



Independent evaluation of the North East Hampshire and Farnham Vanguard

## MISSION TEST CLINIC

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## 1. Background and overview of the service

'Mission' is an acronym for Modern Innovative Solutions Improving Outcomes in [Asthma, Breathlessness and/or COPD]. The clinic model was initiated and developed by Professor Anoop Chauhan, respiratory consultant and Director of Research and Innovation at Portsmouth Hospitals NHS Trust. The Mission model of care involves taking a team of respiratory specialists from secondary care to run clinics and educate/mentor staff within the primary care setting to identify, treat and manage patients with respiratory conditions. The model has already been proven to significantly reduce healthcare utilisation - since 2014 a series of pilot programmes have been run which have tested the model and shown good outcomes in terms of patient experience and in reducing healthcare utilisation among the selected patient cohorts (see Table 1). Since September 2016, the Mission team has been testing the model at scale in the South East Hampshire region. Funded jointly by Wessex AHSN and the Better Local Care locality MCP, with additional support from PHT and a contribution from Pfizer Pharmaceuticals, the team aims to see up to 1000 patients before the end of the project in Autumn 2017.

Essentially the clinic model is driven by three main objectives: proactive, early identification of patients at risk from poorly controlled disease followed by specialist intervention; effective integration between specialist and primary care; and upskilling of both patient and primary care providers to enable better self-management and increased confidence and knowledge to keep patients better and more independent. Its anticipated outcomes are improvements in patient knowledge and confidence, a more rapid and efficient experience of care, reductions in key measures of healthcare utilisation (ED attendances, hospital admissions, unscheduled GP visits and out of hours contacts); and increased confidence, knowledge and ability in primary care providers to support these patients effectively in the community. Evidence from the earlier 'Mission COPD' pilot indicates that all these outcomes can be achieved, and that the model is regarded positively by both patients and staff. Table 1 below shows the percentage reduction in key measures of healthcare utilisation measured after 'Mission' interventions.

Table 1: Measured reductions in healthcare utilisation

Type of contact	Asthma (cohort=79) <sup>1</sup>	COPD (cohort=108) <sup>2</sup>	Breathlessness (cohort=42) <sup>3</sup>
ED visits	67% (6 to 2)	97%	100% (4 to 0)
Hospital admissions	100% (6 to 0)	55%	100% (2 to 0)
Out of hours contacts	80% (5 to 1)	98%	100% (2 to 0)
Unscheduled GP visits	49% (61 to 31)	38%	84% (92 to 15)
Exacerbations	37% (43 to 27)	50%	89% (46 to 5)

<sup>1</sup> 12 months before compared to 6 months after (annualised)

<sup>2</sup> 12 months before compared to 6 months after (annualised)

<sup>3</sup> 12 months before compared to 6 months after

The core Mission team consists of respiratory consultants and registrars, specialist nurses, respiratory physiologists, a respiratory physiotherapist and project management and admin support. Additional HCPs join the core team for follow-up clinics – dietetics, psychology, smoking cessation and further specialist nurse mentorship/education as required. Patients identified as being in need of further specialist assessment can be referred on to a dedicated Mission clinic (in hospital) with access to further diagnostics (e.g., CT scanning) and other specialities (e.g., ENT).

Working in parallel with local GP practices, the Mission team identifies suitable patients by way of search algorithms followed by manual filtering of results (further detail on search criteria is available but not included in this report). Patients are asked to attend a ‘rapid’ clinic at a local facility. This can be their own GP surgery, a neighbouring surgery, or a local community hospital, depending on accommodation available to host the clinics. Patients are seen by the core team members in a ‘carousel’ type clinic, with the average appointment taking around 90 minutes from start to finish. Baseline measures are collected, patients are consented for follow-up and/or research where appropriate, and clinical decisions are recorded by the Mission team directly into the patient’s electronic records, and a post-clinic MDT is held which is attended by practice staff alongside the Mission team. Patients may be discharged back to GP care, asked to attend a follow-up clinic (again, held in the community setting) or referred on to a hospital-based Mission clinic.

In spring 2016, North East Hampshire and Farnham CCG made contact with the Mission team to begin to explore the feasibility of adopting the Mission clinic model for respiratory patients in the region. After a series of meetings and discussions between the two teams, it was agreed that the Mission team would support NEH&F in delivering a trial clinic, which was held in Monteagle Surgery in Yateley, on 24 September 2016.

## 2. Scope of this report

It should be noted that this was a test of the model and its operational and practical aspects, rather than an assessment of its clinical or cost effectiveness. The number of patients seen was small, and although they will be followed up, it would be difficult to draw any conclusions from the clinical outcomes of this patient group at this time. An analysis of the impact on health care utilisation usually relies on at least 6 months to have elapsed post-intervention to compare with a similar period pre-intervention. This time period has not yet elapsed.

It should also be noted that the clinic planning and delivery was supported extensively by the Mission team – further clinics would require the locality to consider staffing, administration and management in detail. This report is based on the views and experiences of the Mission team who supported the clinic, supplemented by additional information from NEH&F CCG.

## 3. Preparation

Five patients with a diagnosis of COPD were selected (by local clinicians) from the practice list. The clinic was booked for a Saturday, to ensure room availability and to minimise disruption to the daily running of the practice. Standard documentation (e.g., patient baseline data collection templates, feedback forms, clinic record templates) were provided by the Mission team. A respiratory specialist nurse (Jayne Longstaff - JL) and QI fellow (Ellie Lanning - EL) described the clinic process in detail in advance of the date. It was agreed that the project's lead consultant (Professor Anoop Chauhan - AJC), respiratory QI nurse (JL) and physiotherapist (Ruth De Vos - RDV) would support the clinic on the day. The Mission team supplied all required equipment and documentation (e.g., data collection templates, feedback forms, questionnaires and clinic record templates, as well as FeNO monitors, spirometer and oscillometer). The lead consultant (AJC) ran through the plan again on the day. The clinic was attended by Dr John Seymour, consultant respiratory physician and Dr Arfan Ahmed, GP (from NEH&F) and Jane Chiverton, COPD nurse specialist, from BOC.

## 4. Clinic delivery

The Mission team members felt that the clinic was well organised and ran smoothly. The team provided the following functions: Lead consultant (AJC) Nurse and physiologist (JL), physiotherapist (RDV) and general clinic management (JL and RDV). Local staff were felt to be very well engaged and willing to help and learn from the clinic. Roles and responsibilities had been clearly defined in advance. The venue was appropriate for the clinic with adequate parking and room availability, though this may have been more problematic on a weekday when the surgery would have been open.

The patients were appropriately selected and suitable for the Mission clinic. They were adequately informed and knew why they had been invited and what the clinic was for. Patient feedback was collected (see following section) and the Mission staff reported positive comments from those they had seen. Baseline data was collected appropriately and treatment decisions were recorded in patients' notes without any difficulty.

A MDT meeting followed the clinic, which was attended by the Mission team members and practice staff. All patients reviewed had complex co-morbidities and their review resulted in a change in treatment and management.

All five patients had onward referral; including to pulmonary rehabilitation, cardiology, sleep study, local community matron and an online COPD management tool including a six-week pulmonary rehabilitation programme (MyCOPD).

## 4. Patient feedback

Feedback was collected from five patients and was uniformly positive. 5/5 patients reported being 'very satisfied' with both the information that was given and the team that welcomed them. 4/5 said they were 'very satisfied' with the clinic booking process, with one patient being 'satisfied'. All patients (5/5) said they would recommend the service to family or friends if they had a lung condition.

Asked which factors were important to them in choosing to attend the clinics, a variety of motivating factors were chosen, with 'improving my breathing control' indicated by all (5/5) patients. 'Discussing new treatments' and 'accessing specialty tests' were each indicated by

4/5 patients. 'Improving inhaler technique' was chosen by 2/5 patients, as was 'to confirm if I have a lung condition/COPD'. One patient selected 'to see a specialist'.

Of those patients (3/5) who ranked their responses, all indicated 'to improve my breathing control' in first position. 2/3 chose 'to discuss new treatments' in second position and one chose 'to access speciality tests'.

When asked whether there was anything that could have improved the clinics, 3 patients provided comments: 'Not really'; 'very satisfied with the whole session'; and 'Really helpful – having learnt several things so no need to change anything'.

2/5 patients reported feeling 'very confident' in managing their health following the clinic, with the remaining 3/5 feeling 'confident'. Additional general comments were received by 3/5 of the patients: 'thank you'; 'good clinic'; and 'small group so everything was personal'.

## **5. Impact on Use of Other Health Services**

For the reasons provided in section 2, an analysis of pre and post health care utilisation has not been undertaken at this time. We understand that the CCG has requested this analysis from CSU and that this analysis could be run 6 months following the clinic.

## **6. Conclusions**

### **6.1 Process**

In terms of preparation, there was effective communication between the Mission team and the locality in advance of the clinic. As a one-off clinic, it was expected that the Mission team would provide the majority of the staffing resource and also support the organisation and running of the clinic on the day. If future clinics are planned, in addition to medical and nursing staff, three key roles are essential: physiologist, physiotherapist and clinic administrator.

The venue was appropriate and all patients were suitable for the clinic. Future clinics would need to be planned to ensure similar suitability (room availability, patient parking, weekday/weekend, IT systems).

## 6.2 Outcomes

Pre-clinic data on hospital episodes (admissions and ED attendances) has been gathered for the patients seen and this will be compared with episode data post-clinic. This is via a pseudo-anonymised report from the Commissioning Support Unit (CSU) so there will be no need to contact patients directly.

Patient feedback forms (summarised above) give a clear indication of the positive experience the patients had. Even though we are looking at small numbers, the feedback is in keeping with the team's findings from analysis of larger cohorts.

The Mission team suggests that patients should be followed up for a minimum of 6 months post-clinic for effective evaluation. This precludes any analysis of outcomes at the time of writing of this brief report. Also, as noted, the cohort size is too small to allow any conclusions on clinical efficacy beyond the individual experiences of these few patients.

Overall the clinic worked well and patients were very satisfied with the experience. The Mission staff benefited from the experience of supporting a clinic in a different locality and informal feedback suggests that local staff also enjoyed the opportunity: 'The clinic was a great introduction into understanding alternative diagnostic respiratory equipment . . . particularly helpful in allowing patients time to discuss their concerns, understand the changes to treatment and have an action plan all on the same day' (Jane Chiverton). Local staff were well engaged and enthusiastic and while the trial clinic did rely on considerable support from the Mission team, no particular barriers to local implementation were immediately apparent. CCG-led planning and good engagement and buy-in from GPs and acute provider(s) is essential and key roles would need to be supported locally. Some transitional support from the Mission team would be suggested.

Author: Fiona Maxwell, AHSN Programme Manager