Integrated care: respiratory medicine ready and waiting

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ABSTRACT

A less hospital-centric approach to healthcare with specialists working nearer to patients in the community has been strongly advocated in several recent publications. In the field of respiratory medicine a team approach to the care of those with long-term respiratory conditions has been in practise for decades with such integrated approaches being shown to significantly improve outcomes. This approach is now gaining momentum with an increasing number of UK respiratory specialists undertaking sessions outside hospitals. Specific suggestions regarding the scope of this work, training, mentorship and governance have now been suggested by the specialist British Thoracic Society.

KEYWORDS: Integrated care, respiratory medicine, virtual clinics, in-reach, out-reach, community training

Significant changes in the way we deliver care have taken place recently, many in an unplanned way with unintended consequences. Increasing specialisation and the opting out of general medical responsibilities by some hospital physicians has led to the new speciality of acute medicine. Nurses, physiotherapists and pharmacists have taken over responsibilities previously undertaken by doctors, and general practice has taken over care previously provided by hospitals. Over a longer time the health burden has changed with long-term conditions and an increasingly elderly population dominating need.

These changes have lead to a persons' care being passed from one health professional to another and multi-consulting has become the norm. Such fragmentation is inconvenient to patients, can lead to no one person having oversight, confusion and inadvertent contradictory actions can occur, waste is possible and neither patient nor professional experience satisfaction. If the patient also requires social care their problems are compounded. So professionals, not politicians, responded. Integrated care pathways and bundles of care were introduced and when evaluated, for example in the care of those with chronic obstructive pulmonary disease (COPD), outcomes were shown to be better.[1] Assisted early discharge schemes reduced the need for hospitalisation[2] and when a patient-centred approach was adopted, outcomes were much improved.[3]

Into this changing field have come central edicts and political direction but the Future Hospital Programme[4] and Five-Year Forward View[5] have all strongly advocated a less hospital-centric NHS. As a speciality, respiratory medicine has long been involved with respiratory-trained practice nurses playing a key role in the review of those with asthma and COPD, and with community- and hospital-based specialist nurses providing admission avoidance and early discharge schemes. Respiratory physiotherapists have made pulmonary rehabilitation available earlier after an exacerbation, and based such courses in community centres as well as in hospital gyms. Approximately, 10–15 years ago innovative respiratory physicians in north-west England started sessional work outside of hospitals.[6]

Today integrated care or the best possible care for the patient, delivered by the most suitable health professional, at the optimal time, in the most suitable setting, is finally gathering pace but continued evaluation of the benefits is essential. Integrated care involves a team and it needs leadership whether by a nurse, doctor, pharmacist or physiotherapist. In 2007, the British Thoracic Society produced a paper outlining the possibilities for respiratory physicians to undertake more of this work, and in 2014 followed this with a position statement and a new working group.[7] From small beginnings new appointments of consultants in integrated respiratory medicine have increased, and the working group have published online[7] case stories of these colleagues who are spending between 10 and 90% of their time in the community. Duties undertaken by some or all of these consultants are shown in Box 1. The benefits are under evaluation but it has been estimated that one intervention, virtual respiratory clinics reviewing prescriptions in individual general practices, has saved £200,000 in one year in just one clinical commissioning group[8]. The burden of COPD was the initial driver in many areas but we now need to consider what other care is amenable to this approach. The *National review of asthma deaths*[9] highlighted the need for an asthma lead in each health facility and others have demonstrated how aspects of a respiratory sleep service can be delivered with good outcomes outside hospital.[10] New services need to embrace enhanced respiratory care within mental health settings, care homes and prisons, and enlarge home ventilatory support services and new services for those with idiopathic pulmonary fibrosis; a group with a prognosis not dissimilar to many cancers but with often poor end-of-life facilities at present. Mock job descriptions for such new

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Box 1. A list of activities reported to be currently undertaken by UK consultants in integrated respiratory medicine.[7]

- medical input into multidisciplinary team review of respiratory patients (community and hospital)
- medical input into COPD early supported discharge scheme (or admission avoidance scheme)
- clinical input into the domiciliary oxygen service
- medical input into community-based pulmonary rehabilitation service
- specialist input into a community-based one-stop diagnostic clinic
- specialist input into other forms of open access near to patient lung function tests
- medical input into community respiratory nursing team
- community-based COPD and bronchiectasis clinics
- weekly visits to GP surgeries/health centres for virtual clinics reviewing with GPs either respiratory prescriptions, or recent patients with respiratory presentations, or referrals to hospital or those on high-dose inhaled steroids
- medical input into community smoking cessation services
- in-reach respiratory services to acute medical unit /admissions ward
- in-reach services to in patients on long-term mental health units
- respiratory input into clients of substance abuse clinics
- home visits to patients with severe respiratory disease, complex breathlessness, neuromuscular disease and respiratory compromise and others on long-term ventilation.
- educational activities for general practitioner and practice nurses
- healthy lung activities in shopping centres and community centres.

COPD = chronic obstructive pulmonary disease; GP = general practitioner.

appointments and the additional training needs of such appointees has been delineated.[7] Trainees have been reported to feel that their current community training is inadequate, but many express a willingness to undertake this work, perhaps especially among those wishing to work less than full time.[11] It seems unlikely that this can be accommodated within the current respiratory and general medical curriculum, and innovative training posts need to be established such as at the Whittington Hospital, NHS Haringey & NHS Islington community services where two respiratory registrars have been trained.[12] In other areas, proleptic appointments or training fellowships will have to be established.

Leadership of integrated care may be by several health professionals, but where leadership is taken on by doctors it is likely that most will come from a traditional respiratory medicine background or from general practitioners with a special interest. For some this will be their first consultant appointment and a remaining foothold in hospital seems essential for credibility, mentorship, access to investigations and to maintain general medical skills. Others will come to integrated care after decades as a hospital chest physician and for these community relocation may be appropriate.

The development of such integrated respiratory care represents an opportunity for new approaches. While patient-centred care is no less important in hospitals than in the community, the focus on long-term conditions necessitates acquisition of competencies in shared decision-making, self-management support and motivational interviewing. It is also essential that those appointed to these posts can themselves handle common comorbidities, whether cardiac, depression, diabetes or osteoporosis.

Some might ask whether there is sufficient evidence for developing these roles. We are aware from the work of the team who are trialling the Comprehensive Care Physician Model at the University of Chicago that there is a concerning gap between evidence and hope when it comes to doing things differently to manage the increasing healthcare burden. The work programme, which is expected to report in 2017, has the hypothesis – based on evidence – that the same highly skilled physician providing both ambulatory and hospital care will improve outcomes and decrease length of hospital stay and healthcare cost.[13] In the UK, integrated respiratory, or 'long-term condition' clinician roles and programmes as described here, mirror this and we look forward to confirming whether we are indeed moving in the right direction.

A time of change is a time of opportunity and those involved in the care of those with respiratory ill health are ready and waiting. ■

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