

North Oxfordshire Locality Commissioning Meeting

Date of Meeting: 17 April 2018	Item No: 7 i					
Title of Paper: Integrated Respiratory Team pilot						
Is this paper for	Discussion		Decision		Information	✓

Purpose and summary of the paper:

Summary of the project to pilot an Integrated Respiratory Team (IRT) approach.

IRT aims to increase diagnosis of respiratory disease, identify patients at risk of exacerbation, optimise clinical management, introduce early holistic & EoL care – ultimately improving quality of life and self-care for patients and their carers

Action Required:

- Note the project and bring questions to the NOLG meeting
- Amar Latif will attend NOLG to discuss the project

Author: Dr Amar Latif

Clinical Lead: Dr Amar Latif

Integrated Respiratory Team

A joint working pilot between OCCG
and Boehringer Ingelheim

Background

- ❑ UK: 1.2m people with COPD costing £800m per year
- ❑ 193 new diagnoses of COPD per 100,000 people per year
- ❑ Oxfordshire: COPD GP-registered population of 9,892 and an Asthma GP-registered population of 42,179
- ❑ NHS RightCare: approx. 1,800 people with undiagnosed COPD

	Activity (2016/17)	Cost (2016/17)	Activity increase since 2013/14
Emergency admissions (IRT cohort)	2,733	£5,254,279	27%
Emergency re-admissions within 30 days (IRT cohort)	762	£1,874,122	113%
Outpatient appointments (all respiratory)	18,444	£2,285,663	41%

Patient Story 1

- ❑ Mrs LC, 63 yr old woman, no past medical history, 40 pack yr smoking history.
 - ❑ Family called 111 as pt breathless with ?chest infection
 - ❑ Seen on home visit during out of hours period
 - ❑ Breathless
 - ❑ Unable to complete full sentences
 - ❑ Difficulty mobilising
 - ❑ Oxygen saturation 70%
 - ❑ 999 ambulance called and patient admitted
 - ❑ DIAGNOSIS: Exacerbation of undiagnosed COPD
-

Patient Story 2

- ❑ Mr DF, 73 yr old gentleman, end stage COPD
 - ❑ Multiple calls to 999/111 with breathlessness
 - ❑ 24 hr oxygen therapy
 - ❑ Care plan: preferred place of death - home
 - ❑ Multiple admissions and readmissions with exacerbation of COPD
 - ❑ Underlying anxiety
 - ❑ Admitted with COPD exacerbation Dec 2017
 - ❑ Died in hospital
-

- ❑ 62 patients had an emergency respiratory admission. 41 had **recognized** respiratory pathology, 21 did not
 - ❑ 46% of the respiratory patients (41) who had an emergency respiratory admission were **managed wholly in primary care**. Only 54% known to the community specialist team or seen in OPD
 - ❑ Respiratory diagnoses: 51% had COPD, 32% asthma, 17% other
 - ❑ 18 had died, 14 of these did not have respiratory pathology
-

What are the problems?

- ❑ Current system leads to inadequate identification of high risk patients with respiratory problems - even after an emergency admission!
 - ❑ Our respiratory specialist team is not integrated across primary, community and secondary care
 - ❑ No presence of specialist team in primary care setting
 - ❑ Inadequate respiratory training for primary care practitioners
 - ❑ Absence of community respiratory consultant leadership
 - ❑ Poor recognition of the need for holistic supportive care and end of life care in advanced COPD (Living with Breathlessness Study, 126 UK practices, Farquhar et al, Cambridge 2016)
-

Will identification of a high risk patient cohort, in order to optimise their care using an enhanced integrated multidisciplinary respiratory team, improve patient outcomes?

High risk cohort:

- those at risk of admission with airways disease and/or end stage breathlessness
 - those likely to have un-identified respiratory disease
 - those with sub-optimally managed COPD and asthma
-

Project summary

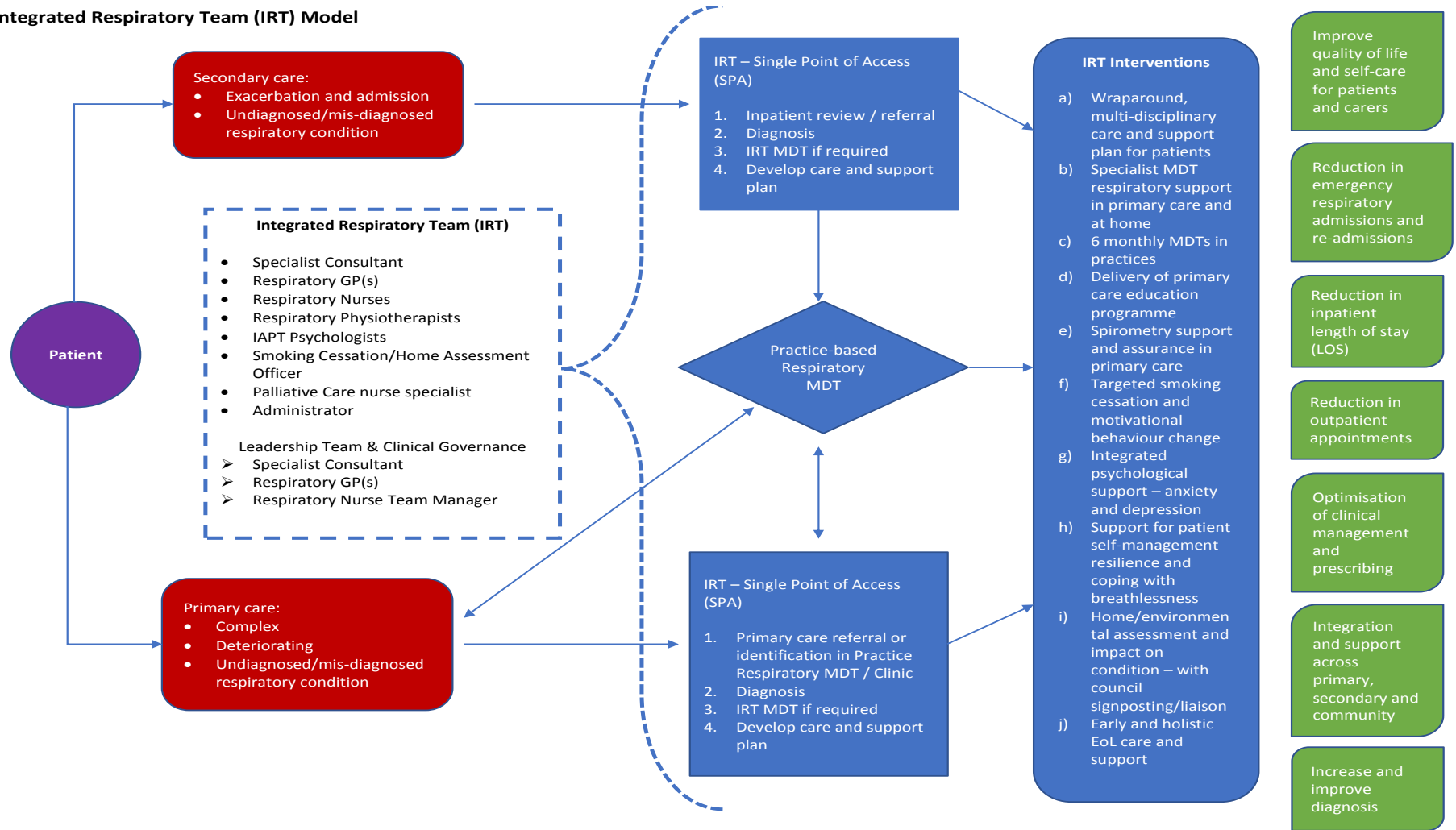
- Oxfordshire Respiratory Project Group (ORPG): Consultant, GPs, Community Respiratory Nurses and Physios, Psychologist, Pharmacist, Public Health & Commissioner
- Joint meetings between ORPG and Boehringer Ingelheim (BI) to develop proposal over 6 months
- Pilot IRT over 18 months starting 1 June 2018 with outcomes evaluated and potential for service to be fully commissioned by OCCG at end of project
- IRT will be phased in across the six Oxfordshire localities that cover 70 GP practices
- IRT remit will include:
 - ✓ Airways disease: Asthma and COPD
 - ✓ Bronchiectasis
 - ✓ Interstitial lung disease including sarcoidosis
 - ✓ Airways clearance advice for patients with neuromuscular disease or on NIV



IRT will increase diagnosis of respiratory disease, identify patients at risk of exacerbation, optimise clinical management, introduce early holistic & EoL care – ultimately improving quality of life and self-care for patients and their carers

IRT Model

Integrated Respiratory Team (IRT) Model



Secondary care:

- Exacerbation and admission
- Undiagnosed/mis-diagnosed respiratory condition

Integrated Respiratory Team (IRT)

- Specialist Consultant
- Respiratory GP(s)
- Respiratory Nurses
- Respiratory Physiotherapists
- IAPT Psychologists
- Smoking Cessation/Home Assessment Officer
- Palliative Care nurse specialist
- Administrator

Leadership Team & Clinical Governance

- Specialist Consultant
- Respiratory GP(s)
- Respiratory Nurse Team Manager

IRT – Single Point of Access (SPA)

1. Inpatient review / referral
2. Diagnosis
3. IRT MDT if required
4. Develop care and support plan

Practice-based Respiratory MDT

Primary care:

- Complex
- Deteriorating
- Undiagnosed/mis-diagnosed respiratory condition

IRT – Single Point of Access (SPA)

1. Primary care referral or identification in Practice Respiratory MDT / Clinic
2. Diagnosis
3. IRT MDT if required
4. Develop care and support plan

IRT Interventions

- a) Wraparound, multi-disciplinary care and support plan for patients
- b) Specialist MDT respiratory support in primary care and at home
- c) 6 monthly MDTs in practices
- d) Delivery of primary care education programme
- e) Spirometry support and assurance in primary care
- f) Targeted smoking cessation and motivational behaviour change
- g) Integrated psychological support – anxiety and depression
- h) Support for patient self-management resilience and coping with breathlessness
- i) Home/environmental assessment and impact on condition – with council signposting/liaison
- j) Early and holistic EoL care and support

Improve quality of life and self-care for patients and carers

Reduction in emergency respiratory admissions and re-admissions

Reduction in inpatient length of stay (LOS)

Reduction in outpatient appointments

Optimisation of clinical management and prescribing

Integration and support across primary, secondary and community

Increase and improve diagnosis

Business case – why do it?

- ❑ Improved quality of care for patients
 - ❑ Improved self care for patients:
 - Respiratory physiotherapy, pulmonary rehabilitation, smoking cessation, cognitive behavioural therapy
 - ❑ Care closer to home
 - ❑ Sustainable and cost-effective strategy to reduce future non-elective admissions, re-admissions and outpatient referrals.
 - ❑ Reduce pressure on A & E
 - ❑ Coordinated patient management with multi-disciplinary working
 - ❑ Improved education in primary care
 - ❑ Integrated physical and mental health support for patients
 - ❑ Improved recognition and care for patients at end of life
-

Project outcomes

Reduction in the differential between expected and observed prevalence of COPD	30% reduction in respiratory outpatient appointments
20% reduction in emergency respiratory admissions	Increase in the number of patients recognised as needing end of life and/or supportive care and having advance care plans in place
20% reduction in emergency respiratory re-admissions within 30 days	Improved recognition of mental health problems and improved mental health outcomes
20% reduction in respiratory length of stay (LOS)	Improvement in smoking cessation as measured by 4 week quit rate of those referred to smoking cessation services by IRT
Reduction in respiratory admissions overall	

Business case – activity and cost

	Activity saving	Cost saving
Inpatients: 20% reduction in non-elective admissions	547	£1,050,856
Inpatients: 20% reduction in non-elective re-admissions within 30 days	152	£374,824
Inpatients: 20% reduction in Length of Stay	1 day	£39,312
Outpatients: 30% reduction in outpatient appointments	3,689	£685,699
Prescribing		£143,000
Total (gross) saving		£2,293,691

Stakeholder benefits

The Goal: Better management of patients with airways disease and/or end-stage lung disease who are at risk of admission to hospital

PATIENTS



BENEFIT

- Improved quality of life
- Care closer to home
- Earlier and accurate diagnosis
- Holistic, multi-disciplinary care planning
- Support to enable better self-care and resilience
- Psychological support to manage breathlessness anxiety and exacerbations
- Proactive medicines management
- Facilitated access to preventative measures

NHS



BENEFIT

- Less emergency admissions and re-admissions – reducing pressure on A&E
- Reduced outpatient appointments
- Reduction in hospital length of stay
- Better coordinated and integrate care with less delay and hand offs
- Integration of physical and mental health
- Proactive and preventative approach reducing system costs overall
- Optimised clinical management and prescribing

BOEHRINGER INGELHEIM



BENEFIT

- Demonstration of BI's commitment to improving patient care
- Development of partnering experience & expertise
- Building of true collaboration with our customers
- Greater access to senior customers
- Enhanced PR and reputation

Resourcing and investment



Oxfordshire
Clinical Commissioning Group

	2018 (BI Financial Year Jan-Dec)	2019 (BI Financial Year Jan-Dec)	Total (18 months)
BI Funding Contribution	£342,168	£776,798	£1,118,966
	2018-19 (OCCG Financial Year Apr-Mar)	2019-20 (OCCG Financial Year Apr-Mar)	Total (18 months)
OCCG New Spend Contribution	£145,579	£176,639	£322,218
OCCG contribution from existing spending and resource			£963,157
Estimated Project Saving (gross) generated from activity savings (saving over a financial year compared to 2016/17 baseline)			£2,293,691
Estimated Net Saving for OCCG (compared to new spend contribution)			£1,971,473

Project plan – preparation and phase 1

Phase	Timeframe	Actions
Phase 0 - preparation	Jan – March 2018	<ul style="list-style-type: none">• BI approval• Provider executive approval• OCCG Finance Committee approval• OCCG sign agreement with BI• MOU/Contract Variation signed by OCCG and Providers to deliver pilot IRT
Phase 1 - mobilisation	March – Aug 2018	<ul style="list-style-type: none">• Recruitment & job plan changes for phases 1 and 2• Single point of referral and pathway/protocol development• Purchase of equipment• Communication• Go live in West locality: 1 June 2018• Evaluation of Phase 1

Project plan –phases 2 and 3

Phase	Timeframe	Actions
Phase 2 - mobilisation	Aug 2018 – Jan 2019	<ul style="list-style-type: none">• Purchase of equipment• Go live in in South East and South West localities: 1 Sept 2018• Evaluation of Phase 2
Phase 3 - mobilisation	Sept 2018 – Dec 2019	<ul style="list-style-type: none">• Recruitment & job plan changes for Phase 3• Purchase of equipment• Communication• Go live in City, North and North East localities: 1 Dec 2018• Evaluation of overall project

Future Patient Story 1

- ❑ Mrs LC, 63 yr old woman, no past medical history, 40 pack yr smoking history.
 - ❑ Proactively identified via IRT as likely to have COPD given smoking history
 - ❑ Diagnostic spirometry undertaken
 - ❑ Diagnosed with COPD
 - ❑ Started on appropriate medical therapies
 - ❑ Develops cough and chest infection – commences rescue antibiotics and steroids
 - ❑ Reviewed by IRT clinical team and no hospital admission required
-

Future Patient Story 2

- ❑ Mr DF, 73 yr old gentleman, end stage COPD
 - ❑ 24 hr oxygen therapy
 - ❑ Care plan: preferred place of death – home
 - ❑ Referred to IRT for intensive therapy
 - ❑ Able to access IRT team for early advice when exacerbation starts
 - ❑ Seen by psychological therapist – underlying anxiety addressed
 - ❑ Identified as being on end of life spectrum
 - ❑ Early involvement of palliative care team
 - ❑ Able to allow patient to die in line with his wishes at home
-

Questions
