

Consultant Physicians in Integrated Respiratory Care

A discussion paper from the British Thoracic Society

Introduction

There are over thirty respiratory conditions many of which are long term. *Our Health, Our Care, Our Say – a new direction for Community Services*, sets out the Government's vision for the future of care outside hospitals. There have been a number of initiatives which have subsequently led to the care of patients moving from what was traditionally known as secondary care to care in the community nearer the patients' home. Respiratory physicians are comfortable with such a move as long as it can be demonstrated to provide better standards of care for patients. The large number of respiratory conditions and the fact that the symptoms of lung disease are shared with disorders of other systems means that accurate diagnosis is essential. Many of these patients have multiple diseases and the correct apportioning of symptoms to each disorder is of vital importance; this is not always fully appreciated by all involved in the care of these patients. Some health authorities have recently made innovative appointments of consultants in integrated respiratory care and this informal British Thoracic Society (BTS) document is intended to inform discussion regarding the possible role and value of such appointments. *The BTS emphasises the need for evaluation of such innovations*. Such innovations may or may not prove to be effective/cost effective and thus need rigorous independent evaluation. In parallel fields, studies of innovative new ways of delivering health care have not always been shown to be truly more cost effective than traditional methods. This report covers the work which might be undertaken by consultants in integrated respiratory care, the advantages and disadvantages of such an approach and outlines the potential working relationships and training needs.

Possible roles for a Consultant Physician in Integrated Respiratory Care

Consultants in integrated respiratory care in post at present have arrived from differing backgrounds with different funding and contractual arrangements. However the driver for appointment has usually been a desire to keep patients out of hospital, with the single biggest client group being those with chronic obstructive pulmonary disease (COPD). However such appointments should have a wider brief and will certainly involve both clinical responsibilities, medical advisory responsibilities and training responsibilities. Specific responsibilities might include

1. Introducing, promoting and aiding coordination and integration of respiratory care between what was traditionally regarded as the primary and secondary care sectors.
2. Providing medical leadership in the multi-disciplinary team for the existing integrated services with a special reference to COPD admission avoidance and early discharge schemes, and to pulmonary rehabilitation and oxygen assessment services
3. Supporting high quality pulmonary function assessments in the community. This might involve support for practices providing their own spirometry and measurement of oxygen saturation (where issues of health and safety and competency in interpretation are of great importance) but might also involve provision of a centrally directed, peripatetic service.

4. Acting as a learning resource for respiratory medicine and providing continuing education for general practitioners and practice and community based nursing staff.
5. Working closely with and mentoring GPSIs
6. Trialling and *evaluating* outreach clinics both within individual practices (place of work teaching) and in community based consultant clinics.
7. Assessing and managing patients with complex breathlessness in the community; liaising where appropriate with cardiac services and cardiac failure teams
8. Working with others to promote better end of life care for those with severe lung disease (including COPD, lung cancer, diffuse parenchymal lung disorders and cystic fibrosis)
9. Developing new services for patients with respiratory ill health and more specifically ensuring high standards for those receiving home ventilation. They might similarly develop new services for patients with diffuse parenchymal lung disease, many of whom currently suffer much discomfort and fall outside existing COPD services and palliative care services.
10. Trialling and evaluating community based follow up services for those with obstructive sleep apnoea syndrome being treated with nasal C.P.A.P
11. In some areas it may also be appropriate for the consultant in integrated respiratory care to be the provider of medical advice to the TB nursing team.
12. An opportunity exists for such a consultant to develop a high profile in the promotion of good respiratory health – promoting tobacco avoidance, the value of exercise, clean air and the avoidance of obesity.

Possible Advantages and Disadvantages of Consultants in Integrated Respiratory Care

The advantages of readily available medical advice and support to the services outlined above should be self apparent but needs evaluation. The aim is to ensure consistency of care both in terms of accuracy of diagnosis and optimal management. It is to be hoped that this leads to less waste of resources and unnecessary admissions and earlier diagnosis of both primary and secondary morbidities. A consultant in integrated respiratory care has the potential to liaise with palliative care teams and community heart failure teams and should be able to provide leadership within strategic groups. Potential disadvantages of this approach would be if the model is not cost effective and attention also needs to be paid to the question of who retains clinical responsibility for patients. In the short term there may also need to be some attention paid to record keeping and who owns and who maintains patient records. This should become less of an issue as we introduce electronic health care records.

With regards to potential financial benefits, commissioners should be aware of the possibility that such an appointment could increase, rather than decrease, respiratory workload – the iceberg scenario, and there is almost certainly considerable unmet respiratory need in the community at the present time.

Working Relationships

The consultant in integrated respiratory care would clearly be only one small part of a multi disciplinary team and it is essential that she or he has close working relationships with both community and hospital colleagues with special interactions with respiratory nursing teams, community matrons, general practitioners, general practitioners with

special interest, physiologists and clinical scientists, practice nurses and physiotherapists. To ensure the correct development of such a speciality the consultant would also need to liaise very closely with commissioners and primary care trusts and social services.

The question as to who employs the consultants and how the post is funded and its longevity needs careful attention as does the need for joint appraisal and line management. A Consultant at the beginning of their career who entering this sub-speciality will need to maintain a significant hospital presence for access to clinics and diagnostic facilities but also to take occasional part in an acute medical rota in order to develop and then maintain their clinical skills and credibility. A mid-career or late-career Consultant who changed to work as a Consultant in Integrated Respiratory Care in the locality in which he or she was previously employed might have already gained enough experience of acute illness and local resources and might not need to do acute medicine. Inevitably such an appointee might soon become indispensable and problems might arise regarding the covering of leave. In some large districts the responsibilities might be such that two or more consultants in integrated respiratory care are needed (for example where one develops a special expertise in home ventilation); in other districts there may be one substantive consultant in integrated respiratory care but some of his/her hospital sessions may be back filled in the community by traditional secondary care consultants undertaking some community functions (teaching, outreach clinics etc). In the short term at least where there is a GPwSI some cross cover arrangements may be mutually beneficial. Contracts and continuity of employment will clearly need to be similar to those for existing respiratory consultants if high quality applicants are to be attracted to these posts.

What Training Might be Necessary to Produce Tomorrows Consultants in Integrated Respiratory Care?

Many of the clinical responsibilities of such an appointee would be for liaison with pulmonary rehabilitation, admission avoidance and hospital at home schemes which are already a growing part of respiratory trainee's activities. However many of these will need strengthening for a consultant in integrated respiratory care and further discussion between the BTS, SAC and registrar training programme directors is necessary. Some of the issues will be broader than respiratory medicine alone and will need to be addressed by the successor to the JCHMT. The British Thoracic Society will also be in discussion with colleagues in diabetes, rheumatology, cardiology and dermatology about potential common areas of training. Some additional training in primary care and community services may also be appropriate.

Conclusion

It is not always appreciated by those outside the speciality how diverse are the conditions cared for by respiratory physicians and nor is the full extent of poly morbidity appreciated. The overlap of symptoms of lung disease with disorders of other systems is so great that the highest standards of diagnostic acumen and diagnostic facilities are needed if the best modalities of treatment are to be selected for patients. There is likely to be a considerable unmet respiratory need in the community and the appointment of consultants in integrated respiratory care represents an exciting way of enhancing the care of those with lung disease but its cost effectiveness and quality and safety needs to be carefully evaluated.

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This report has been put together as the result of informal discussion between a number of interested parties and subsequently sent for consideration by experts in primary care and secondary care and nursing colleagues, and also colleagues in other parallel medical disciplines. Their input is much appreciated

MRP 07/11/07