

Innovation in the delivery of care closer to the patient

Special Commendation Ashford and St Peter's Hospitals, Chertsey

Who are we?

We are a multi-professional team, primarily for the management of chronic lung disease, across primary and secondary care, as follows:

Secondary Care1: Professor Mark Britton, Lead Consultant Respiratory Physician; Drs Paul Murray and Michael Wood, Consultant Respiratory Physicians; Lesley Spencer, Lung Cancer Nurse Consultant; Helen Tilley, Clinical Specialist Respiratory Physiotherapist; Amber Lane and Camille Burgin, Senior Respiratory Physiotherapists; Dawn Reeves-Turner, Sister Medical High Dependency Unit; Mary O'Sullivan Sister respiratory ward; Gail Roberts & Stephanie Sutch, Deputy Sisters, respiratory ward; Paritosh Solanki, Pharmacist; Ros Javed, Senior Physiological Measurement Technician; Sophie Owen & Linda Spooner, Respiratory Dept Medical Secretaries.

Primary Care2: Julia Bott, Consultant Respiratory Physiotherapist; Vikki Knowles, Lead Respiratory Nurse Specialist – Respiratory Care Team; Sue Bennett, Respiratory Nurse Specialist (RNS), band 7; Anne Moxon, Carol Connolly and Charlotte Cunningham-Smith (RNS); Anita Clear & Deborah Hepburn – TB Nurses; Jessica Callaghan, Respiratory Occupational Therapist (OT); Fran Dyer, Clinical Specialist Respiratory Physiotherapist; Annelies Klinker and Pamela Lang, Respiratory Physiotherapists; Heather Congdon, Medical Secretary; Audrey Conway, Administrator.

Where are we based? Ashford & St. Peter's Hospitals NHS Trust1, St. Peter's Hospital, Guildford Road, Chertsey, Surrey KT16 0PZ; Surrey PCT North West Locality2, St Peter's Hospital.

Specific Details of the Service

We have a proactive and dynamic primary care service aimed at keeping patients as fit and as well as possible at home, preventing admission and facilitating early discharge where possible and appropriate. We do this by monitoring patients (akin to case management) as a whole team, keeping careful records so that every team member can help any individual either in person at an out-patient clinic, with a home visit, or via a telephone call. We have a dedicated telephone line from which messages are retrieved 3 times daily and appropriate action taken in order of urgency and priority. We ensure our patients are as knowledgeable about their disease and its management as they can and are willing to be. We have close working relationships with the local General Practices and communicate with them frequently regarding care of their patients. Should patients require admission, we have a robust non-invasive ventilation (NIV) service on the respiratory HDU, as well as in specified ward areas, and an in-patient post-exacerbation Pulmonary Rehabilitation (PR) service. Specific features of the teams' success are as follows:

- A joint Primary Care/Secondary Steering Group for Respiratory Services, facilitating good communication and seamless care throughout the patient journey.
- Regular clinical supervision for team members with the respiratory physicians
- Hospital at Home Service following BTS Guidance (2006)
- Home visits & telephone calls to support patients and facilitate admission avoidance.
- A unified out-patient PR service at 3 sites across the PCT in both secondary and primary care facilities, ensuring an accessible programme for all patients.
- A PR maintenance class in local council facilities in one locality, with plans to pilot a full PR programme there in the Autumn (if this proves successful, to roll out both the maintenance and full PR services in other council facilities in other localities).
- A post exacerbation PR Service twice weekly on the respiratory ward available to in-patients continuing on discharge.
- Community respiratory nurse and physiotherapy led clinics, receiving referrals from respiratory physicians, general practi-

tioners and community nurses. Patients are offered any or all of the following: general respiratory assessment, medication reviews, spirometry, weight, assessment for suitability for PR, home oxygen assessment to include SpO2 at rest and on exertion, arterial blood gas analysis, brief airway clearance or breathlessness management advice, and holistic assessment with referral on to other Allied Health Professionals for eg joint or back pain, dietary advice, podiatry services.

- An NIV service provided by secondary care physiotherapists & nurses, under the direction of the consultant physicians, supported by expertise from within the team.
- Respiratory nurse specialists review ward patients to advise and liaise with relevant health care professionals to facilitate early/prompt discharge.
- Respiratory patient follow-up post admission in the community respiratory nurse led clinics.
- Out patient physiotherapy appointments and home visits for eg., airway clearance, breathlessness management, or personalised rehabilitation advice.
- Out patient OT appointments and home visits for mental and physical health problems eg anxiety, depression, adaptations to the home, aids to daily living.
- A local Oxygen policy (in accordance with the BTS Emergency and Domiciliary Oxygen Guidelines) with: Long Term Oxygen Therapy (LTOT) assessment and Ambulatory O2 assessment as part of the PR programme, and a locally designed Oxygen Prescription chart to increase good oxygen prescribing and delivery practice.
- A local COPD Integrated Care Pathway for the primary care practitioners .
- We run courses and training sessions for GPs and Practice Nurses as well as NIV teaching sessions throughout secondary care and, when needed, primary care.
- We piloted in-house a multi-professional University module on 'acute ward management of the respiratory patient', which has improved patient care.

With one acute RNS we had found increasing problems providing care across the boundaries and deciding who to follow up in the community. We had no Pulmonary Rehabilitation service in our area and were faced with an increasing burden of long-term patients for whom little was on offer. It therefore seemed logical to develop a multi-disciplinary Respiratory Care Team which could streamline care. This project allowed the development of a comprehensive service linking primary and secondary care.

Initially a pulmonary rehabilitation service was started and then the monitoring service (Respiratory Care Team) was developed about a year later after making a successful financial recovery bid, procuring additional respiratory nurses and physiotherapists, and an Occupational Therapist. A third Respiratory Consultant Physician was successfully bid for and appointed.

Our admission rates have fallen by 18% per year since the team was established and our average length of stay is now well below the national average. Our PR outcomes are as good, or better, than any other published data. The PCT has been so impressed with our team's results that it has just decided to fund the creation of similar teams throughout the areas of Surrey with no such service.

We will ensure that we support and advise the newly created Surrey teams and work closely with them, as well as existing services, to obtain a Surrey-wide respiratory service at as high a standard as possible. Our team's model and the PCT wide initiative could be copied relatively simply and we could advise areas trying to do this. Julia Bott, julia.bott@surreypct.nhs.uk; tel:01932 723660.