

Whittington Health Respiratory Service

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Background

Whittington Health, an integrated care trust in north London, UK, was formed in 2011 through the merger of the Whittington Hospital, a district teaching hospital, and the community health services in the London boroughs of Haringey and Islington. It serves an ethnically diverse population of 460,000, with sizable lower socio-economic populations in both boroughs. Whittington Health's respiratory service provides services across the hospital and community care settings.

Strategic goals

Reflecting the goals of the integrated care trust in which it is located, the Whittington Health respiratory service is an innovative and award-winning service for patients and the community. The flagship service for patients with chronic obstructive pulmonary disease (COPD), including those with respiratory failure,¹ the respiratory service has evolved over more than a decade (COPD is the fifth largest cause of death in the UK, and the second most common cause of admission to hospital). The respiratory service

aims to involve and enable patients to be as proactive as possible in managing their own care. The team's mission is to improve the outcomes and experiences of people living with respiratory illnesses in the local community.

Leadership

Two consultant chest physicians, Dr. Louise Restrick and Dr. Myra Stern, established and lead the Whittington Health respiratory service. Based on their work with patients and caregivers, they used ever-deepening perspectives in developing the service's approaches. Their shared methodology is shaped by a commitment to both patients and their needs, and to translating the evidence on clinical effectiveness into service delivery.

Restrick and Stern work with five respiratory consultants in Whittington Health. The respiratory service includes a specialist outpatient respiratory clinic based at Whittington Hospital; a 21-bed acute inpatient unit, including a 4-bed high-dependency unit; and the Whittington Integrated Community Respiratory (CORE) team, which supports patients in their homes following discharge from hospital or referral from general practitioners (GPs) (The King's Fund 2014). The CORE team is comprised of hospital consultants and GPs, as well as nurses, physiotherapists, a pharmacist, smoking cessation advisors and a psychologist. The consultants' positions are partly funded by the primary care commissioners, allowing them to work as "integrated respiratory physicians" across the whole patient pathway.

Patient Engagement

The patients engaged in Whittington Health's respiratory service come from the COPD groups originally established by the Haringey and Islington primary care trusts that were developing local strategies for chronic patients, the patient and caregiver representatives on the GP Local Enhanced Service (LES),² the long-term exercise programs and those currently receiving care from the respiratory team in hospital, in clinics and at home.

Throughout their evolution, the service models in Whittington Health's respiratory service have been shaped by patients' views and developed in partnership with patients and caregivers. The service's patients have complex problems and cope with immense difficulty. When the respiratory teams want to make changes or introduce a new service, they are committed first to understanding the patients' points of view. Every new idea or potential change the team tries is developed or discussed with patients and, where necessary, altered to accommodate their views.

As part of standard practice, the respiratory service team recruits patients and caregivers to provide advice on service redesign initiatives and tests improvement ideas with patients during admission to the respiratory ward. The National Health Service provides taxis for travel to meetings and offers financial support for meeting attendance. Working with COPD patients can be challenging. Those who are fit enough to participate often do not know they are ill, and those who do know they are ill are often too unwell to attend meetings.

Whittington Health's respiratory service team also receives patient feedback from more conventional routes, such as thank you cards, interviews with patients and patient survey data. The team surveys inpatients every month and the results are provided to the ward manager, and the team conducts intermittent surveys using patient satisfaction questionnaires. Educational materials for patients are developed and tested with them before being published.

Key Strategies to Support Patient Engagement

Service models

The Whittington Health respiratory service team has developed a succession of service models, each one crafted in response to lessons learned from the previous model and to the changing local and/or national contexts. The team has applied and developed the principles of enhanced recovery during respiratory admission and is developing a multi-morbidity model that addresses both the disease-specific issues of COPD and the other common conditions that affect people with COPD.

Integrated services link primary and secondary care together in order to achieve the best possible clinical quality outcomes and lowest possible cost. After 10 years, the changes pioneered in north London have become accepted best practice and have influenced national, regional and local respiratory service strategies. Whittington Health's service has won national awards for improving and integrating respiratory services (IMPRESS n.d. a); innovations in patient involvement (IMPRESS n.d. b); multidisciplinary teamwork and management (Personal communication 2006); and quality improvement (DOH 2012).

Evolving service delivery

Restrict and Stern introduced the first innovative service-delivery model – the Rapid Early Discharge (REDS) model – in 2002 (Stern and Restrict 2014), based on evidence from early discharge experiments.³ The physician consultants were supported by Whittington Health's respiratory service manager who wanted to reduce the number of inpatient bed days. The REDS model began with the appointment of a respiratory nurse specialist as project manager to collect baseline data. In the new model of care, GPs retained responsibility for their own patients, with additional support from the hospital. GPs were given direct access to the hospital specialist team via both e-mail and mobile phones. The aim of the REDS model was to reduce lengths of inpatient stay by discharging patients rapidly back home from hospital (as soon as their treatment had been optimized and it was safe to do so, with support from community staff and continuing care by GPs).

The REDS model was successful in improving GP and patient satisfaction, but Restrict and Stern decided it was insufficient to meet their patients' needs. Only one in three patients met the criteria for REDS due to the severity of their disease and other undiagnosed and diagnosed conditions that produced complex needs and multi-morbidity. Moreover, while patients liked the home visits and felt safe, it was clear that both patients and GPs wanted patients to receive more support over a longer time frame.

Listening to patients' accounts, the hospital's clinical team heard that breathlessness is frightening for patients and families, and during exacerbations, patients feel safer in hospital. Overall, the consultants realized that only a small number of patients could be discharged early and only 150 bed days were saved in a year.

After the REDS experiment, the team decided to pilot a model that focused exclusively on the most resource-intensive patients (i.e., patients with the highest bed days). What would it take to address their fear of breathlessness and provide longer-term support? The new model of service they designed was a radical departure from national policy and Whittington Health's own strategy. The needs analysis showed that a significant proportion of COPD patients lived alone, were socially isolated, presented late, had multiple co-morbidities and high rates of tobacco dependence. A significant proportion also had mental health problems and the group had a high mortality rate at a relatively young age.

The new model was the first iteration of an approach that went on to become the routine way of working; it was informed by patient input, a population needs analysis and collaboration with local GP leaders and commissioners. Instead of reducing lengths of stay, the respiratory service team decided the goal for resource use would be to reduce bed days over the course of a year while providing continuing support for the group of very sick COPD patients. The earlier community support strategy had made patients more, rather than less, dependent on their key workers, and patients felt abandoned when support was withdrawn. With the new service model, care-team members were given behaviour-change skills training and learned how to develop shared care plans. They then worked with patients to help them manage their own health. In this last phase, the emphasis shifted away from "providing care" to "working with patients," and support was reduced gradually over a period of months on an on-request basis via telephone.

Following the needs analysis, the respiratory service team worked with Islington GPs to develop an LES for people with COPD, funded through additional support from Public Health. GPs and their teams received training in the management of COPD and incentives were put in place to encourage them to find cases, diagnose COPD earlier and improve prescribing for those patients. Every professional in contact with COPD patients was trained in smoking cessation and smoking cessation advice, and prescription of quit-smoking medications was offered to all patients, including those with advanced disease.

To address patients' fear of breathlessness, the team developed a planned response to respiratory failure. The purpose of hospital admission was reframed to enable patients in respiratory failure to receive life-saving, evidence-based treatment, and all patients now receive interventions to enable them to "live better at home" with breathlessness. This adaptation of the service was a radical departure from the earlier approach incorporated in REDS. Under the new approach, patients are admitted to hospital for as long as required to stabilize their condition, help them cope with their level of

breathlessness and then return home safely. Hospital admission is used to increase patients' understanding of COPD and to develop appropriate self-management skills.

For ward-based staff, integrating the respiratory service means liaising with a social worker, community respiratory teams, GPs and district nurses. Ward-based staff strive to treat hospital discharge as part of the approach to integrated care. Community staff, meanwhile, are invited onto the ward to meet patients and the ward team, and discuss what they can offer in the community. Care-planning conferences are held on the ward with patients and their families and, where necessary, with staff from mental health. Staff aim to help patients actively take charge of their own care and medications. In the community, staff organize themselves so that on Fridays they can meet patients who are struggling with health issues to help them cope over the weekends. Patients' feedback on the liaison between hospital and community is excellent and, for some patients, the shared care plans have reduced annual bed days. The key services for these patients include pulmonary rehabilitation, physical activity classes in the community, psychological support and improved integration with palliative care.

Impact

Whittington Health's respiratory service team has achieved significant improvements in patient experience, costs and clinical outcomes, including a reduction in COPD mortality (now the lowest in London). Ninety-day mortality is 2.6% versus 8.6% nationally.

Patient input has resulted in a number of innovations, including the development of a long-term exercise program; singing groups; psychological support to quit smoking and for coping with anxiety and depression; and an increased focus on discussions about end-of-life and palliative care during outpatient appointments and home visits.

Whittington Health and the Clinical Commissioning Group (the funder) have recognized the respiratory service team's work as a highly innovative example of what can be achieved by delivering an integrated, person-centred model of care. Together with the Islington Clinical Commissioning Group and the local authority, Whittington Health was selected as one of 14 national pathfinders for integrated care in England in 2013. The Quit Smoking Team, led by Stern, was awarded the Clinical Leadership Team of the Year in association with the 2014 Whittington Health Excellence Awards.

Summary

The Whittington Health respiratory service provides an innovative, integrated approach to managing patients with a challenging clinical condition, across hospital and community settings. For more than a decade, the multidisciplinary service model for COPD patients has been shaped by patients' views and developed in partnership with patients and caregivers. Their direct input has helped shape the service that is improving the management of their long-term health.

This case study is based on research carried out in 2012. The case was revised and edited in 2015 as part of research commissioned by the Federal Advisory Panel for Healthcare Innovation to inform their report: *Unleashing Innovation: Excellent Healthcare for Canada* (<http://www.healthycanadians.gc.ca/publications/health-system-systeme-sante/report-healthcare-innovation-rapport-soins/index-eng.php>).

Notes

1. Respiratory failure occurs when there is insufficient oxygenation of the blood and/or elimination of carbon dioxide from the blood. Respiratory failure can result from COPD, asthma, pneumonia and other conditions.
2. The LES is a GP service that uses local discretionary funding to primary care trusts (and now clinical commissioning groups) allowing local commissioners to reward a local priority on top of normal Quality and Outcome Framework payments. In Islington, the LES was designed by local GP leads and public health working with Restrict and Stern. The LES offers incentives (£600) for GPs to become clinical leaders in COPD to enhance their and their teams' skills in managing patients with respiratory disease, and also rewards case-finding and referral to pulmonary rehabilitation.
3. Results were published in IMPRESS (a joint initiative of the British Thoracic Society <<http://www.brit-thoracic.org.uk>> and the Primary Care Respiratory Society (PRS)-UK <<http://www.pcrs-uk.org/>> that acts as a medical-led think tank for innovations and improvements in service delivery).

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