

Multidisciplinary Respiratory Virtual Clinics

Fran Robinson interviews **Dr Noel Baxter, Dr Binita Kane, Dr Georges Ng Man Kwong and Dr Jørgen Vestbo**, to discuss their experience of setting up and running multidisciplinary respiratory virtual clinics



Multidisciplinary respiratory virtual clinics (RVCs) offer an innovative way of bringing together hospital lung specialists and primary care clinicians to improve the care of people with long-term conditions such as COPD.

RVCs involve discussions of case notes and treatment plans in general practice in sessions lasting 2–3 hours. Patients discussed come from two sources. Based on an EMIS search, patients on intensive treatment with no exacerbations are examined to see if step-down on unnecessary treatment (mainly inhaled steroids) is appropriate. In addition, practices can select patients they want to review prior to the RVC, prioritising complex cases and those causing diagnostic difficulty.

Evaluations of RVCs for COPD show that a reduction in high-dose inhaled corticosteroid (ICS) prescribing can be achieved with patients being moved on to effective high value interventions such as pulmonary rehabilitation and smoking cessation. For example, two years ago Lambeth saved £200,000 in a year by reducing ICS in RVCs.

Primary care clinicians' confidence to manage respiratory conditions improves and they appreciate the networking opportunity and having a specialist visit the practice. The specialist hospital teams feel that the RVC makes good use of their time and that they gain a greater understanding of the challenges and culture of general practice. Even though patients are not present in the RVCs, they appreciate that a trusted opinion had been given on their case.

Dr Noel Baxter, PCRS Executive Chair, GP and clinical commissioner

Noel has been involved as a clinician and a commissioner in helping to set up RVCs in Southwark and encouraging his primary care colleagues to become involved in the process.



In Southwark the consultant physician, respiratory specialist pharmacist or respiratory specialist nurse or physiotherapist will go into practices and work with primary care clinicians according to their learning needs around asthma and COPD. Practices are offered two visits a year.

Each year the RVC model has had a slightly different focus, with themes ranging from COPD, asthma and diagnosing breathlessness to cardiorespiratory care, depending on which area the CCG is incentivising practices to improve.

Noel explains: "Virtual clinics can work in any way. But practices get more out of them if they fit round a quality improvement project. They can also work very effectively at GP federation level because these organisations have their own analysts and IT people and can get good baseline data. This enables them to analyse bigger populations while also providing a micro level of benefit within individual practices.

"RVCs improve communication pathways and relationships between primary and secondary care. So Dr Irem Patel, one of the earliest pioneers of RVCs who is one of our two integrated respiratory physicians, has visited every practice and everyone knows and trusts her and now feels able to pick up the phone to her with any respiratory queries.

"When you incentivise RVCs financially you get more engagement because practices will then prioritise what they are going to work on in a particular year.

"You still end up with practices that don't engage with the process because they haven't got the headspace to do it. Sometimes practices might feel that they have someone who is a respiratory expert and they don't need the extra help. But my experience is that practices benefit from the RVC because of the multidisciplinary team working together. This also raises respiratory medicine up



Learning points - Dr Noel Baxter

- Anyone interested in setting up RVCs should start by seeing how other people are doing it. This is also a good way to pick up connections with people who can support and help you. PCRS has set up a new network for integrated care physicians which could be a good place to start making contacts.
- Try to prevent your project getting stuck at CCG level. You need somebody on the commissioning side who can give it a push and explain why it's important so that the money can be found to get it started.
- Setting up an RVC is all about persistence and persuasion, building relationships, building bridges and developing a network.

the agenda of the practice. It also gives GPs an opportunity to see how their nurses and pharmacists are doing and whether they need more support in looking after respiratory patients.

"In Southwark in the last year we have explored the idea of introducing some cardiological expertise into RVCs because patients with COPD often have cardiac causes of breathlessness or heart failure. One of the trusts has been interested to develop a cardiorespiratory RVC to break down some internal hospital boundaries and to prevent patients bouncing between cardiac and respiratory specialties.

"Now that respiratory disease has been named as a key area in the 10-year plan for NHS England, this is a fantastic opportunity for those areas that don't have integrated respiratory services or RVCs to look at new ways of delivering the improved outcomes that will be expected of them."

Dr Binita Kane, Consultant Respiratory Physician, University Hospital of South Manchester and member of the PCRS Service Development Committee

Binita Kane became interested in RVCs when she was asked to develop an integrated respiratory care service.

She first spent some time shadowing Dr Irem Patel, Consultant Respiratory Physician Integrated Care Kings Health Partners/Lambeth and Southwark CCG, and contacted Professor Jørgen Vestbo, Professor of Respiratory Medicine at the University of Manchester and an international expert on COPD, who became her mentor in the process.

Binita then engaged the CCG pharmacist because she says it was clear from London experience that pharmacy engagement and the medicines optimisation team had helped to drive the RVC within the CCG.

They started with a pilot of 10 practices. They stepped down ICS in up to three-quarters of the patients they discussed in the RVCs. A second pilot has now been commissioned.

She says: "The benefits of the RVC have been huge. It has effectively paid for itself with cost savings from reducing inappropriate medication. However, it is so much more than that because what happens is the secondary care clinician goes into the practices, starts having a conversation about the patients which have been specifically targeted through case finding, but this soon becomes a free-flowing conversation and a whole new area of education for the practice.

"The feedback has been absolutely phenomenal, the practices have absolutely loved the clinics. Generally practices were doing the right thing and the mentorship has given them the reassurance they need."

Binita is now working with a body called Health Innovation Manchester and a respiratory working group to roll out RVCs across 500 practices and 10 localities in the entire devolved Greater Manchester Health and Social Care Partnership, working with both industry and non-industry partners.

"Partnership working and devolution gives an incredibly unique opportunity for Greater Manchester to do it differently. We are all working together to improve population health at scale and reduce variation across the system," she says.

Binita has also been working with Health Education England to develop a virtual learning hub to consolidate the learning from the

Learning points - Dr Binita Kane

- The hardest thing for me at the beginning from a practical point of view was arranging the actual clinics. This requires dedicated time and convincing both GPs and consultants to get off the hamster wheel of crisis managing all the time and that this model of care is worth investing time, money and effort in.
- You need a clinical champion from secondary care to drive the process. However, with the current workforce crisis it might not be practical to set this up as a consultant-led model. Think laterally about who could be trained up – a nurse consultant, an advanced nurse practitioner or a specialist consultant pharmacist. The advantage of having a consultant leading the process is that they are trusted by GPs.
- You could spread RVCs to asthma as they have done in London. The greater challenge with asthma is it's harder to advise from a distance because asthma is more challenging to treat, but there is still a role to educate clinical teams about asthma management.

RVCs and provide short videos of respiratory experts explaining key principles. It will also have a chat room facility so that all the practices can discuss the issues everybody else is having.

Dr Jørgen Vestbo, Professor of Respiratory Medicine, Manchester University NHS Foundation Trust

Jørgen did most of the 10 pilot RVCs described by Binita and has done a further 15 RVCs in Manchester. Jørgen has a COPD clinic at the Wythenshawe site and is otherwise involved in COPD research and leads the Respiratory Theme of the NIHR Manchester Biomedical Research Centre.

He says: “For me, the RVCs have first and foremost been an almost ideal way of having a dialogue between primary and secondary care. From the feedback we have had, this has worked well for the participating practices and I have certainly learned a lot.”

The RVCs Jørgen has been involved in have lasted two hours each and almost all of them have been with the same CCG pharmacist.

He says “It is quite amazing what you can get through in two hours! We always start with the search prepared by Katie and talk rational pharmacotherapy and stepping ICS down, but over the 2 hours we end up spending a lot of time discussing COPD in general. For me this is wonderful as we get to discuss smoking cessation and pulmonary rehabilitation/physical activity – my two favourites.”

Dr Georges Ng Man Kwong, Consultant Chest Physician, Pennine Acute Hospitals NHS Trust

Georges decided to pilot a RVC in 2013 when he took on the role of clinical lead for the Pennine Lung Service, an integrated respiratory service based in Oldham.

It took about two years to set up because the service wasn't commissioned and everyone was working on it in their spare time. Eventually they set up an RVC pilot, based on the London model, in nine GP practices.

They spent up to three hours in the clinics with the GPs and/or the practice nurse, then measured the changes. They made recommendations to change treatment and modify approved treatment in about 60% of patients, reduce or stop ICS therapy in one in four patients and nearly a third of patients were identified as being suitable for pulmonary rehabilitation. A small number of patients were recommended for further investigation for other lung

Learning points - Dr Georges Ng Man Kwong

- Recognise the power of collaboration and breaking down the barriers between the different cultures of primary and secondary care. The shared learning is beneficial for both sides. As a secondary care consultant I've learnt a lot about the primary care challenges and perspectives and just how well GPs and practice nurses know their patients. For example, we can give people drugs and pulmonary rehabilitation until the cows come home, but this will be ineffective if the root cause of their problem is that they are lonely and anxious. In these situations we need to identify other services in the community that can help them. I now have a much more holistic view of patients.
- It is important to spread the word about RVCs – they reduce prescription costs, improve patient care and quality of life and reduce hospital admissions.
- RVCs should not be held in isolation. They should be part of a wider model of integrated respiratory care.

diseases such as bronchiectasis, and a few patients were taken off the register.

Dr Kwong is now working closely with Oldham CCG to develop an asthma RVC. He says: “The idea is that the RVC will be one part of a respiratory model, not just for COPD but for all lung disease, and the virtual clinic will be just one component for a transformational change of service within a GP cluster (one of five) in Oldham. The aim is to formally evaluate another pilot within the cluster, establish a network and then take that blueprint out to the rest of the locality. Going forward I very much hope the RVC model is an idea that will catch on.

“The challenge has been to engage busy GP practices. There is little published evidence on RVCs and the service we were setting up wasn't commissioned. But the practices we did connect with gave some very positive feedback on the clinics. For the future I hope eventually we will be able to upskill our primary care colleagues so that they will be able to do the virtual clinics themselves.”

“On a personal level the RVCs have changed my attitude and mind-set. I now feel I'm serving the local community rather than the hospital and my perspective is much more patient centred and holistic.”

“RVCs are a slow burner but there is definitely a future for them within integrated respiratory care services.”