the same cohort. Patient satisfaction responses to the clinics were high.



#### Post hospital

Prevention of unnecessary emergency A&E attendances for patients seen within the post-hospital MDT clinics was measured for the post-hospital workstream. **The gap between A&E attendances lengthened by an average of 0.49 days** balanced against **no discernible change in emergency length of stay** for the same cohort. Patient satisfaction responses to the clinics were not undertaken. There was a positive return on investment as far as the reduction in A&E frequent attenders and some early evidence of follow-up outpatients.

### 2. Staff impact

#### Feedback from staff

A Likert scale entered by staff after they saw patients in the in-reach acute medical unit (AMU) clinic reported that staff agreed that the clinics facilitated service provision for acute respiratory medical patients, added educational value and personal development to them, and had a positive impact on their workload.

### 3. Patient experience

- **Integrated clinics:** Patients attending clinics 'strongly agreed' that there was value in a consultant being present and that they were able to discuss more about their conditions.
- **In reach model:** Patients seen by the In Reach Respiratory Team 'strongly agreed' that they were satisfied with the care of their condition and that care was timely and efficient.

## Successes and challenges

### Successes

- ✓ The team remained resilient through challenging times, which was the result of a shared vision and clinical engagement and distributive leadership.
- ✓ The pre-hospital workstream managed to reduce the frequency of combined attendances to either A&E, outpatient and emergency admissions by 0.32 days on average for the cohort of patients that were treated.
- ✓ By sharing knowledge between the respiratory consultant and general practice staff some early signs of improved practice and patient self-management were demonstrable through patient and staff feedback.
- ✓ The in-hospital workstream had a positive impact on the rhythm of the day for the specialist wards, improved training opportunities and positive feedback from nurses. There was no discernible impact on length of stay in the studied period.
- ✓ The post-hospital workstream managed to reduce the A&E arrivals by on average 0.49 days for the cohort of patients treated within the MDT clinics, by providing alternative avenues for these patients post-acute discharge, rather than re-attending as an emergency admission.

### Challenges

- The two biggest challenges were the loss of two members of the improvement team and their change management experience. For example, the team lost its change project manager at an early stage and were without one for a period of time. Once the role was filled, the project resumed with great vigour.
- Experience in running PDSA cycles and driving improvement through data was limited among the clinical members of the team. At the critical time when posts were vacant, support was provided by unfunded work from the improvement analyst. With effective liaison with the executive team we managed to get back the same analyst to support the project.

Read the full report from Sandwell and West Birmingham's development site team at [www.rcplondon.ac.uk/delivering-the-future-hospital](http://www.rcplondon.ac.uk/delivering-the-future-hospital)

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