The London Respiratory Network 2010-16 using a VBHC approach

Noel Baxter, GP and Clinical commissioner, Southwark
VBHC – part of a broader strategy

- 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’

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

Right Care
Doing the ‘right things’ and doing things right first time
Using Maps

London Respiratory Team working with Muir Gray 2010

‘London Respiratory Team’ 2010-2013 – DH funded ‘SHA’ COPD leadership
London Senate Helping Smokers Quit Programme 2014-2016
Working out the ‘right’ things to do: using a Value framework

* includes experience for population

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*

What is High Value Respiratory Care?
LRN COPD ‘Value’ Pyramid 2011

- **Telehealth for chronic disease**: £92,000/QALY*
- **Triple Therapy**: £7,000-£157,000/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

*not specific to COPD*
High value interventions in COPD
Are we delivering them?

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

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

- 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

Focused on addressing:
- Misuse
- Overuse
- Underuse

& the need to address breathlessness as a symptom better

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.
LRN work on breathlessness and its impact

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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)

Breathless and low oxygen saturation

Respiratory failure = diagnosis and treatment in hospital

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.

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

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

- **Positions to ease breathlessness** IRT Leaflet
- **Breathing Techniques** IRT leaflet
- **Managing your energy levels** IRT leaflet
- **Relaxation for breathlessness** can be an important part of support available IRT Relaxation Leaflet

**Tips for Managing thoughts about breathlessness** IRT leaflet

**Tips for managing breathlessness using a Handheld Fan** IRT Leaflet

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

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 Haah... 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

MAP 1 - Acute London Hospital Sites with COPD Discharge Bundle

- Discharge Bundle with CQUIN or Commissioned
- Discharge Bundle
- No Discharge Bundle

Source: London Respiratory Team Surveys
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

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

NHS England
Specialist Level Palliative Care:
Information for commissioners
April 2016
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
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?

\[
\text{value} = \frac{\text{outcomes}}{\text{cost}}
\]
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

\[
\text{value} = \frac{\text{outcomes}}{\text{cost}}
\]
Thank you
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?*

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**Engagement**
- Patient, family and carer
- Staff

**Segmentation**
- Condition
- Population

---

**Outcomes Hierarchy:**

<table>
<thead>
<tr>
<th>Health status</th>
<th>Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of recovery</td>
<td>Time to recovery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process of recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disutility of care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sustainability of health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term consequences</td>
</tr>
</tbody>
</table>
‘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!

\[
\text{KHP Value} = \frac{\text{‘Outcomes that matter to patients’}}{\text{‘Resources used over the whole pathway’}}
\]
Do better outcomes cost more?

- Fewer complications
- Sustained functionality
- Fewer readmissions

➢ Understand resources but focus on improving outcomes

Requires a system perspective

What about quality? – ensures adherence but not results

(Gunjur, 2015)
Making it work in practice for KHP: A collaborative effort to navigating the way forward

- Informed conversations
- Patient segmentation
- Multi disciplinary teams
- Work force
- Academic research
- Technology
- Communication & Transparency
- PROMS
- Patient, family & carer engagement
- Outcome scorecard