Getting the Vision Right: A multi-disciplinary approach to providing integrated care for respiratory patients

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Dr Irem Patel, Integrated Consultant Respiratory Physician
The vision

For people with respiratory disease in Lambeth and Southwark to experience care that is:

• High value
• Consistent
• Coordinated
• Supported

For healthcare professionals looking after them to have confidence and a clear pathway to deliver care

Southwark Clinical Commissioning Group
Lambeth Clinical Commissioning Group
Context: health care provision

- 2 teaching hospitals (AHSN)
- 2 respiratory teams, ≥ 2 consultants
- One integrated community provider
- 2 CCGs
- 2 GP respiratory leads
- 600,000 population
- 100 GP practices
Context: Lambeth and Southwark

'1 in 5 deaths due to smoking'

London Respiratory Team

Southwark Clinical Commissioning Group
Lambeth Clinical Commissioning Group
KING'S HEALTH PARTNERS
Context: COPD mortality in Lambeth and Southwark
COPD: the disease trajectory

- A story with no beginning……

- A middle that is a way of life……

- An unpredictable and unanticipated end……

Hilary Pinnock et al, BMJ 2011; 342
COPD: organisational factors for improved outcomes

Guideline based therapy
Regular review – clinical registry
Individualised self management
Advanced access to knowledgeable HCP

Decision support
Clinical information systems

Improved outcomes

Steuten et al Int J COPD 2009;4:87–100

Southwark Clinical Commissioning Group
Lambeth Clinical Commissioning Group
High value ("right care") approaches: COPD value pyramid

- Telehealth for chronic disease (£92,000/QALY)
- Triple Therapy (£7,000, £187,000/QALY)
- LABA (£8,000/QALY)
- Tiotropium (£7,000/QALY)
- Pulmonary Rehabilitation (£2,000-8,000/QALY)
- Stop Smoking Support with pharmacotherapy (£2,000/QALY)
- Flu vaccination (£1,000/QALY in “at risk” population)
## Optimal Service Model for COPD care in L&S: Tiers of Care

<table>
<thead>
<tr>
<th>TIER 1: Essential Care</th>
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</thead>
<tbody>
<tr>
<td>- Accurate timely diagnosis</td>
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<tr>
<td>- Case finding</td>
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<tr>
<td>- Disease register</td>
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<tr>
<td>- Annual review</td>
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<tr>
<td>- Disease specific education</td>
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<tr>
<td>- Immunisation</td>
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<tr>
<td>- Smoking cessation</td>
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<tr>
<td>- Diet and exercise</td>
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<tr>
<td>- Responsible resp prescribing</td>
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<tr>
<td>- Self management advice</td>
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<tr>
<td>- Specialist advice as needed</td>
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<table>
<thead>
<tr>
<th>TIER 2: Enhanced Essential Care</th>
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<tbody>
<tr>
<td>- Annual review</td>
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<tr>
<td>- Pulmonary rehab</td>
</tr>
<tr>
<td>- Escalation of therapy</td>
</tr>
<tr>
<td>- Exacerbations in community</td>
</tr>
<tr>
<td>- Post exc reviews</td>
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<tr>
<td>- Post discharge reviews</td>
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<tr>
<td>- Self management plans and rescue Rx</td>
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<tr>
<td>- Bone protection</td>
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<tr>
<td>- Care Planning</td>
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<tr>
<td>- Dietetics</td>
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<tr>
<td>- Psychology input</td>
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<tr>
<td>- Social input</td>
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<tr>
<td>- Case management</td>
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</tbody>
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<thead>
<tr>
<th>TIER 3: Specialist Care in Community</th>
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<tbody>
<tr>
<td>- Admission avoidance</td>
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<tr>
<td>- Early Supported D/C</td>
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<tr>
<td>- Oxygen assessment</td>
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<tr>
<td>- MDT r/v</td>
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<td>- IRT clinics</td>
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<td>- IRT domiciliary r/v</td>
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<tr>
<td>- Complex psychological input</td>
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<tr>
<td>- Complex social input</td>
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<tr>
<td>- Advanced care planning</td>
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<tr>
<td>- Telephone support</td>
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<tr>
<td>- Triage referrals (SPR)</td>
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<tr>
<td>- Education for community HCPS</td>
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</tbody>
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<tr>
<th>TIER 4: Hospital Care</th>
</tr>
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<tbody>
<tr>
<td>- Acute admission</td>
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<tr>
<td>- NIV</td>
</tr>
<tr>
<td>- Complex disease</td>
</tr>
<tr>
<td>- Complex comorbidity</td>
</tr>
<tr>
<td>- Age &lt;50</td>
</tr>
<tr>
<td>- Rapid deterioration</td>
</tr>
<tr>
<td>- Surgical Rx</td>
</tr>
<tr>
<td>- Lung Transplant</td>
</tr>
</tbody>
</table>

VIRTUAL CLINICS
Primary prevention: Accurate diagnosis

- Spirometry screening of high risk patients in community and general practice
- Accurate performance and interpretation of spirometry (ongoing assessment of competencies with support)
- COPD register (ongoing validation with support)
- Stratification of registers by disease severity: mild, moderate, severe
- Enhanced referral pathways to specialist support for diagnostic difficulty

Secondary prevention: Treatment and management of stable disease

- Expanded Templates to guide NICE guideline based management
- Vaccination
- Named specialist respiratory nurse for practice clusters
- Specialist medication reviews by community pharmacists
- Self management education and written individualised action plans
- Anticipatory care Knowledge and support for carers

Tertiary prevention: Treatment and management of complex/severe disease

- Case management by appropriate case manager (respiratory nurse specialist or Community Matron)
- Evidence based oxygen prescribing and follow-up
- Consultant and nurse led clinics with MDT support (including physiotherapy, psychology, dietetics)
- Non Invasive Ventilation
- Planned hospital admission for those who need it

Community Pulmonary Rehabilitation

- Enhanced General Practice and community specialist services
- Enhanced referral pathways to specialist support for diagnostic difficulty

Co-ordinated social care

Specialist and generalist community, hospital and OOH services

- Unscheduled care
- Admission avoidance through intermediate care
- Hospital admission
- Supported discharge to reduce LOS via EDS programme or intermediate care
- Post admission review in consultant and nurse led clinics

Supportive and palliative care

Specialist and generalist community and hospital

- End of life care
- Gold Standards Framework
- Prognostic indicators for primary and secondary care
- Specialist support
- Referral pathways
- Treatment and management

Specialist and generalist community and hospital

Admission avoidance

Education and clinical support

- Smoking cessation, health promotion and self care
- Smoking cessation, health promotion and self care

Health promotion and education

Information and Clinical Audit

Southwark Clinical Commissioning Group
Lambeth Clinical Commissioning Group
Structured admissions and enhanced recovery: the COPD Discharge Bundle

**CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) DISCHARGE CARE BUNDLE**

To be completed on patients admitted with a primary diagnosis of Exacerbation of COPD.

Inform the COPD specialist of all COPD patients within **24 hours of arrival** including patients discharged.

Put patients sticker on this form and ward and fax to Hammersmith 33066 or Charing Cross 17044 or St Marys 27988.

**CARE BUNDLE STEPS**

1. If patient is a smoker offer smoking cessation assistance
   - Non-Smoker
   - Completed
   - Declined

2. Pulmonary rehabilitation screened for suitability
   - First point of contact, either by the CNS Nurse or Physiotherapist, who will assess and refer patient. If not done ward nurse to contact prior to discharge (fax referral form)
   - Referral Made
   - Declined
   - Not Done

3. Self Management
   - Management Plan
     - Given
     - Already has
     - n/a
   - Oxygen Alert Card
     - Given
     - n/a
   - Breathe Easy
     - Given
     - Already has
     - n/a
   - Rescue Pack
     - Given
     - Already has
     - n/a

4. Satisfactory use of inhalers demonstrated and understood
   - Please assess during medication rounds. Observe the patients using the device(s) and document on electronic prescribing record adequate technique demonstrated. (Refer to pharmacist or CNS if extra support is needed).
   - Satisfactory
   - Referral Made

5. Follow up arrangements made and given to patient
   - Spirometry on discharge
   - Outpatient Appointment Requested
   - Community Appointment Requested

- Admission an opportunity for high value interventions
- Specialist review
- Structured admission
- Supported discharge and enhanced recovery
- CQUIN
- Integrated approach

Southwark Clinical Commissioning Group
Lambeth Clinical Commissioning Group
Multidisciplinary integrated care: Supported discharge

Dear [Patient Name],

The Surgery, High Street, London.

RE: XXXXXXXxx, DOB: XX-XX-XXXX, Hospital No: XXXXXXX, NHS No: XXXXXXXX

For your information the above patient has been:
- Discharged from ACPs Assessment Unit at Kings College Hospital following an admission for an exacerbation of their COPD (H3122) on 20/01/2014.

**Diagnosis**
- COPD (H3z-1)

<table>
<thead>
<tr>
<th>Spirometry</th>
<th>Date: 14 February 2012</th>
<th>Read Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEV1</td>
<td>0.59</td>
<td>3090</td>
</tr>
<tr>
<td>FEV1 % pred</td>
<td>20%</td>
<td>3395</td>
</tr>
<tr>
<td>FVC (FVC)</td>
<td>1.65 (52% predicted)</td>
<td>3388 (3386)</td>
</tr>
<tr>
<td>FEV1/FVC or FVC</td>
<td>31%</td>
<td>336R</td>
</tr>
<tr>
<td>Disease severity</td>
<td>Very Severe</td>
<td>-</td>
</tr>
<tr>
<td>MRC Dyspnoea</td>
<td>5</td>
<td>1734N</td>
</tr>
</tbody>
</table>

**COPD Bundle Interventions:**
- Current smoking status and intervention
  - Ex-smoker
- Medication optimisation
  - Inhaler technique checked and therapeutic with devices.
  - Changes to medications made/suggested:
    Changed Carboacta to 750mg twice per day in line with the licensed maintenance dose.
- Pulmonary rehabilitation status
  - Referred to local service, he is due for his first session 27th January at 3pm.
- Self-management plan
  - Agreed and issued (68FV1) provided with a copy of the COPD CCG action plan pages 2-4.

Please review this at his next appointment with you.
Agreed goals with patient to be followed up with GP

### King's College Hospital

**Rescue pack**
- Assessed and suitable for rescue pack. Jim currently does not have a supply. I have asked him to book an appointment with the practice to arrange a resupply.

**Follow-up arrangements**
- Home visit follow-up by the Integrated Respiratory Team.
- Review in outpatient Consultant-led clinic – follow-up to continue at GSTT.
- Telephone support by the Integrated Respiratory Team.

### Additional information:

**Oxygen prescription**
- Mr. XXXX is managed by the HOSAR team at GSTT for his oxygen needs. I have asked them to book a review as he has not been seen in six months since his commencement of LTOT.

### Onward referrals made
- Nil

### Other specialties involved in patient care
- Nil

### Advanced care planning discussions
- Nil

### Patient health improvement goals

<table>
<thead>
<tr>
<th>Goal</th>
<th>Achieved by</th>
<th>Reviewed by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Book a review at the practice to discuss Action plan, resupply rescue pack and arrange flu jab.</td>
<td>two weeks</td>
<td>GP review appointment</td>
</tr>
<tr>
<td>2. Chase up communication to understand current process in arranging more to sheltered housing. Begin to sort his belongings to tidy his house with support from friends.</td>
<td>1 month</td>
<td>IRT Home Visit</td>
</tr>
</tbody>
</table>

### GP recommendations
- Please review goals as indicated above.
- Please resupply an emergency pack of oral antibiotics and prednisolone for this patient to keep at home for the use in the management of future exacerbations.

Following Lambeth and Southwark COPD prescribing guidelines we would usually suggest Doxycycline 200mg for 1 day followed by 100mg for 6 days and 7 days of prednisolone 30mg both for seven days.

Yours sincerely

Kevin Taylor
Typed but not signed to avoid delay.
Responsible Respiratory Prescribing: Virtual Clinics

Clinical session, not a meeting
Focus on high value care
Template to create search patients
Link to medicines management
Review complex cases
Update session
Pharmacist support key

Lambeth and Southwark integrated guideline for the management of COPD
COPD Additional Prescribing and Disease Management Information

Lambeth and Southwark integrated guideline for the management of adult asthma

Southwark Clinical Commissioning Group
Lambeth Clinical Commissioning Group
KING'S HEALTH PARTNERS
Supporting local respiratory skills: integrated delivery of respiratory education

New and exciting training run by KHP/Lambeth and Southwark Integrated Respiratory Team.

COPD, Spirometry, Asthma training.

Open to all healthcare staff with an interest in Respiratory.

Commissioned by Lambeth and Southwark CCG.

Wheezy thinking about Asthma?

Feeling obstructed by COPD?

Out of puff with Spirometry?

Take a deep breath and come along to one of the new and innovative sessions.

There will be 2 sessions on each topic Spirometry, Asthma and COPD above at a range of venues in Lambeth and Southwark across 2014 - 2015. You are welcome to attend any session in Lambeth or Southwark.
High value approaches – COPD value pyramid

- Flu vaccination £1,000/QALY in “at risk” population
- Stop Smoking Support with pharmacotherapy £2,000/QALY
- Pulmonary Rehabilitation £2,000-8,000/QALY
- Tiotropium £7,000/QALY
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Getting the diagnosis right and getting the right care by the right person at the right time
Home oxygen assessments and reviews

<table>
<thead>
<tr>
<th></th>
<th>Mar-12</th>
<th>Jun-12</th>
<th>Sep-12</th>
<th>Dec-12</th>
<th>Mar-13</th>
<th>Jun-13</th>
<th>Sep-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly Southwark</td>
<td>132671</td>
<td>82548</td>
<td>90007</td>
<td>85923</td>
<td>99352</td>
<td>89002</td>
<td>98476</td>
</tr>
<tr>
<td>Quarterly Lambeth</td>
<td>151796</td>
<td>81214</td>
<td>93827</td>
<td>97899</td>
<td>111937</td>
<td>100895</td>
<td>104962</td>
</tr>
<tr>
<td>Quarterly L&amp;S total</td>
<td>284467</td>
<td>163762</td>
<td>183833</td>
<td>183822</td>
<td>211289</td>
<td>189897</td>
<td>203438</td>
</tr>
</tbody>
</table>

Baseline cost – Last quarter of old contract and no HOSAR service - £ 284,467

Mean cost over first 6 completed quarters of new HOSAR and contract - £ 189,355

Savings per average quarter – £95,111

Savings over 18 months of new HOSAR - £570,671
Breathlessness & Cough pathway development

Southwark Clinical Commissioning Group
Lambeth Clinical Commissioning Group
People who make this happen
Resources

NHSE London Respiratory Strategic Clinical Network

Repository for London Respiratory Team 2010-13

Impress – Breathlessness, COPD value work & more…