Greener AHP Case Study Report

NELFT

**Pandemic Innovation: A Home-Visiting Service for Laryngectomees**

Partner Organisations – **N/A**

Topic area/Greener NHS workstream:

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| Adaptation | |  | Communications and engagement |  | Estates and facilities |  |  | Food, catering  and nutrition |  |
| Funding and  financial mechanisms | |  | Medicines |  | Research, innovation and offsetting |  |  | Strategic ambition |  |
| Supply chain | |  | Sustainable  models of care |  | Travel and transport |  |  | Workforce, networks and system leadership |  |
|  | Other (please specify): | | | | | | | | |

**For more information about the themes, see** [*Delivering a ‘Net Zero’ National Health Service*](https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/) **report (pp.64-74)**

Key message/aim:

**Our new domiciliary service led to unanticipated benefits for the local environment in terms of reduced travel miles. These were only recognized through following a formal Quality Improvement approach which requires the routine collection of ‘balance measures’. Teams should consider measuring potential sustainability outcomes for all projects, even where this is not the primary focus of the project.**

What was the problem?

The Speech and Language Therapy (SLT) department at North East London NHS Foundation Trust (NELFT) offers specialist laryngectomy rehabilitation in North East London. This region is diverse with areas of high social deprivation. The service includes care of the permanent neck stoma and management of surgically placed voice prostheses.

Historically, clinics were offered at a local acute hospital. In March 2020, outpatient clinics were closed. Initially, another hospital provided emergency support, however this was unsustainable and some patients, concerned about travelling and covid exposure, declined appointments. Waiting times rose to 83 days, increasing the risk of avoidable medical complications.

What was the solution?

Patients expressed their preference for local care, concerns around attending large, public hospitals and around delays to care. They welcomed the idea of home visits.

We engaged with professional stakeholders (other SLT services, professional advisors, ENT colleagues and trust clinical leadership). This ensured changes were clinically robust, safe, and additional support requirements were in place.

The new protocols required additional equipment, staffing changes and risk assessments:

* Two laryngectomy specialist SLTs
* Emergency equipment, including defibrillator, suction machine, and bag valve mask
* Covid-secure PPE
* Completed risk assessments for every appointment ensuring:
  + Safe working environment – clean, access to running water, electricity, space for equipment
  + Low-risk clinical history, i.e. recent prosthesis changes all uneventful, no new tissue changes, no significant deterioration in general health, capacity to consent
  + High clinical risk associated with non-intervention, e.g. likely pulmonary aspiration, dislodgement of voice prosthesis

Multiple outcomes were measured using statistical process control charts.

Primary outcome: waiting time to appointment

Balance measures:

* distance travelled (by clinicians and patients)
* adverse events
* service user ratings (efficacy, comfort, safety, quality)

Qualitative data:

* service user survey
* informal feedback from clinicians

What were the challenges?

Laryngectomy home visits are largely unprecedented in the UK and most specialists anticipated threats to patient safety working outside of a hospital setting. This combination of concern and lack of experience slowed the development and approval of protocols. Financing and ordering of equipment also delayed progress.

What were the results/impact?

* **Patient outcomes:**
  + Waiting times reduced from 83 days to 4 days (average)
  + Service users felt safe, comfortable and that care was high quality
  + No serious adverse events and no increase in non-urgent ENT intervention
* **Environmental impact**
  + Combined distance travelled per appointment (patients and clinicians) reduced slightly
  + Since the easing of pandemic restrictions, car sharing for clinicians has been re-introduced, halving the distance travelled noted during the study
* **Social impact**
  + Likely clinical benefits in the early weeks post-surgery and during palliative care
  + Travel burden has reduced significantly for patients and their loved ones
  + Non-attendance rates reduced slightly compared to pre-covid, suggesting improved accessibility
  + Increased joint working with other community services for vulnerable patients, including: people with English as a second language, dementia, lacking access to private transport, at the end of life, or who were clinically extremely vulnerable to covid
* **Financial impacts**
  + Capital outlay for additional equipment, including: equipment bag, defibrillator, suction, bag valve mask, sharps box
  + Increase in clinician mileage (uncosted)
  + Reduction in overhead costs, due to significant reduction in use of room in hospital outpatient setting (uncosted)

What were the learning points?

Home visits for people following laryngectomy are safe and effective. They are the preferred model for NELFT patients, with 94% requesting home visits in the future. They brought unanticipated benefits supporting people to adjust post-operatively and manage increasing symptoms at the end of life.

The redesign of our service, away from a centralised, hospital-based model, to a domiciliary service, has had benefits over and above the anticipated improvements in access to services and patient satisfaction. The change has had a significant impact on the travel miles required for the service, with a reduction effectively in both emissions and local traffic. If this model were adopted for other, hospital-based services, there could be significant benefits for the environment and local conditions.

Although we were aware our patients favoured a community-based model, due to perceived clinical safety concerns, we initially followed nationally recommended practice, advising patients to access care at hospital. In future, we will be more confident in using our patients’ preferences to drive change, rather than wait for potential adverse outcomes to ‘force’ it.

Next steps

To put the service on a secure, future footing, we are now engaging with our patients and carers in a full experience based co-design (Point of Care Foundation) project to consider the strengths and weaknesses of the current service model and collaboratively undertake further innovative work to improve care.

The team has presented the project at national and international conferences and continues to publicise its work to a wider audience via its twitter profile @NELFTAdultSLT. The team is also in the process of writing up the original project and plans to write up the coproduction project for publication.

What the team and/or patients and carers had to say:

Patients and carers consistently reported high levels of satisfaction with the domiciliary service. Their perception of benefits to care mirrored the impressions of staff.

‘I think it’s important that SALT comes to homes. To be honest, there have been days when dad felt quite rough and if we had to get him in the car, it just wouldn’t have happened. He was weak and walking of any kind would have meant he just didn’t receive care.’

‘Being able to have them come into the home helped me know how to care for myself at home – because if they could do it here, so could I!’

Resources and references

Tordesillas, S (2020) Laryngectomy SLT Management in the Community. Guys and St Thomas’ NHS Foundation Trust and Lewisham and Greenwich NHS Trust (personal communication).

RCSLT (2009) ‘Prosthetic Surgical Voice Restoration (SVR): The role of the speech and language therapist.’ London: Policy Statement.

Want to know more?

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External partners involved: N/A

Has this case study or story been made public in any form before?Yes – conference presentation