The respiratory specialist role in the integrated care team

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Integrated respiratory care – Respiratory Specialists Role

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Specialist role in integrated care

- Need for change
- New Systems of care for LTC
- British Thoracic Society Survey and Report
- Experience and the future
Need for change
Diagnosis in primary care

- Register is a problem in up to 30% of cases
- FEV1 and FEV1/FVC
- FEV1 % predicted
- Restrictive
- Poor quality

Jones RCM Respiratory Research 2008;9:62
Need for change
Systems, Organisations & Value

- Acute trust
- CCG
- Community
- Social care
- Organisations
- Targets
- Incentives
- Structures

- Fragmented
- Waste
Figure 9: Estimated number of additional acute NHS bed days from 2012/13, by age group, based on demographic projections.
Optimising value of interventions for populations
M Gray BMJ 2012

• All clinical groups should estimate which interventions are most beneficial
• Clinicians have a role in making decisions about ‘value’ – on behalf of the populations they serve.
• Marginal benefit +
• High incremental cost
• Low value
New systems of care for LTC

How to improve quality and productivity by integrating COPD care
Community policies & commissioning value

Systems of Health/Social Care

- Decision support: bundles Guideline training
- Delivery design: Systems Supp disch Providers
- Clinical information
  - Risk profile
  - Registers sharing

Informed, educated Patient

Prepared proactive Team

Productive interactions

Ed Wagner CCM

See also Nuffield Foundation
Would you consider an integrated post at this point of your career? (n=216)
<table>
<thead>
<tr>
<th>Question</th>
<th>Those with a current integrated post (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you work in an integrated team?</td>
<td>94%</td>
</tr>
<tr>
<td>Do you line-manage an integrated team</td>
<td>50%</td>
</tr>
<tr>
<td>Is this part of a commissioned care pathway</td>
<td>81.3%</td>
</tr>
<tr>
<td>Is this integrated role aimed at COPD patients only?</td>
<td>50%</td>
</tr>
<tr>
<td>Does the pathway include processes to transfer or pool budgets</td>
<td>31.3%</td>
</tr>
</tbody>
</table>
Integrated respiratory consultants – the case so far...

• Isolated implementation of respiratory integrated consultants (London, Salford, Hampshire, Nottinghamshire, Warwickshire, Highlands)
• Now, more posts being rolled out in the UK
• Some commonalities between posts; however some significant differences
• Perceived as potential career pathway
Poor advice from NICE – need for understanding & interpretation
Rectangle of population health gain and value for money triangle

- **Value**
  - **Population benefit**
  - **Benefit per person**
  - **Numbers who benefit**

- **VfM**
  - **Costs**
Triangles with good & poor value for money

- Good VfM: Low costs, High population health gain
- Poor VfM: Low costs, Low population health gain
- High costs, High population health gain
Mild-moderate COPD

- Smoking cessation
- Exercise
- Overtreated
- Unnecessarily treated

Population health benefit vs. Total cost (£)

- Negative costs indicate savings.
- Positive costs indicate increased costs.
COPD Value Pyramid
COPD FEV1 >50% predicted

Value = \_\_\_outcome\_\_\_ cost

- **Triple Therapy**: £78,000-£130,000/QALY
- **Two Long Acting Bronchodilators**: £80,000
- **LABA & ICS**: £52,000/QALY
- **One Long Acting Bronchodilator**: £5,000 (LABA)-£8,000 (LAMA)/QALY
- **Short Acting Bronchodilator** (no QALY available)
- **Pulmonary Rehabilitation**: £2,000-£8,000/QALY
- **Stop Smoking Support**: £2,000/QALY
- **Flu Vaccination**: £1,000/QALY in ‘at risk’ patients
Single practice

- 298 patients
- Review diagnosis
- Never smoker 10%

- COPD
- Restrictive change
  - ILD or obesity
- Co-morbidity
- Bronchiectasis
- Asthma
The register - searches

• FEV1 >80% predicted and FEV1/FVC >0.7
• BMI >35
• Never smoker
• DOSE score >4
• FEV1 > 50% predicted on ICS/LABA or triple

Walters JA Factors associated with misdiagnosis of COPD in primary care. Prim Care Respir J 2011;20:396-402

Single Practice

- Changes made in 41 patients
- Overtreatment
- Diagnosis and co-morbiditity

- Savings of £17,000
Single CCG

- 150,000 population – 2677 with COPD
- 20% normal FEV1
- Ownership of the problem
- Diagnostic training
- Bundles & early discharge
- Risk profiling
- Self management
Single CCG

- 14 practices
- 890 patients with COPD
- 23% did not have COPD
- Nurse educators linking systems
- 11% Reduction in emergency admissions
- 7.1% Reduction in bed days
Conclusion
Specialists, Systems & Integrated Care

• New ways of working / different skills
• Systems across organisations
• Various components
• Consistency and variation in populations
• Value for a Healthcare Community

• **Not** just doing clinics in the community