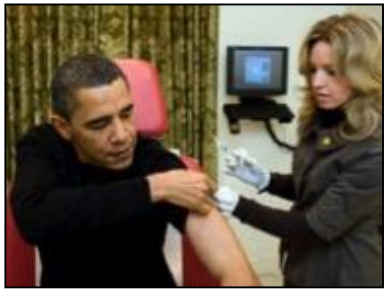
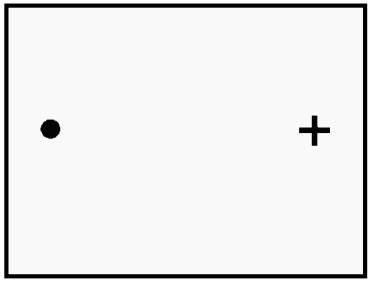
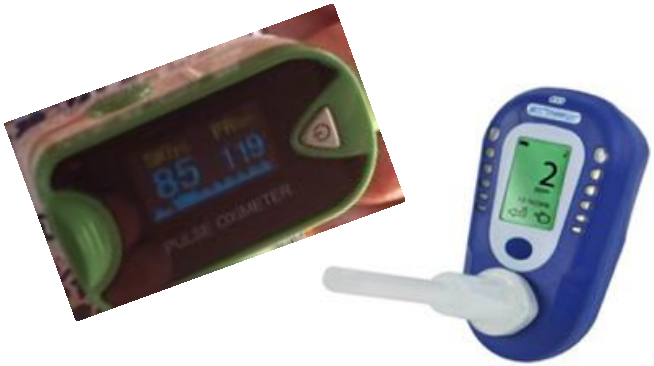
The London Respiratory Network 2010-16 using a VBHC approach

NHS England
London Strategic Clinical Networks





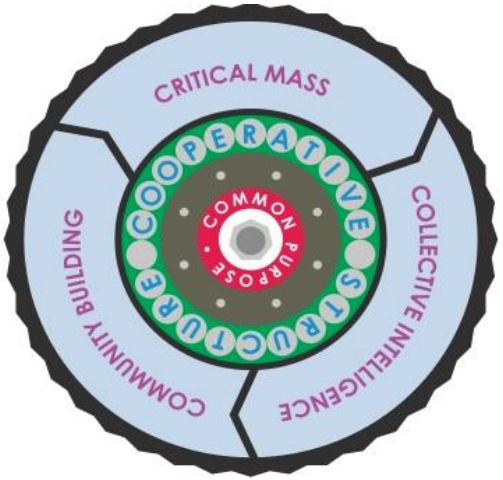


Noel Baxter, GP and Clinical commissioner, Southwark

VBHC – part of a broader strategy

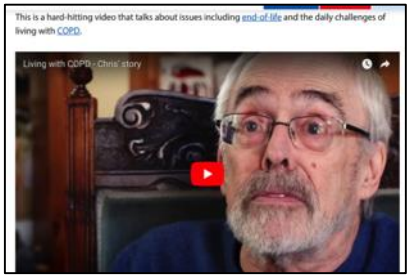
NHS England
London Strategic Clinical Networks

- Used learning from social movements & systems thinking
- Listened to & partnered with **patients & carers**
- Aimed to motivate & enable clinical leaders
- Focused on building **clinical collective leadership***
- Paid attention to **network principles**
- Used **Right Care** & **Value** as frameworks



*Shared leadership Model:
Respiratory Clinician, **GP** & **Programme Leader**

What ‘respiratory’ patients & families told ..and still tell us.. about their **needs?**



It’s 1:30am in the morning and I am alone

Sitting on the edge of my bed, cold but unable to lie down

It’s getting harder to breathe.

My mind is trying hard to keep calm, but I am stiff with anxiety

Shall I call for an ambulance? NO.

‘I don’t want to die’

‘breathlessness is frightening and disabling’

‘hospitals & GP teams don’t talk to each other enough’

‘I want ‘better’ conversations with those involved in my care’

https://www.blf.org.uk/your-stories/copd-affects-every-part-of-my-daily-living

London Respiratory Priorities 2010-16
Right care, value & collective clinical leadership

IMPRESS
improving and integrating respiratory services

***Right* Care**

Doing the 'right things' and doing things right first time

Using Maps

London Respiratory Team working with **Muir Gray** 2010

The NEW ENGLAND JOURNAL of MEDICINE

HOME | ARTICLES & MULTIMEDIA | ISSUES | SPECIALTIES & TOPICS | FOR AUTHORS | CME

Perspective

'Value'

What Is Value in Health Care?

Michael E. Porter, Ph.D.

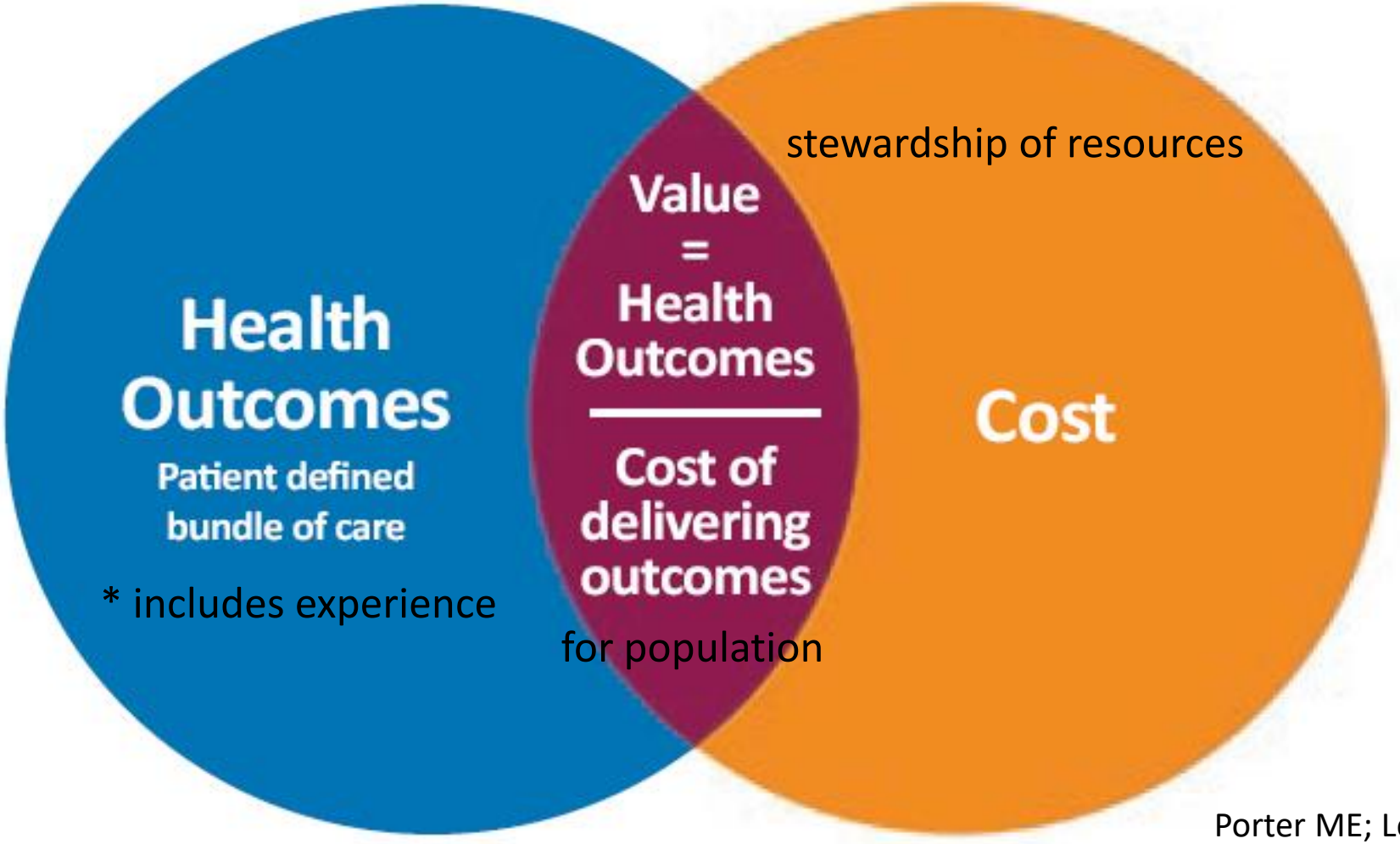
N Engl J Med 2010; 363:2477-2481 | December 23, 2010 | DOI: 10.1056/NEJMp1011024

RightCare

Home | Our Programme

'London Respiratory Team' 2010-2013 – DH funded 'SHA' COPD leadership
'London Respiratory Network' NHSE London funded 'SCN' 2013-2016
London Senate Helping Smokers Quit Programme 2014-2016

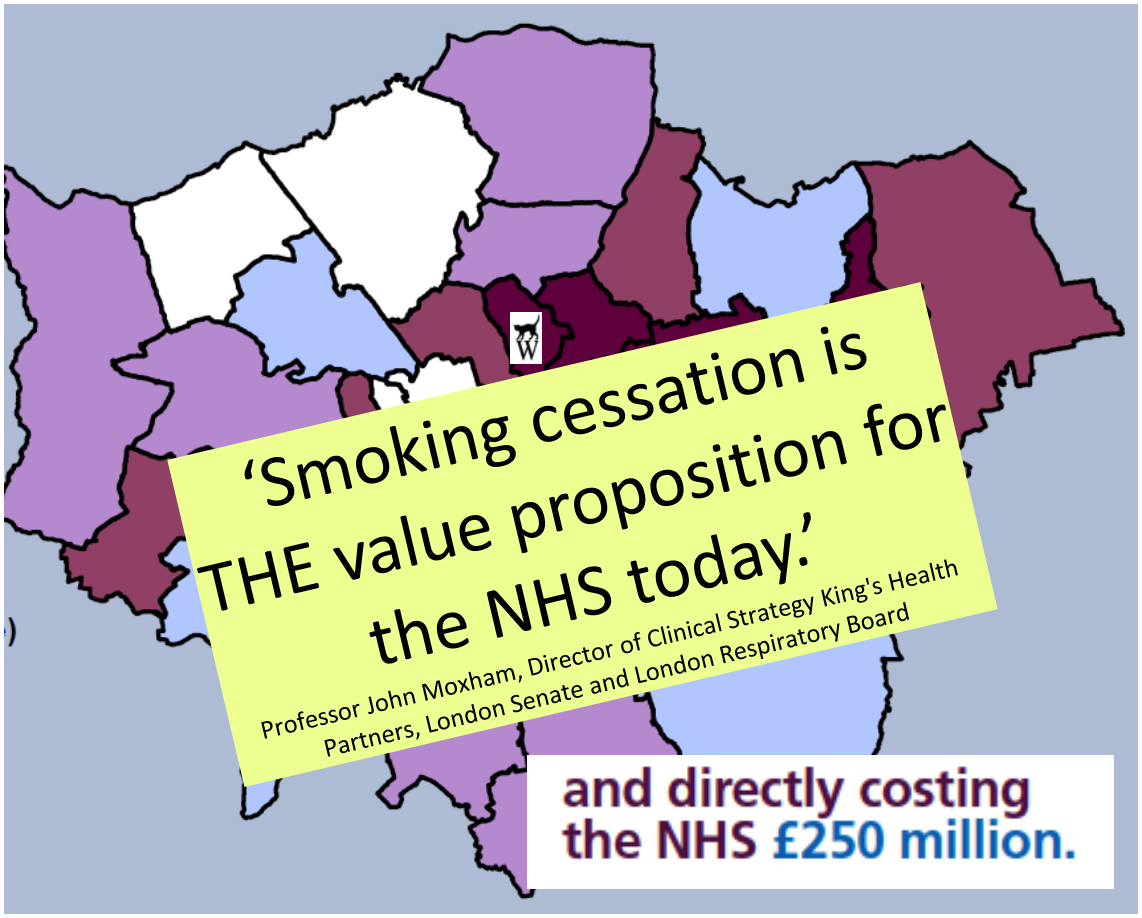
Working out the ‘right’ things to do: using a Value framework

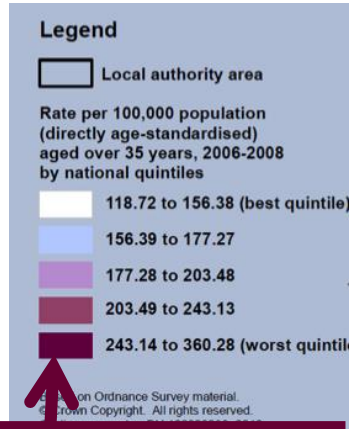


Porter ME; Lee TH
NEJM 2010;363:2477-2481; 2481-2483

Londoners' dying from smoking

1,125,000 smokers in London and smoking causes 8,175 deaths/year*

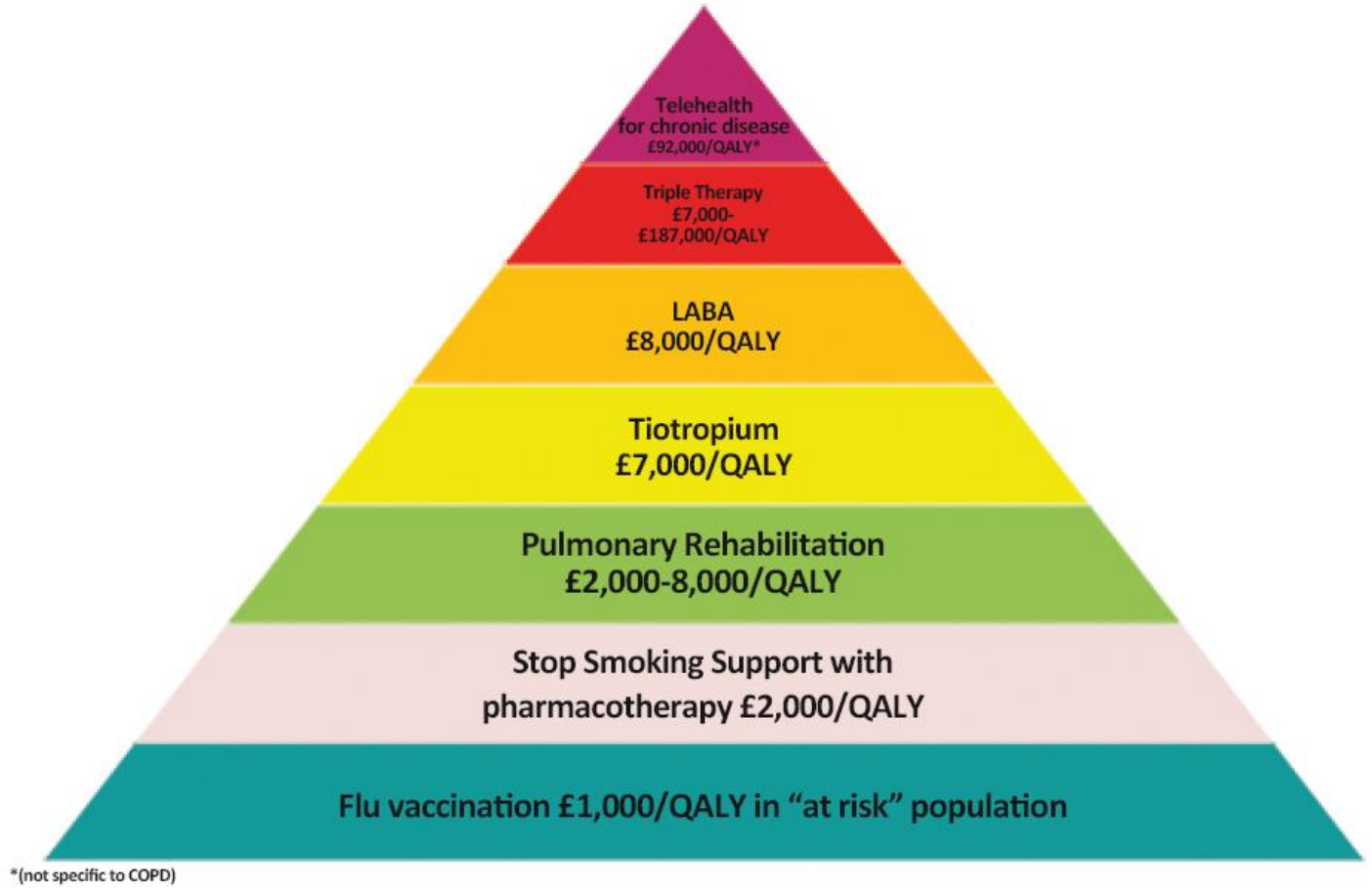




'1 in 5 deaths due to smoking'

*London Senate Helping Smokers Quit Programme Report 2016

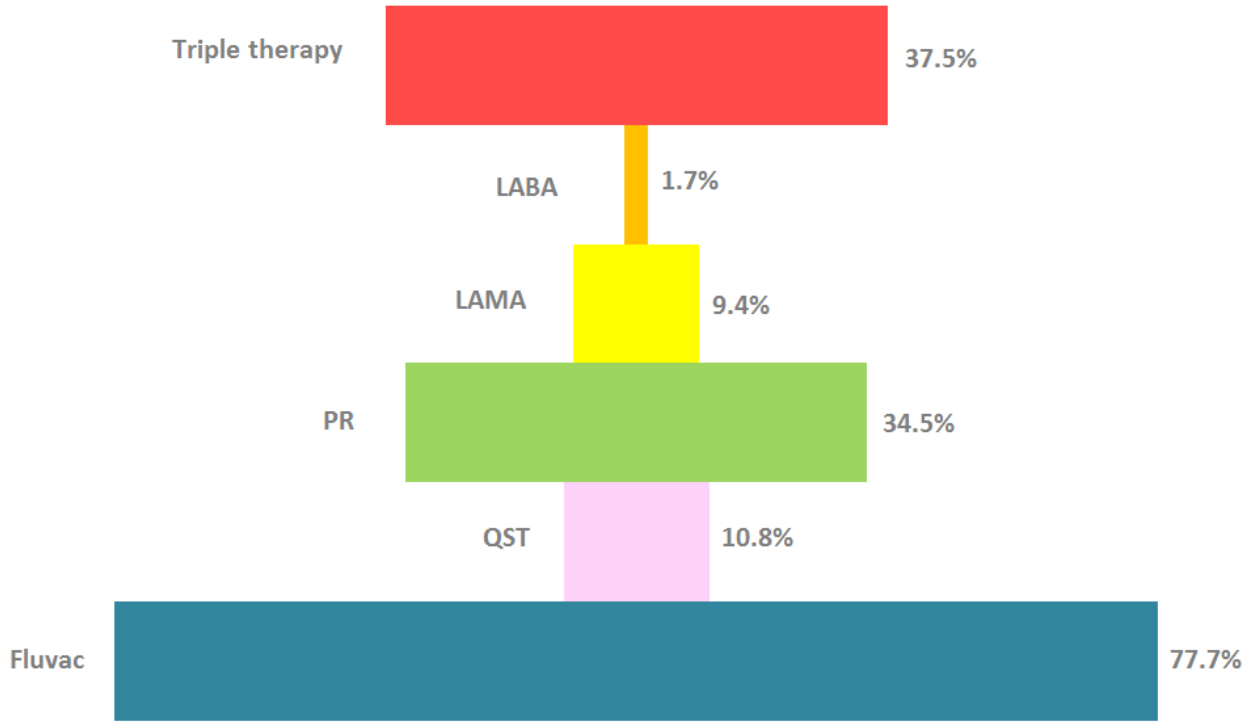
What is High Value Respiratory Care? LRN COPD 'Value' Pyramid 2011



*(not specific to COPD)

High value interventions in COPD
Are we delivering them?

London Strategic Clinical Networks

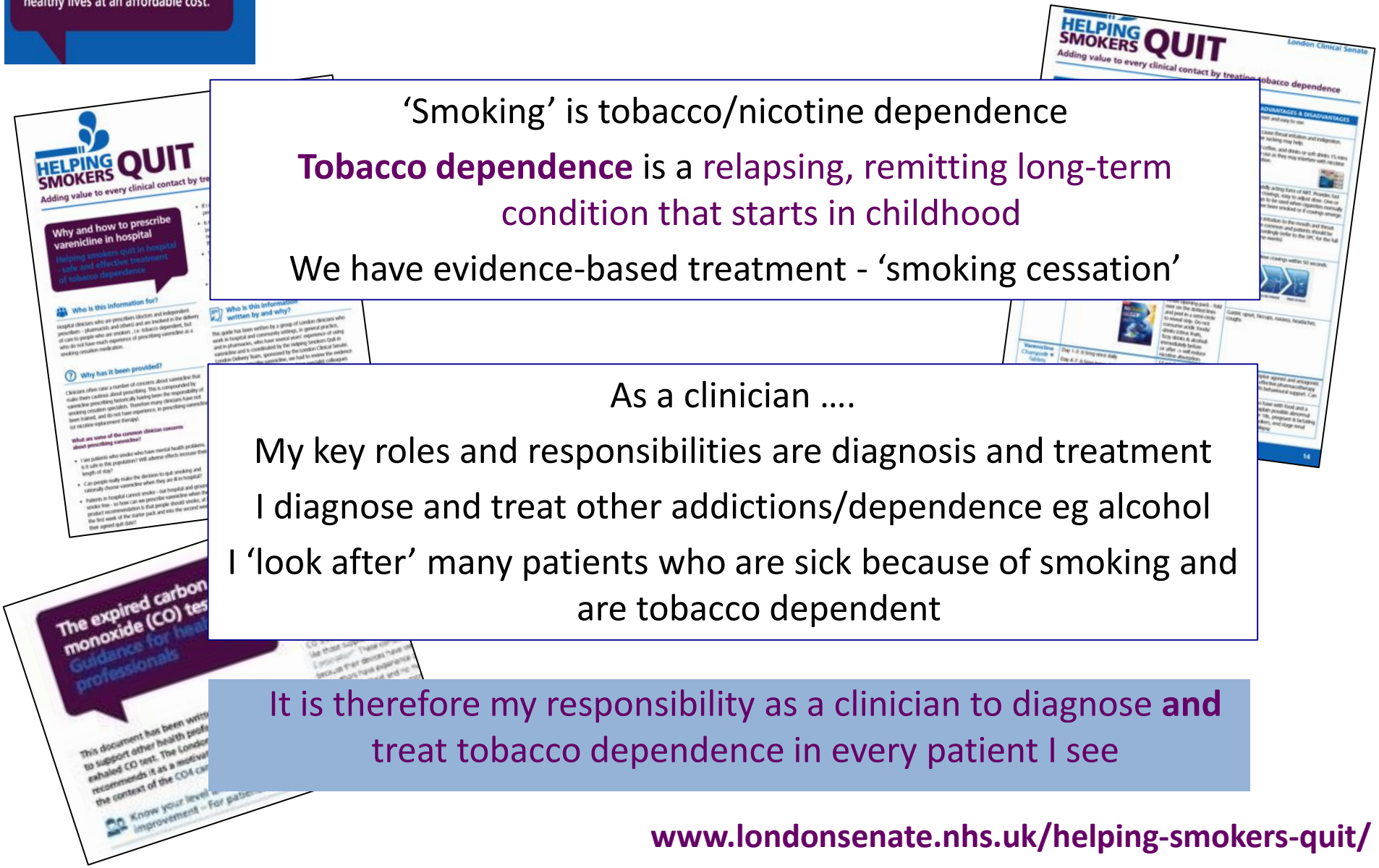


The value pyramid providing a representation of the proportion of people who were receiving value-based interventions for COPD in **Wales** in 2014-15.

Tobacco dependency is a long term and relapsing condition that usually starts in childhood; treating it is the highest value intervention for today's NHS and Public Health system, saving and increasing healthy lives at an affordable cost.

Changing how we think about smoking

NHS
London Clinical Senate



'Smoking' is tobacco/nicotine dependence

Tobacco dependence is a relapsing, remitting long-term condition that starts in childhood

We have evidence-based treatment - 'smoking cessation'

As a clinician ….

My key roles and responsibilities are diagnosis and treatment

I diagnose and treat other addictions/dependence eg alcohol

I 'look after' many patients who are sick because of smoking and are tobacco dependent

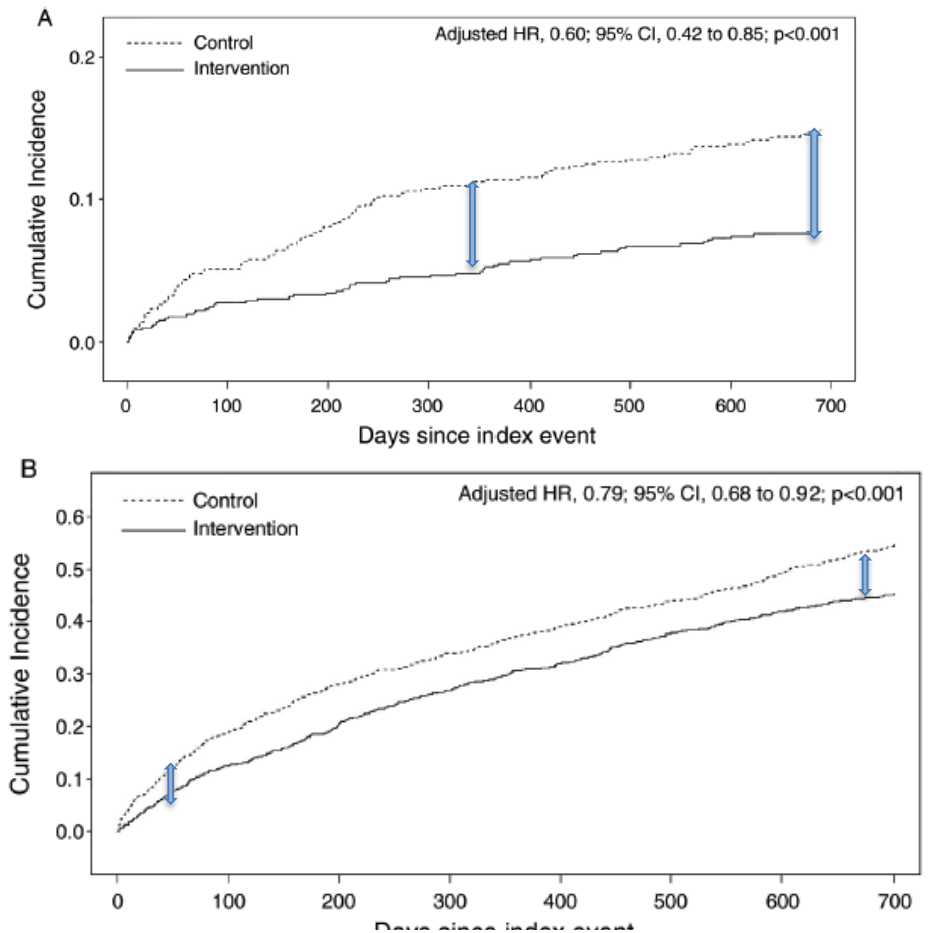
It is therefore my responsibility as a clinician to diagnose **and** treat tobacco dependence in every patient I see

www.londonsenate.nhs.uk/helping-smokers-quit/

Influencing: treating tobacco dependence as the 'value proposition' for the NHS* Sharing the Ontario Study Results …

HELPING SMOKERS QUIT

NHS London Clinical Senate



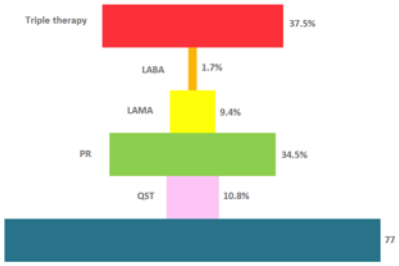
Mortality halved by **1 year**
11.4% vs 5.4%; p<0.001

Re-admission halved by **30 days**
13.3% vs 7.1%; p<0.001

Figure 2 Cumulative incidence of mortality (Part A) and all-cause rehospitalisation (Part B) from index hospitalisation to 2-year follow-up in the control (n=641) and intervention (n=726) groups.

Effectiveness of a hospital-initiated smoking cessation programme: 2-year health and healthcare outcomes
Mullen et al **Tob Control** 2016;0:1–7. doi:10.1136/tobaccocontrol-2015-052728

Responsible Respiratory Prescribing: the challenge in 2010



- NHS spend >£1 billion/yr on inhaled medications
- 4 of 5 most expensive medicines to NHS inhalers
- 2 of these 4 were high dose inhaled corticosteroids
  - Limited evidence for increased value from higher dose
  - Increasing evidence of harm from higher dose
- Concern that many diagnoses (& severity assessments) of asthma & COPD not accurate

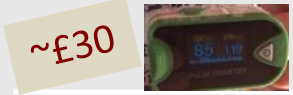
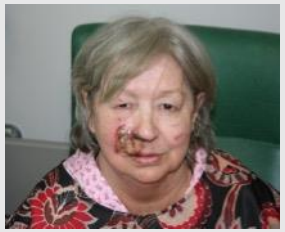
Responsible Respiratory Prescribing: Influence and impact 2010-16

NHS England
London Strategic Clinical Networks

- 100 000 high dose LRN ICS safety card ordered
- No. Responsible Respiratory Prescribing groups increased
- High dose ICS prescribing reduced by QI in many CCGs
- High dose ICS prescribing in England reduced!
- Estimated cost savings approx £20 million/yr 2015-16
- Evidence for role and value of ‘virtual clinics’ published

Responsible Oxygen Prescribing: Where we started in 2010

NHS England
London Strategic Clinical Networks

LRT RO message 1. 	Oxygen is for treating hypoxia not breathlessness, so have and use a pulse oximeter.
LRT RO message 2. 	A specialist team for oxygen assessment should be part of a commissioned integrated respiratory service. This will improve effectiveness of oxygen therapy, reduce waste and reduce costs. See **http://tinyurl.com/4ye3nws**
LRT RO message 3. 	Protect patients who are at risk from excessive oxygen. Identify at risk patients and use a combination of limiting oxygen to 28% in ambulance transit (universal precautions), 02 alert cards and/or patient specific protocols (PSPs) and report adverse events through the local SUI system. See **http://tinyurl.com/4ye3nws** for a step-by-step guide to oxygen.

Focused on addressing:

Misuse

Overuse

Underuse

& the need to address breathlessness as a symptom better

LRN work on breathlessness and its impact

It's 1:30am in the morning and I am alone

Sitting on the edge of my bed, cold but unable to lie down

It's getting harder to breathe.

My mind is trying hard to keep calm, but I am stiff with anxiety

Shall I call for an ambulance? NO.

'I don't want to die'

'breathlessness is frightening and disabling'

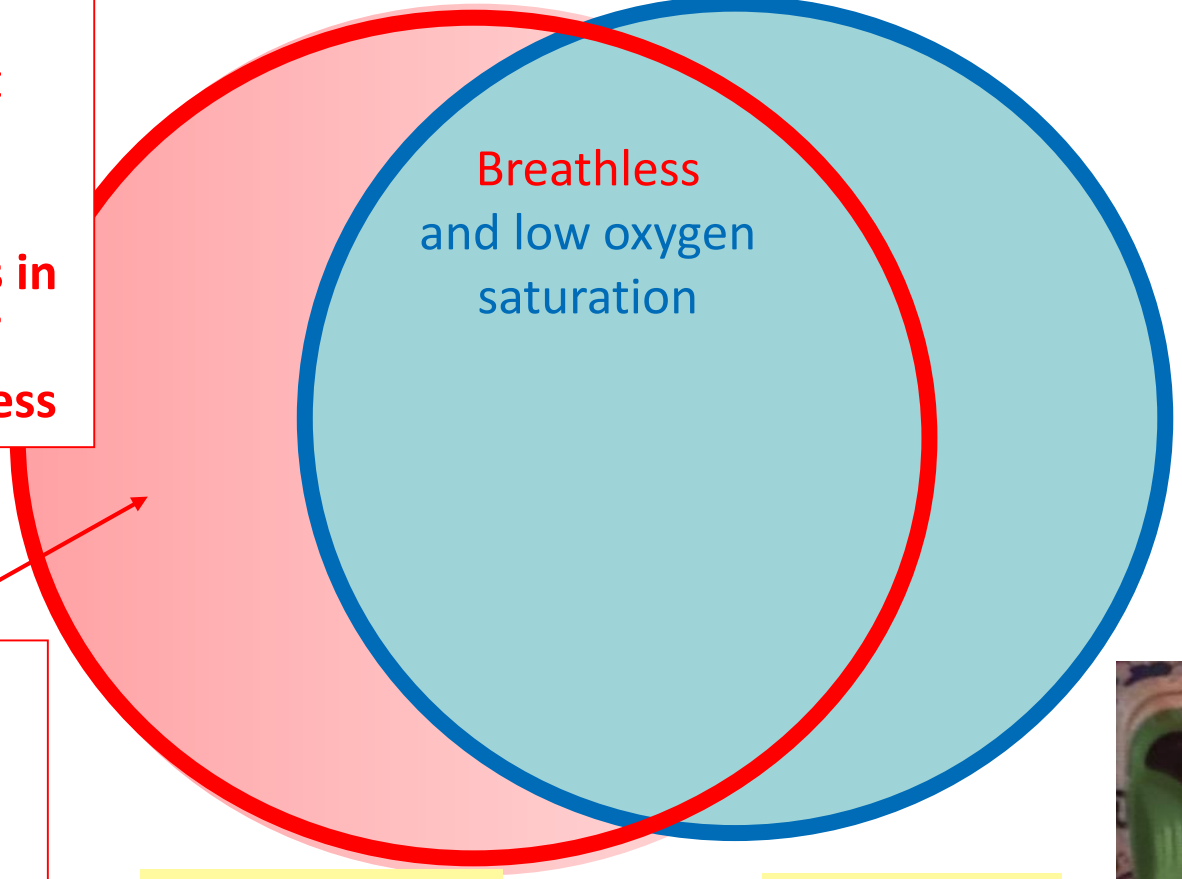
Why respiratory patients come to hospital & keeping patients safe

'Care at home' provided correct diagnosis made, correct treatment started AND **patient feels in control of breathlessness**

Breathlessness (symptom) Can be frightening …

Respiratory Failure (low oxygen saturation)

Respiratory failure = diagnosis and treatment in hospital

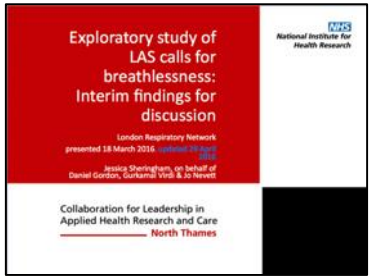


Breathless with normal oxygen saturation

Ask and listen

Measure

Collaborative work on reducing impact of frightening disabling breathlessness



Patient-centred approach

- Talk about breathlessness (not 'dyspnoea')

Common & distressing symptom

- Work with psychologists

Could be managed better with same NHS resources

Many causes – diagnosis requires skilled assessment

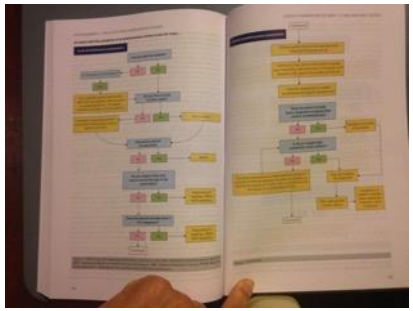
- High quality history, examination, 'tests' & interpretation

Wrong diagnosis common & big impact: cost, experience, harm

Overuse & misuse: oxygen/inhalers/Ambulance/ED/admissions

Underuse: PR/oximeters/admissions/NIV/psych skills

Need pathways that start with breathlessness



COMPLEX – lots more to do

Making the right thing to do the easy thing to do.

Clinical Effectiveness Southwark

QUAY HEALTH SOLUTIONS · ihl improving health · NHS Southwark Clinical Commissioning Group · The Health Foundation

Breathlessness

A guide for Southwark General Practice©

Key Messages

1. Breathlessness can be complex and multifactorial; code the symptom, quantify the burden and work through diagnostic algorithms
2. Identify and treat tobacco dependence early (measure exhaled CO, deliver very brief advice and offer onward referral and quit smoking treatment)
3. Quality Assured Spirometry from Community Lung Function Clinics is an essential component of diagnosis

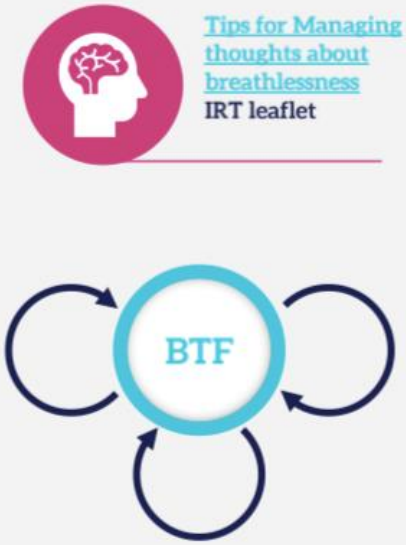
Always work within your knowledge and competency

Managing Breathlessness Support Leaflets for Patients

Adapted from Spathis et al.

Discuss the The Breathing Thinking Functioning (BTF) approach (BTF) approach with patients to help identify strategies to manage their breathlessness at the end of life.

British Lung Foundation Leaflet on Breathlessness



Tips for Managing thoughts about breathlessness IRT leaflet

Positions to ease breathlessness IRT Leaflet

Tips for managing breathlessness using a Handheld Fan IRT Leaflet

Breathing Techniques IRT leaflet

Singing for breathlessness (Breathe Easy Southwark Choir) has shown to improve sensations of breathlessness BLF Website

Managing your energy levels IRT leaflet

Relaxation for breathlessness can be an important part of support available IRT Relaxation Leaflet

Sources of Support for Symptom Control and Palliative Care for Breathlessness

- Physiotherapy for breathing support can be accessed through **Chest Clinic** (eRS)
- Consider referral to IAPT for support around anxiety and breathlessness
- Consider referral to **palliative care** for breathlessness support at the end of life
- Consider adding patients to **Coordinate my Care**, discussion at next practice palliative care visit and having advanced care planning discussions early

Be still... be calm...
Drop the shoulders
Slowly sigh out... and out
Hear the sigh
Haaah... soft and quiet
Feel control returning
Peaceful and safe

– Jenny Taylor, Physiotherapist
St Christopher's Hospice

Collaborative work with Commissioners to enable 'Right' Care: COPD Bundle CQIN

NHS England
London Strategic Clinical Networks

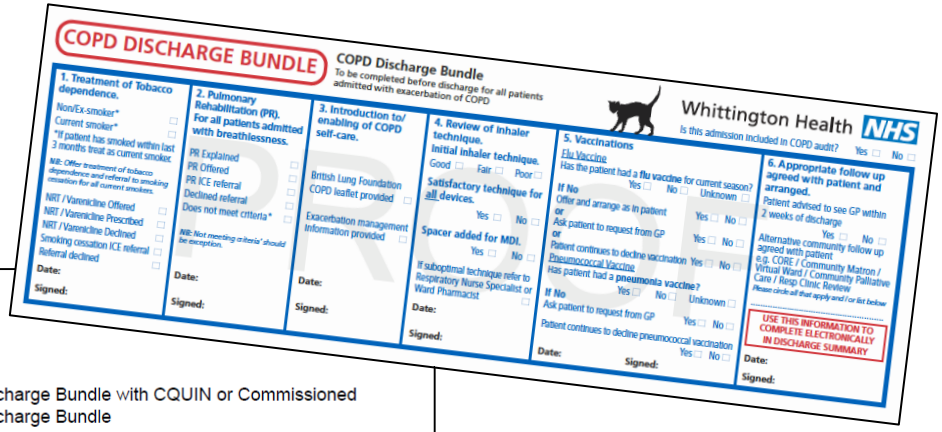
Chest clinic

CHEST CLINIC

RESEARCH UPDATE

Designing and implementing a COPD discharge care bundle

Nicholas S Hopkinson,[1,2] Catherine Englebretsen,[1] Nicholas Cooley,[1] Kevin Kennie,[3] Mun Lim,[1,2] Thomas Woodcock,[1] Anthony A Laverty,[4] Sandra Wilson,[1] Sarah L Elkin,[1,5] Cielito Caneja,[1] Christine Falzon,[1,3] Helen Burgess,[1] Derek Bell,[1] Dilys Lai[1]



COPD DISCHARGE BUNDLE

COPD Discharge Bundle
To be completed before discharge for all patients admitted with exacerbation of COPD

Whittington Health NHS

Is this admission included in COPD audit? Yes ☐ No ☐

1. Treatment of Tobacco dependence.
Non/Ex-smoker* ☐
Current smoker* ☐
*If patient has smoked within last 3 months treat as current smoker.
NB: Offer treatment of tobacco dependence and referral to smoking cessation for all current smokers.
NRT /Varenicline Offered ☐
NRT /Varenicline Prescribed ☐
NRT /Varenicline Declined ☐
Smoking cessation ICE referral ☐
Referral declined ☐
Date:
Signed:

2. Pulmonary Rehabilitation (PR). For all patients admitted with breathlessness.
PR Explained ☐
PR Offered ☐
PR ICE referral ☐
Declined referral ☐
Does not meet criteria* ☐
NB: Not meeting criteria' should be exception.
Date:
Signed:

3. Introduction to/ enabling of COPD self-care.
British Lung Foundation COPD leaflet provided ☐
Exacerbation management information provided ☐
Date:
Signed:

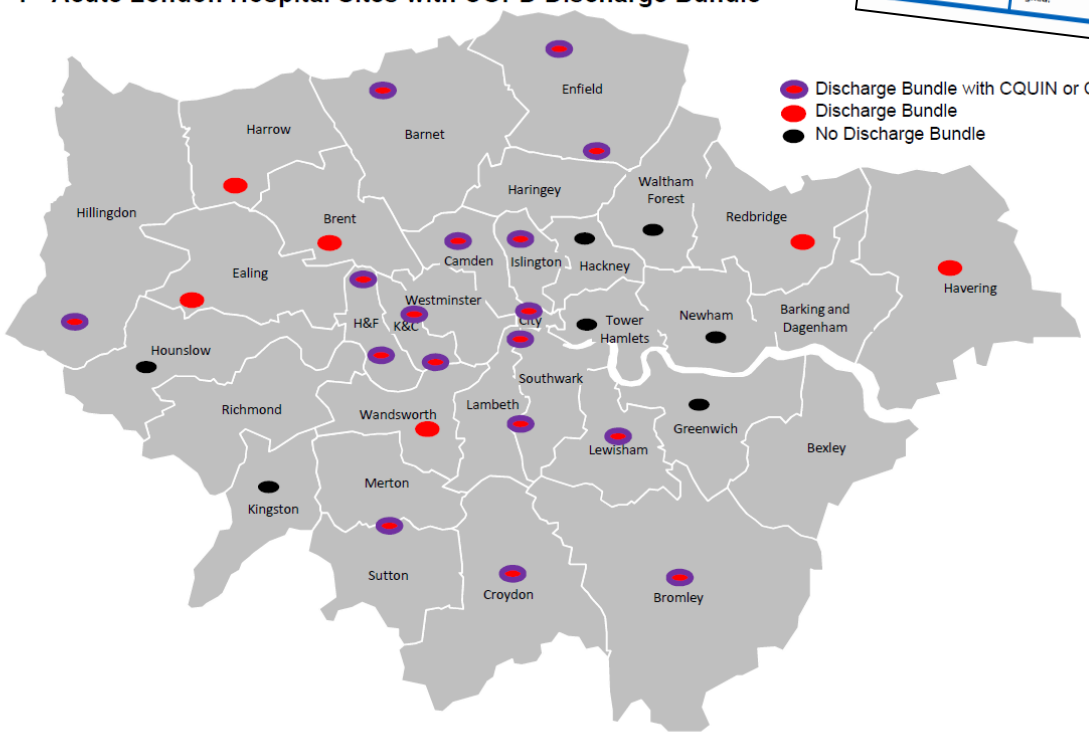
4. Review of inhaler technique.
Initial inhaler technique.
Good ☐ Fair ☐ Poor ☐
Satisfactory technique for all devices.
Yes ☐ No ☐
Spacer added for MDI.
Yes ☐ No ☐
If suboptimal technique refer to Respiratory Nurse Specialist or Ward Pharmacist ☐
Date:
Signed:

5. Vaccinations
Flu Vaccine
Has the patient had a flu vaccine for current season? Yes ☐ No ☐ Unknown ☐
If No
Offer and arrange as in patient ☐ Yes ☐ No ☐
or
Ask patient to request from GP ☐ Yes ☐ No ☐
or
Patient continues to decline vaccination Yes ☐ No ☐
Pneumococcal Vaccine
Has patient had a pneumonia vaccine? Yes ☐ No ☐ Unknown ☐
If No
Ask patient to request from GP ☐ Yes ☐ No ☐
Patient continues to decline pneumococcal vaccination Yes ☐ No ☐
Date:
Signed:

6. A ppropriate follow up agreed with patient and arranged.
Patient advised to see GP within 2 weeks of discharge Yes ☐ No ☐
Alternative community follow up agreed with patient e.g. CORE / Community Matron / Virtual Ward / Community Palliative Care / Resp Clinic Review
Please circle all that apply and / or list below
USE THIS INFORMATION TO COMPLETE ELECTRONICALLY IN DISCHARGE SUMMARY
Date:
Signed:

PROOF

MAP 1 - Acute London Hospital Sites with COPD Discharge Bundle



Source: - London Respiratory Team Surveys

PLOS ONE

RESEARCH ARTICLE

Impact of a COPD Discharge Care Bundle on Readmissions following Admission with Acute Exacerbation: Interrupted Time Series Analysis

Anthony A. Laverty[1]*, Sarah L. Elkin[2], Hilary C. Watt[1], Christopher Millett[1], Louise J. Restrick[3], Sian Williams[3], Derek Bell[4], Nicholas S. Hopkinson[5]

So, today do we commission with VBHC in mind or as a focus in SEL?

The value of and need for palliative care: an academic perspective

Dr Katherine Sleeman
NIHR Clinician Scientist, KCL
Honorary consultant, KCH

The demographics of dying are changing

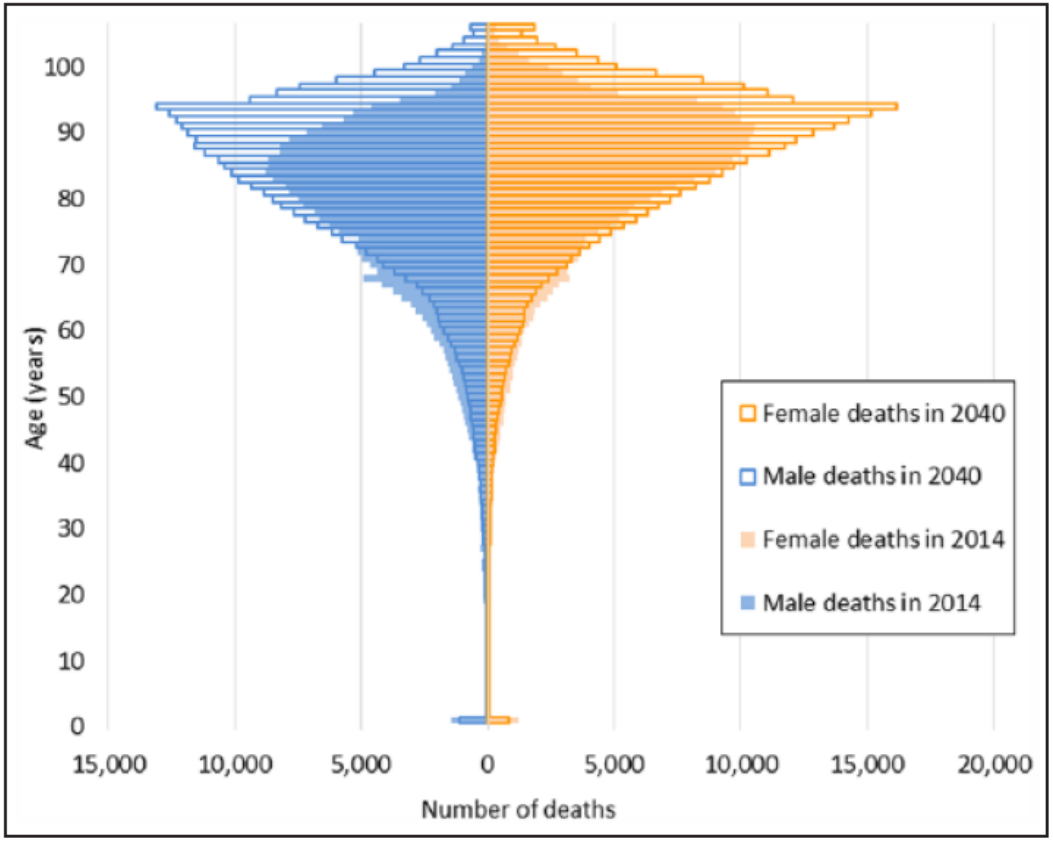
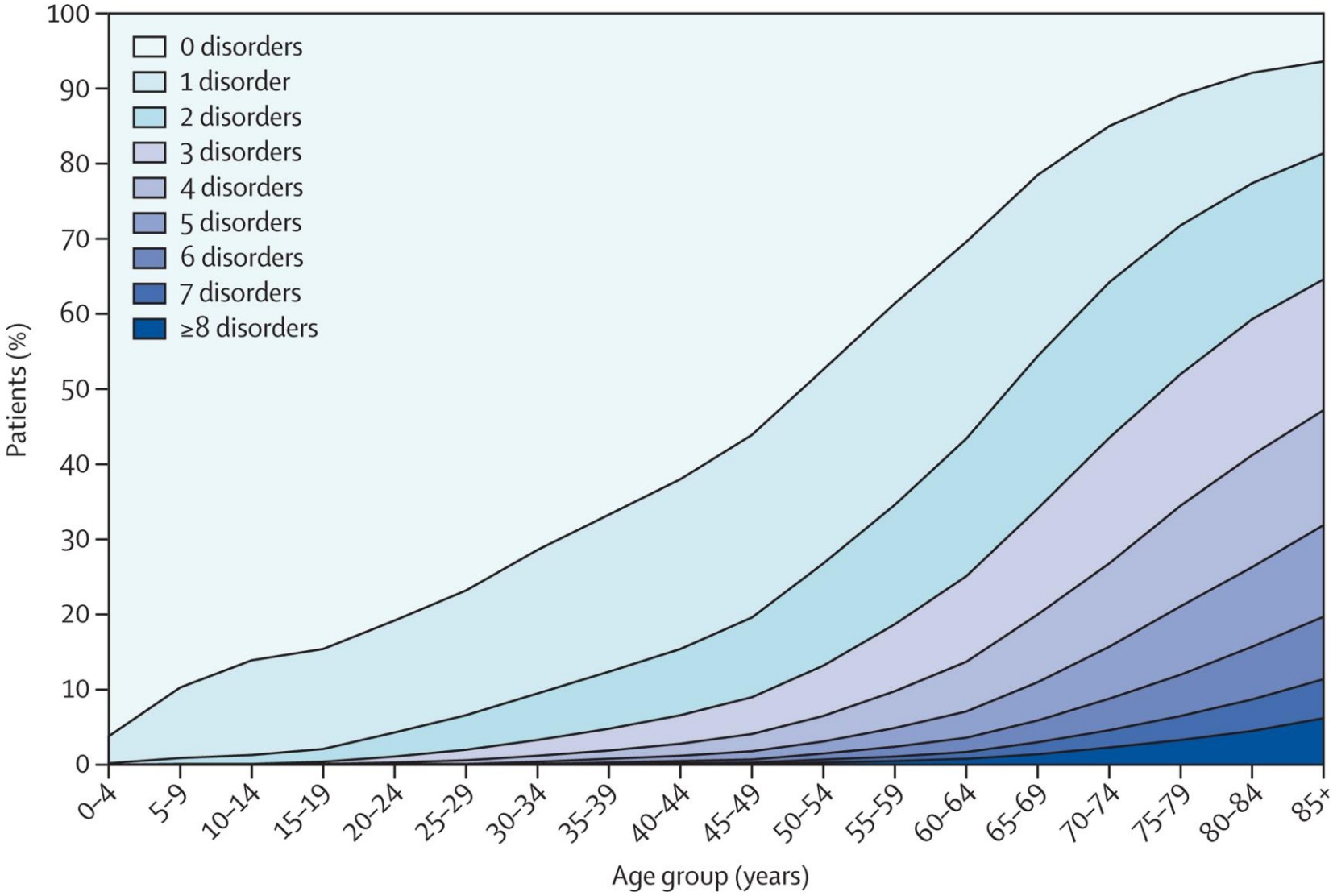


Figure 1. Actual and projected deaths in 2014 and 2040 by age and gender.

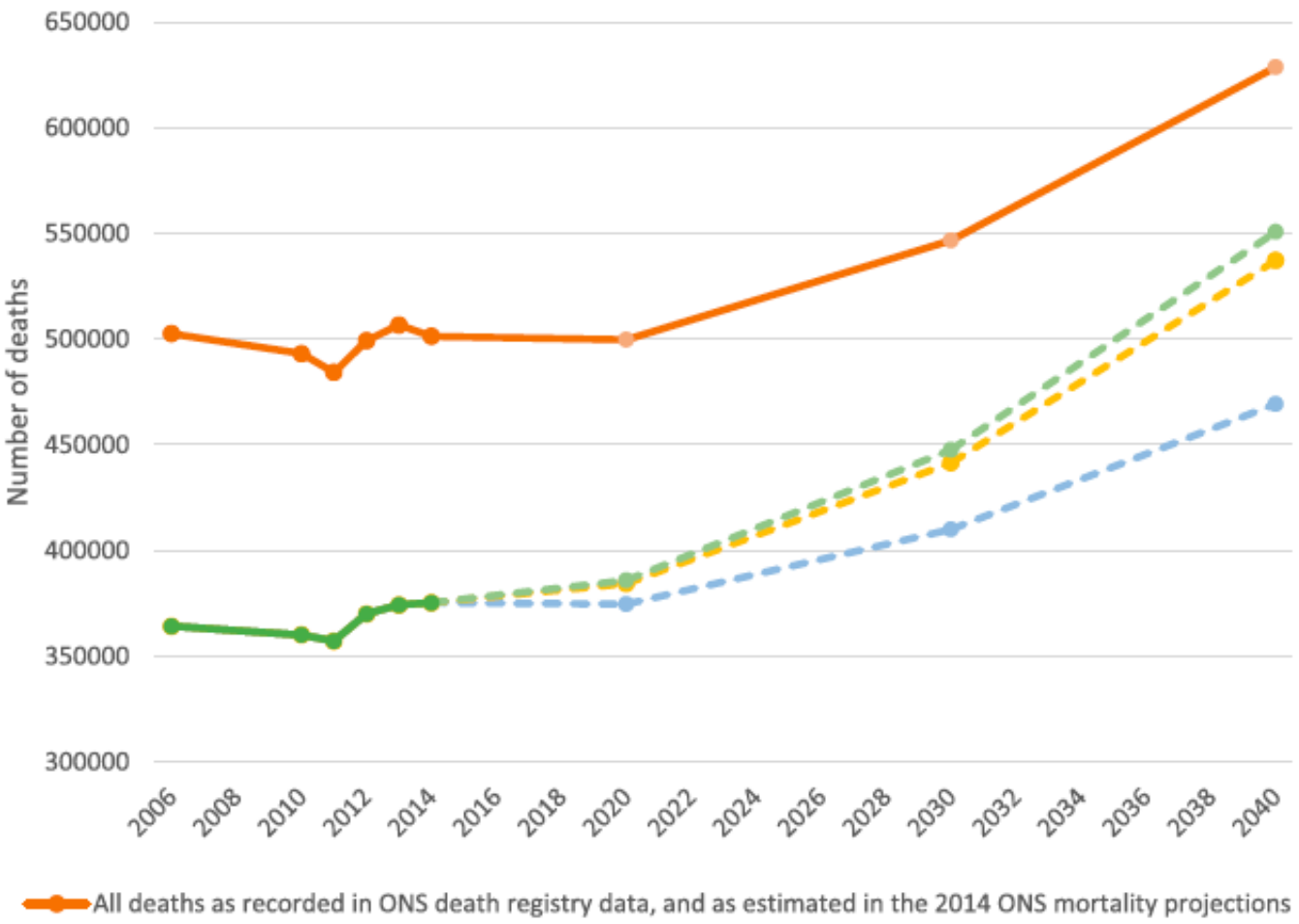
Bone et al, Palliative Medicine, 2017

Older deaths mean more complex deaths



Barnett et al, The Lancet, 2012

The number of people who die each year is going up

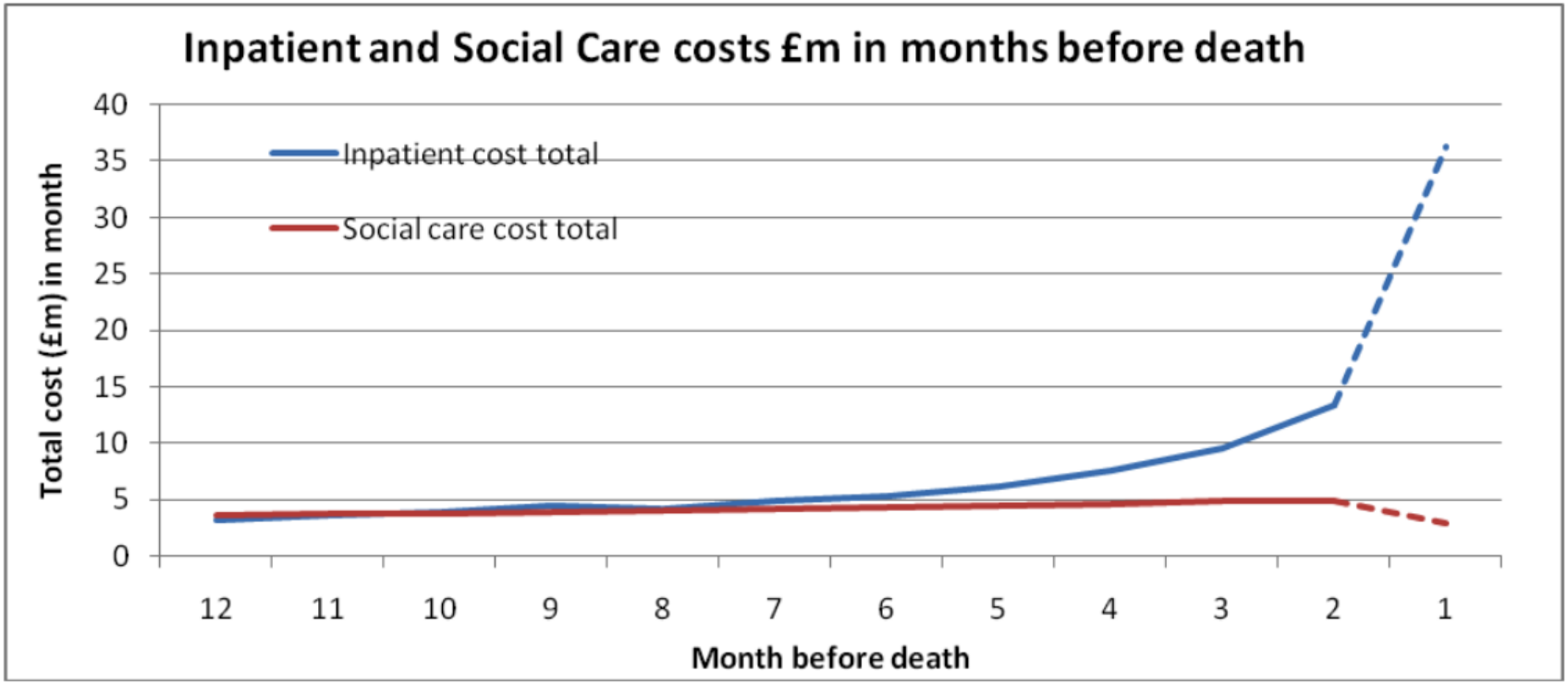


Total deaths in England and Wales

Projected number of people with palliative care needs

Etkind et al, BMC Medicine, 2016

Care for dying people takes resource



n=16,479

Nuffield Trust 2010

Ambitions for palliative and end of life care

01 Each person is seen as an individual

02 Each person gets fair access to care

03 Maximising comfort and wellbeing

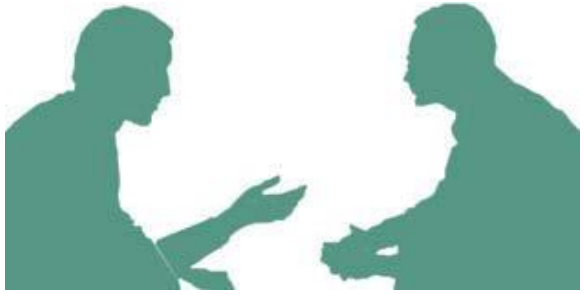
04 Care is coordinated

05 All staff are prepared to care

06 Each community is prepared to help

National Palliative and End of Life Care Partnership
www.endoflifecareambitions.org.uk

How can we measure quality of dying?



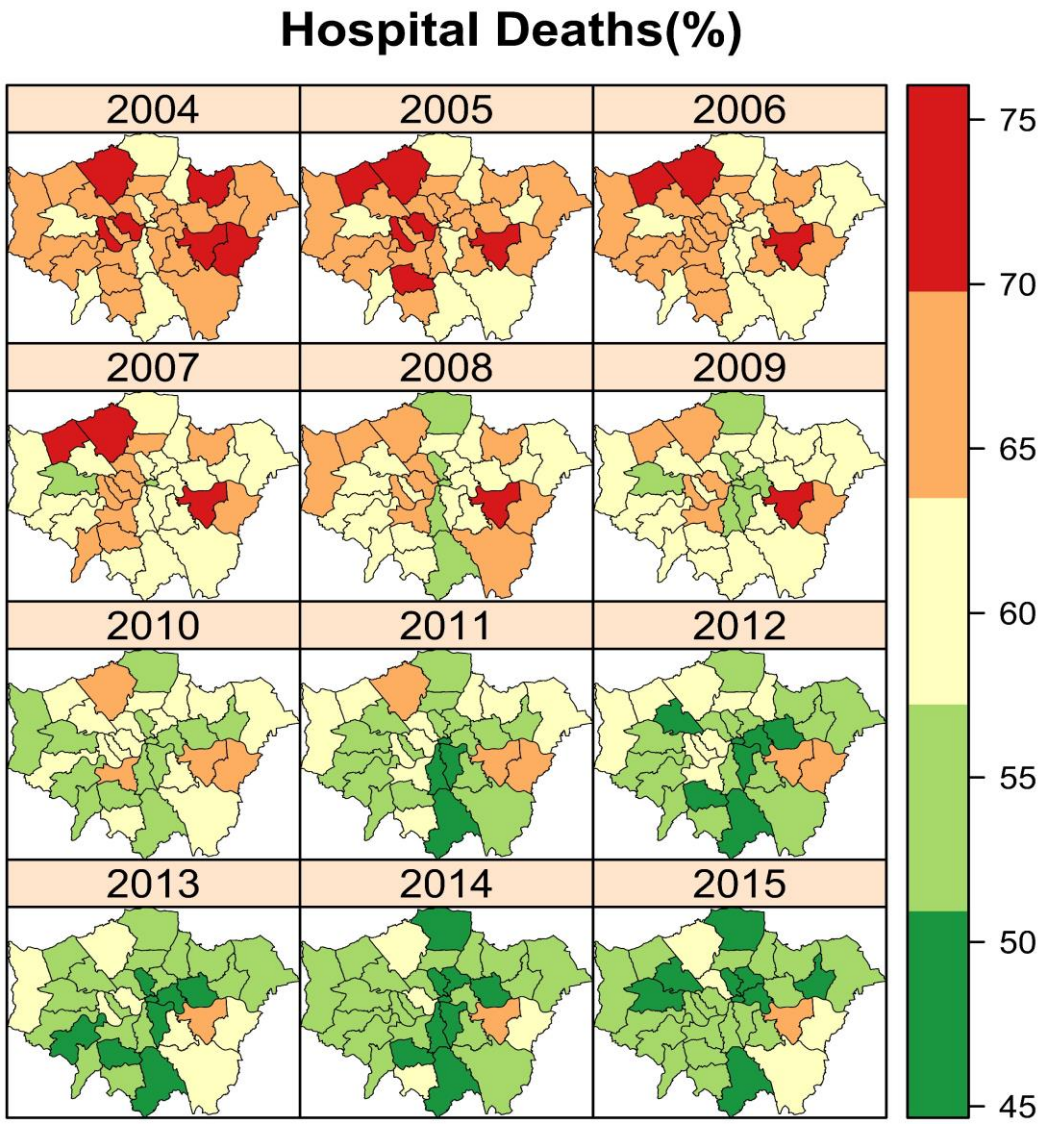
Individual level

Patient Reported Outcome Measure (PROM)

Population level

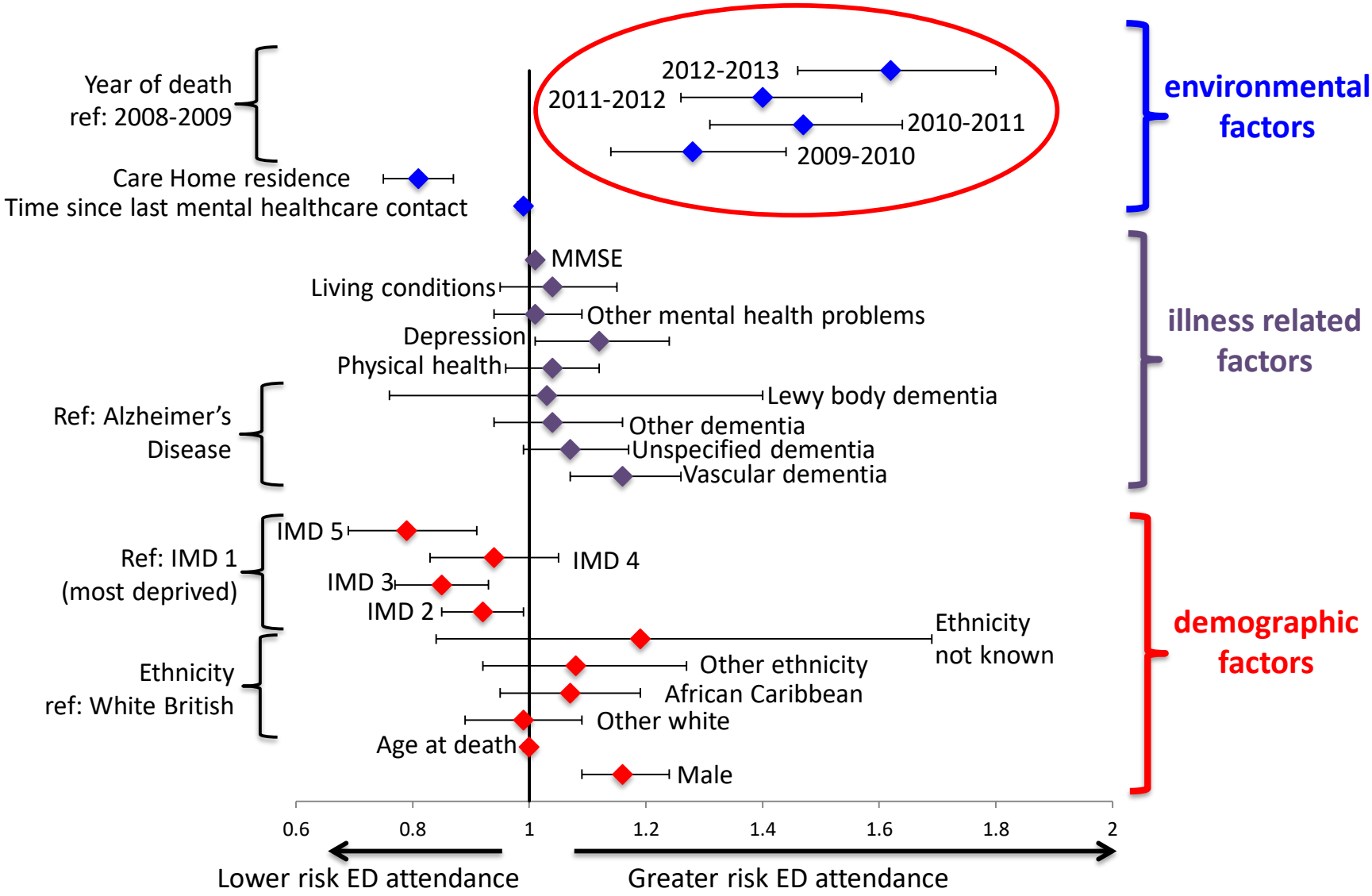
Routine data

Hospital deaths are falling in London



Data Source: https://fingertips.phe.org.uk, figure produced by Dr Emeke Chukwusa

Emergency department attendance is going up



N=4,867 people with dementia

Sleeman et al 2017

$$\text{value} = \frac{\text{outcomes}}{\text{cost}}$$

Specialist palliative care is associated with better outcomes

- Better quality of life and symptom burden
  - Kavalieratos et al, 2017, Systematic Review

Specialist palliative care is associated with better outcomes

- Better quality of life and symptom burden
  - Kavalieratos et al, 2017, Systematic Review
- More home deaths
  - Gomes et al, 2013, Cochrane Review
- Fewer Emergency Department admissions
  - Henson et al, 2014, Systematic Review
  - Bone et al, 2018, Systematic Review

Palliative care is better for patients…

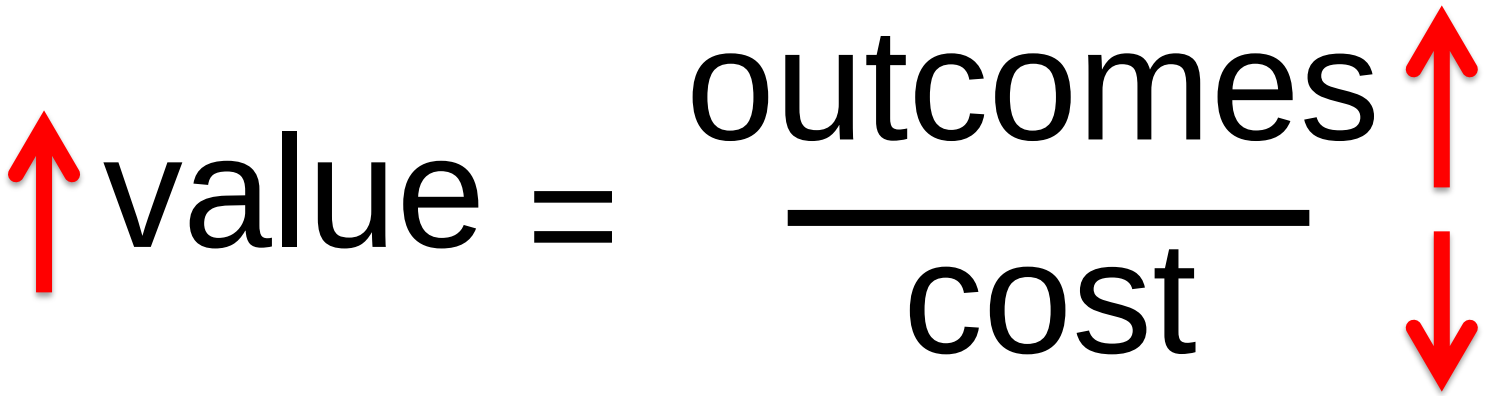
…but what about the system?

$$\text{value} = \frac{\text{outcomes}\uparrow}{\text{cost}}$$

Specialist palliative care is associated with better outcomes

- Better quality of life and symptom burden
  - Kavalieratos et al, 2017, Systematic Review
- More home deaths
  - Gomes et al, 2013, Cochrane Review
- Fewer Emergency Department admissions
  - Henson et al, 2014, Systematic Review
  - Bone et al, 2018, Systematic Review
- Cost saving
  - May et al, 2018, Systematic Review

Palliative care is a high value intervention



Thank you

Sciences Centre for London

Value Based Healthcare

‘Capturing what matters’ Knowledge Exchange

King’s Health Partners
Karin Nilsson // March 2019

What is ‘Value Based Healthcare’?

- A management model aiming to reform the nature of competition on the healthcare market
- Developed by M. Porter and E. Teisberg at Harvard Business School
- Introduces the concept of “value”, a focal point around which to realign all players participating in healthcare delivery
- This concept of value is often presented as a mathematical equation, and defined as health outcomes in relation to dollars spent:

$$\text{Value} = \frac{\text{‘Health outcomes’}}{\text{‘Cost’}}$$

How is this helpful, or even appropriate, for the NHS?

Let’s take a step back....

“Health care can **adapt** certain business concepts to fit its mission, but it cannot **adopt** them” (IHI, 2018)

What is the fundamental purpose of healthcare?

The fundamental purpose of healthcare

.... are we achieving it?

‘Outcomes that matter to patients’* – a way to measure achievements

1. Have a **accurate** picture:

Which are the outcomes that matter?

2. Have **meaningful** picture:

Are the outcomes meaningful?

3. Have a **complete** picture:

Which are the different outcomes?

Tracking

Engagement

- Patient, family and carer
- Staff

Segmentation

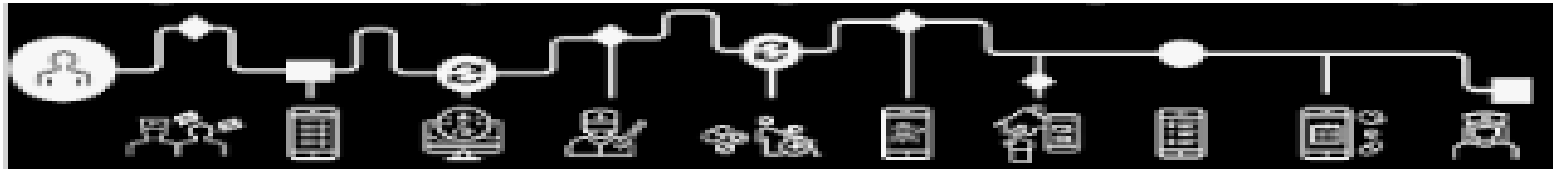
- Condition
- Population

Outcomes Hierarchy:

1. Health status	Survival
	Degree of recovery
2. Process of recovery	Time to recovery
	Disutility of care
3. Sustainability of health	Sustainability of health
	Long term consequences

‘Outcomes that matter to patients’* – how are they created?

Resources along the pathway:



- Healthcare needs are infinite
- Resources are finite – how should they be used?

  - Where they have the **most impact** on outcomes!

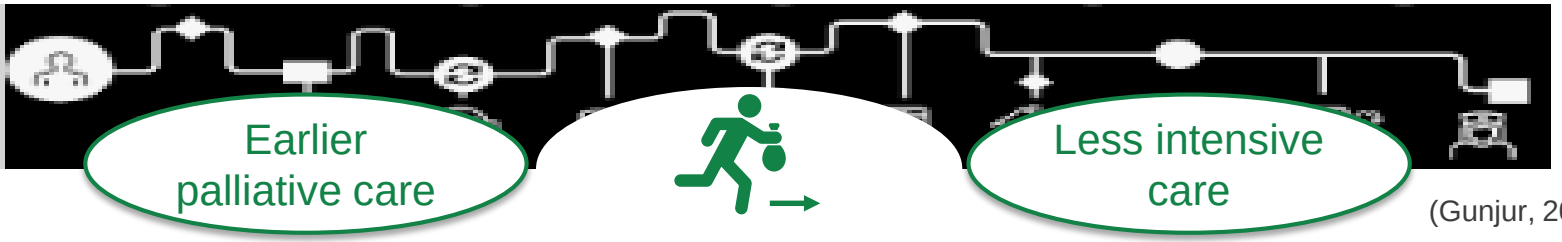
$$\textbf{KHP Value} = \frac{\textbf{‘Outcomes that matter to patients’}}{\textbf{‘Resources used over the whole pathway’}}$$

Do better outcomes cost more?

	Improved outcomes	Resource use
Fewer complications	✓	↘
Sustained functionality		
Fewer readmissions		

- Understand resources but focus on improving outcomes

Requires a system perspective



(Gunjur, 2015)

What about **quality**? – ensures adherence but not results

Making it work in practice for KHP: A collaborative effort to navigating the way forward