QuDoS Multiple sclerosis: NHS case studies 2019

Team of the year commendation

Your name, job title and centre

Hertfordshire Neurological Service, Central London Community Healthcare NHS Trust (formerly West Herts Community Neuro Team Central London Community Healthcare)

Project / initiative name

A variety of MS treatment pathways were developed to provide overall 'joined up' MS care; pathways covered vestibular dysfunction, advanced MS, physiotherapy and exercise, palliative support, and social and mental health

Project start date

March 2019

Challenge

1. A need existed to ensure MS patients with differing care requirements were provided with specialist, optimal services by the healthcare professional with the most relevant expertise (eg, dietician, physiotherapist, speech therapist etc)
2. Separate, siloed team specialities and solo patient visits were putting pressure on healthcare professionals who were over-burdened and unable to deliver optimal care within their specific skillset
3. Care for patients with complex, interdisciplinary MS cases, which required the involvement of multiple specialist teams, was not always well-coordinated (eg, where a hip replacement for an MS patient required involvement from orthopaedics MS specialists and physiotherapists)
4. Service changes had previously resulted in risk of patients with complex cases being side-lined between services and lost to follow-up

Solution

- New care pathways were established through joint (multi-disciplinary) team working for patients where there was an unmet need (eg, MS patients with vestibular dysfunction, patients that haven't engaged with exercise or those whose quality of life could be improved with specific equipment)

Solution cont...

- Joint triage was introduced to help identify MS patients where there was an unmet care need; the approach identified what the need was (eg, physiotherapy, orthopaedics etc), which specialism was needed (eg, speech therapist, dietician etc) and how the need could be addressed (eg, visits, equipment, access, education)
- Patient visits were optimised to include only those specialists whose expertise was needed in each case (a tailored approach)
- Working relationships were developed between specialisms to ensure that care teams were receiving the 'full picture' for each patient
- Care providers from all specialties were educated in multi-disciplinary team working (eg, learning how to identify at the referral stage who has the relevant specialist expertise)
- Specialist tools were developed to help identify patient needs; for example, the multi-disciplinary team developed a series of questions specific to vestibular dysfunction to enable accurate screening; patients identified as having vestibular dysfunction were then referred for specialist rehabilitation
- Liaison with other services allowed for better planning (eg, patient visits were arranged in parallel with visits from carers, health and social care, district nurses or mental health team colleagues)
- Close links were also established with local community groups, charities and businesses (eg, the local gym runs MS exercise classes in a 'toning suite' and collaborative working with the gym instructors has increased their knowledge and skills for supporting people with MS)
- Weekly joint team meetings were set up to discuss complex cases and share the burden of care across the multi-disciplinary team.

Results

- Burden of care was reduced overall for MS team staff
- Patients were provided with more specialist, tailored and relevant care
- More patients now have access to services that are of value to them (eg, the 'toning suite' at the local gym, standing frames etc)
- F2F conversations with specialists have led to patients being more able to understand care recommendations and therefore comply with their treatments (eg, where new equipment was recommended to improve their quality of life)
- MS team members now work closely with specialists which has led to improved cross-disciplinary knowledge; this translates to burden of care reduction for specialists in the long-term too
- MS team members are empowered to involve the relevant specialists immediately, whilst avoiding over-burdening other specialisms where there isn't a clear patient need.

Next steps

There are plans to improve team working further by strengthening existing links and increasing multi-disciplinary team F2F meetings (where of value), plus building connections with more specialties (eg, respiratory specialists).

What was the biggest challenge?

Service change and structural re-organisation was a major challenge, plus commissioning managers willingness' to support activities that were not a strictly specified part of their services remit.

How did you overcome the challenge?

Cross-disciplinary team working, plus increased specialist knowledge and understanding of MS has allowed development of the different care pathways. The team were able to demonstrate, using data and case studies, where there were clear unmet patient needs and then focussed in on those areas.

What would be your advice to others wanting to replicate this project?

- Identify which specialists are needed for individual patients as early on as possible
- Conduct joint triage with other healthcare professionals, if available – where resources are not available, have conversations with patients at the referral stage to encourage them to pursue specialist care (where there is a clear need or potential for patient benefit)
- Foster a good working relationship with other specialists and learn how to communicate clearly and assertively with colleagues about when a specialist should be involved (be direct with team members)
- Conduct multi-disciplinary group visits where appropriate but always ensure that there is a clear rationale for each specialist to be involved (to ensure best use of time)

Testimonial quote

From a wheelchair-using MS patient

"It helps for my care to be coordinated by three people coming together. I felt heard and understood, and confident my needs would be met."

From an MS patient

"I've been using the training suite four or five times a week for about ten weeks... In addition to feeling stronger and having increased energy, the main benefit has been the great sense of well-being... this is helped by the very welcoming and professional, knowledgeable staff at the centre."