Providing Integrated Care for Respiratory Patients

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The Kings Fund
Shaping the Future Workforce to Support New Models of Care
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Traditional Training

- Disintegrated
- Fragmented
- Unjust
Further Training: Cystic Fibrosis
A model of integrated care

**Lifetime care** for the person with CF across transitions
Excellence in clinical practice, teaching and research

Address the **biological and psychosocial needs**
AND their **families/carers**
Including end of life and palliation services

A shift from tertiary centred management of the person with CF to a **multidisciplinary community centred approach**

Offering the person with CF and their families an opportunity for **effective self management** using a wellness approach instead of an acute hospital-based approach.
Co-ordination
Communication
Compassion

Integrated care: what do patients, service users and carers want?

Top Lines
People want co-ordination. Not necessarily (organisational) integration.

People want care. Where it comes from is secondary.
Whittington Health: A New Context, a New Challenge

Acute general teaching hospital
Integrated Care Organisation formed April 2011
Whittington Hospital, NHS Haringey & NHS Islington community services

Provide care to a multi-ethnic inner city population of ~ 500,000

High levels of deprivation
- High smoking prevalence
- High rates mental illness
- Multi-morbidities
- High premature death rate
Enabler 1: Identification of key population group & service area

Islington

COPD Patients
3,400 diagnosed (~4000 Undiagnosed)
Mean age 72
~40% live alone
~30% current smokers
~400 emergency admissions per year

GPs 36 Practices
Enabler 2: Colleagues with a Shared Vision

2002 Early Discharge Service
2004 Chronic Respiratory Support Team for patients with:
- Severe COPD
- Complex with co-morbidities
- High risk of death
- Frequent or Long admissions

In order to improve quality of life & reduce readmissions and bed days without increasing GP workload.

Cost effective - ~1000 bed days saved each year
GP & Patient feedback - excellent
Single point of contact
..... patients told us what was difficult for them
Enabler 3
‘Integrated Respiratory Physicians’

Promoted by the British Thoracic Society & IMPRESS
Designed in Collaboration
Aligned with Trust Policy
Commissioned by our CCG

Genuinely working across acute & community care sites
5 PA’s Divided between 2 consultants

3 PA’s: Enabling, Up skilling and Collaborative Work
- Community Respiratory (CORE) MDTs
- GPs
- Practice nurses, District Nurses & Community matrons

NOT EXPORTING OUTPATIENT CLINICS

2 PA’s – Strategy and Service Development
Enabler 4: Multidisciplinary Community Respiratory Teams

**Whittington Health Community Respiratory (CORE) Team:**
• Three locality based teams
• Specialist nurses, Physiotherapists, Stop Smoking advisor, Psychologists, Dietician, Pharmacist,
• Third Sector (AgeUK, SHINE)
• Holistic Virtual ward rounds (Consultant led)
• Focus on evidence based practice & competencies
• Supported by IT link with hospital electronic records
• Home Visits where appropriate

6/12 audit 2013: 122 patients
Complex disease & challenging psychosocial needs:
• 14 new respiratory diagnoses
• 164 evidence based management interventions
• 64 referrals to improve co-ordination of care
• Low mortality (3 patients ~2%)
Enabler 5: Integrating and Sharing Information Electronically

- iPad database App (quite cheap)
- Easy to design and fast to enter data
- Synchs over wifi with a desktop version (visible to hospital based teams if on shared drive)
- Easier sharing of records between CORE team members (email)
- Better security/encryption options cf paper notes
- More readily extractable date for audit/service improvement
- More uniform documentation (governance issue)
- Easier transparency of workload (service planning)
- Easy sharing of decisions with GP (email of text files) and uploaded onto hospital shared drives
Islington COPD Local Enhanced Service
Improving case finding, diagnosis and evidence based management
Designed and delivered through collaboration
High value outcomes:

- 25% increase in diagnosed COPD prevalence between 2010 - 2013
- 93% increase in referrals to pulmonary rehabilitation between 2010-2012
- 72% of people on COPD register now have self management plan
- 16% decrease in COPD emergency admissions in 2011/12 vs 2010/11
Enabler 7: Face to Face Communication and Collaboration

GPs Practice Visits
Whole practice

- Content driven by GP preference
  - Case discussions
  - Presentations

- Value of face to face contact and open forum

- Better appreciation of variation in practice, patient experience, and need to support GP training and upskilling

- Importance of practice nurses
Islington COPD Nurse Champions

- Funded by Islington Public Health
- Open to practice, district, prison & care home nurses
- Educational sessions
- Supported projects in respiratory areas
- Improve standards, share learning
Enabler 8: Responsible Prescribing Group (RPG)

Respiratory Pharmacist embedded in MDT

RPG Consultants
GPs,
Nurses,
Pharmacists

- Shared Care Guidelines >10 years
- Collaborative work across pathway
- Respiratory Medications – inhalers!
- Quit smoking medication
- Safe and appropriate O₂ Prescribing
Key Principle 1: Shared narrative, shared decision making and supporting behaviour change

- Funded Respiratory Clinical Psychologist sessions
  - Motivational interviewing team training
  - Reflective Practice within team

- Co-creating Health Clinician training

Almost all of the multidisciplinary team
Key Principle 2: Integrating Chronic Illness With living well

‘Breathe better, feel good, do more’

“Social Prescribing”

✓ Long-Term Exercise
✓ Breathe Easy Groups
✓ ‘Sing for your Lungs’
Planning for the Future: Integrated Respiratory SpRs

British Thoracic Society (BTS) recognises the need to train respiratory consultants in integrated working

2010 Respiratory Curriculum Competencies:
"Managing Long Term Conditions: Integrated Care and the Promotion of Self Care"

Broader potential: Long Term Conditions’ Leads
Manage patients with multi morbidity patients where breathlessness is the dominant symptom

Training program includes community AND wards
Working as an Integrated Physician in hospital: Leading a multidisciplinary respiratory team

MDT ‘Board’ Rounds

Liaison Psychiatrist
Respiratory Nurse Specialist
Integrated Respiratory Pharmacist
Occupational Therapist
Respiratory Physiotherapist
Social Worker
Quit Smoking Advisor
Quit Smoking Advisor for house-bound patients

MDT Ward Rounds

Respiratory Team Psychologist
Community RNS
Alcohol Advisor
Hospital Enabler: Colleagues with a Shared Vision

Porter ME; Lee TH
NEJM 2010;363:2477-2481; 2481-2483

*includes experience for population

stewardship of resources

‘Integrated’ Respiratory MDT Teams

London Respiratory Network
www.networks.nhs.uk/nhs-networks/london-lungs
What is High Value Respiratory Care?
COPD ‘Value’ Pyramid

- **Stop Smoking Support with pharmacotherapy £2,000/QALY**
- **Flu vaccination £1,000/QALY in “at risk” population**

*Editorial*

Figure 1. The pyramid of value for COPD interventions developed by the London Respiratory Network with The London School of Economics (modified from19) gives estimates of cost per quality adjusted life year gained. LABA, long-acting β2 agonist; QALY, quality adjusted life year.
Hospital Enabler:
Identification of inpatient population & needs

- Worsening/‘exacerbation’ of long term conditions
- Multi-morbidity and Poly-pharmacy
- Mix of physical & mental illnesses including
  - Drug and alcohol dependence
  - Diagnosed and undiagnosed dementia
  - Morbid obesity
- Difficult life situations including
  - Alone, homeless and from prison
- Communication Needs
  - Learning Disabilities
  - Not able to speak or understand English
  - Not able to read
- Tobacco dependent
- High risk of premature mortality
Hospital Enabler: Identification of population & needs

'1 in 5 deaths due to smoking'
Colleagues with a shared vision: Quit smoking as treatment for sick smokers
Hospital Enabler: Enhanced Recovery 1

‘Get better’ as effectively as possible
What matters to patients ....
Right **diagnoses** & right **treatment**
Every inpatient day counts - **green** days not **red** days

Ward managers & nursing teams

Quit smoking advisor

Consultant physicians & medical trainees

Respiratory Team Psychologist
Hospital Enabler: KREDIT

Kindness
Respect
Empathy
Dignity
Interest
TRUST

Shorthand for respiratory team shared approach to patient care ... and team work
Hospital Enabler:
Enhanced Recovery 2

Anticipatory Care Planning with patients & families
Live better with illnesses at home as people
‘Hoping for the best and planning for the worst’ conversations
Safe transitions in and out of hospital

MDT Care Planning Conferences with patients, families and carers
Shared decision making: agreed shared agenda
Identify & address treatment and care gaps & needs

Enable a good death for those who are dying
TOP 10 TIPS FOR COMMUNICATING WITH GPs

- Doctor – doctor phone calls are important to add nuance
- Don’t be afraid to phone the GP and you can’t predict when is a good time, so call when you need to
- Know that an admission is not that frequent an occurrence per GP so have the confidence to phone
- Whenever possible ask to speak to the GP who knows the patient best
- There is always a duty GP available to answer urgent queries
- Phone the GP on the day of admission to ask missing questions: if you need to leave a message with the receptionist, explain how many bits of information are needed and of what type e.g. ‘It’s about medication’ and by when an answer is needed (you can request confidential information)

>1 in 6 people admitted to hospital had not seen their GP in the previous year

Respiratory physicians at GP workshop in community (COPD LES)

Workshop with GPs on respiratory ward

My name is ....
I am ...
My mobile number is ....
Colleagues with a shared vision:
System levers – Data, Bundles, CQINs, LES

MAP 1 - Acute London Hospital Sites with COPD Discharge Bundle

COPD Patients - Proportion with Completed Care Bundles

Whittington Health COPD Bundle CQIN 2013-14

COPD LES 2013-14
Islington Clinical Commissioning Group

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<tr>
<th>Indicator</th>
<th>Monitoring requirement</th>
<th>Payment</th>
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<tr>
<td>COPD 1: COPD leadership, learning and development</td>
<td>Completion of a practice-based COPD learning session and</td>
<td>£600 lump sum per practice</td>
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<td>COPD 2: Case finding</td>
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<td>COPD 3: Supporting self-management &amp; identification of anxiety/depression in COPD</td>
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<td>COPD 4: Additional management of patients with very severe COPD.</td>
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<td>COPD 5: Managing care post unplanned hospital admission or emergency department attendance</td>
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<td>COPD 6: Audit of Medication use in COPD</td>
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Staff flu vaccination

Do you see patients?
If so, have you had your flu jab to keep our shared patients safe?

Nair H, Holmes A, Car J Editorial British Medical Journal 2012;344

Influenza vaccination in healthcare professionals

Should be mandatory
'Care is only integrated when people want it to be, otherwise it does not happen' *

Care Planning Conference Respiratory Ward Whittington Hospital October 2014

*London Respiratory Team feedback from Londoners living with COPD 2013
Shared Leadership: Sharing values and value ...

Specialists in out-of-hospital settings
Findings from six case studies

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London Respiratory Network
www.networks.nhs.uk/nhs-networks/london-lungs