Respiratory Integrated Care Pilot

A Glimpse into the future healthcare

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Common issues with health care

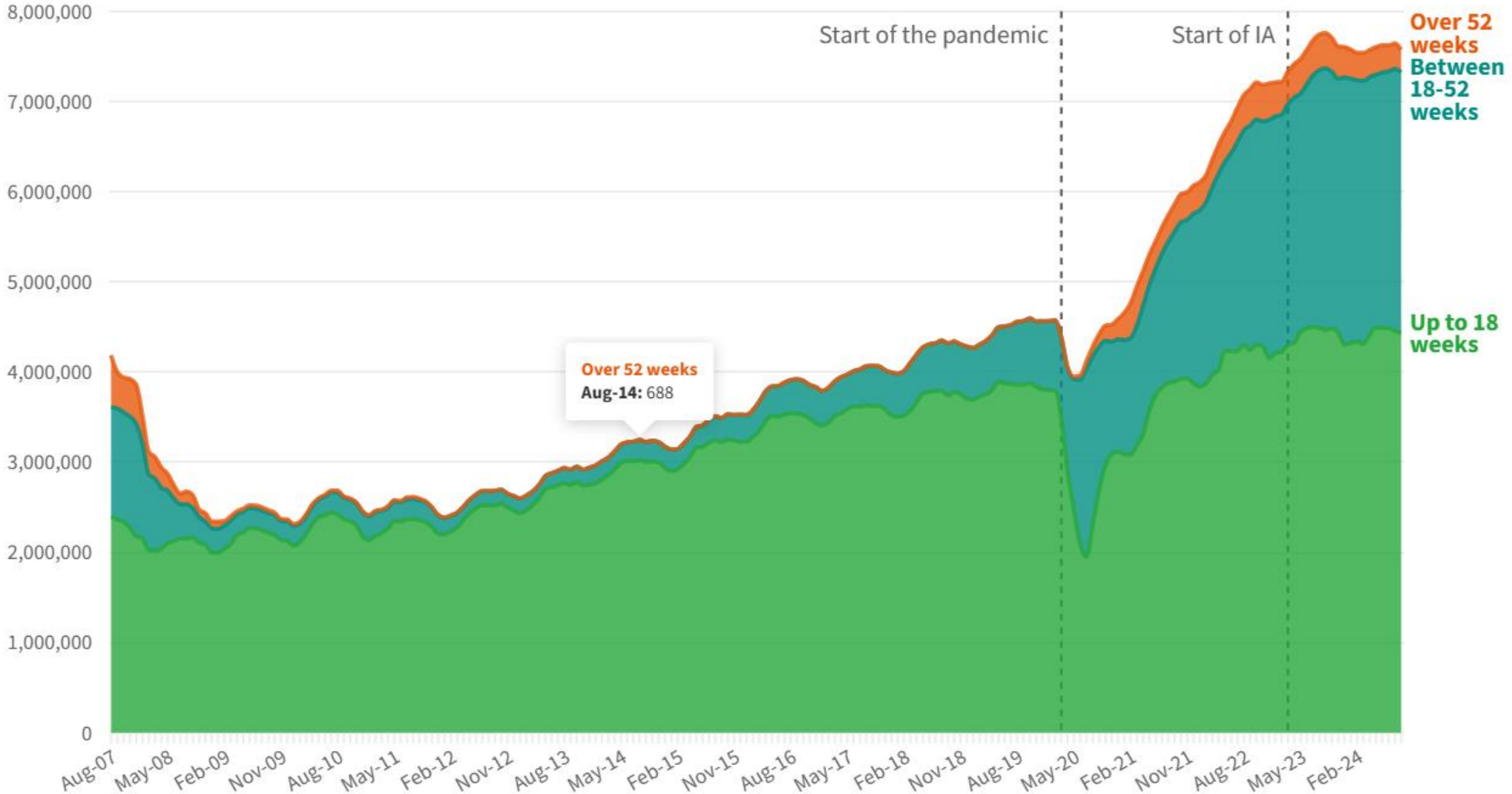
- **Sickness** to prevention
- Care upstream

- **Access**
- Hospital to community

- **Silo working**
- Analogue to digital

Waiting times for consultant-led elective care

August 2007 to September 2024



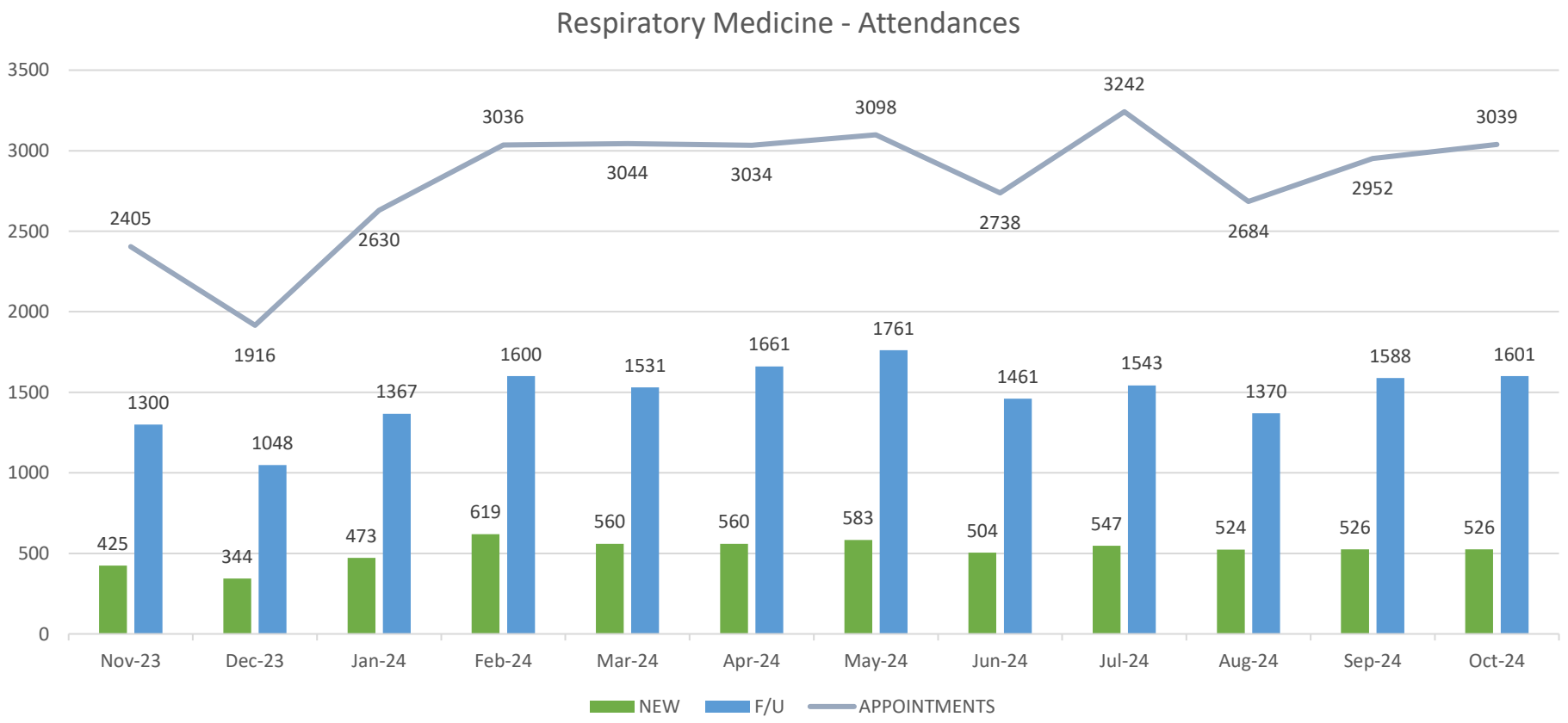
New patient waiting lists as provided by hco 01/11/2024

	Manual	ASI	Rebooking	Referrals for Review	Longest Waiter	Total
Sleep Medicine	90	200	5	0	14.06.2024	295
Respiratory Medicine	Gen - 268	Gen - 536	Gen - 41	2	Gen - 12.07.2023	912
	ILD - 40	Bronc - 2	Bronc - 3		ILD - 14.09.2023	
	L.Covid - 0	L.Covid - 0	L.Covid - 1		L.Covid - 17.10.2024	
	Bronc - 21				Bronc - 03.09.2023	

PNEUMONIA/N		Aug-23	448
Total		-	1655

15-30%
Increase in last 12 months

Patient Attendance



Why integrated care?

Avoid duplication- effective use of resource

- Utilise shared health records
- Integrated chronic disease management

Care delivered at place

- Address health inequality
- Higher patient satisfaction

Prevention and health promotion

- Proactive not reactive- aim to reduce disease burden
- Right care at the right time

SWAN community respiratory care pilot

Scope

- To explore integrated ways of system partners working better together to support patients with respiratory health conditions.

Aim

- Immediate : The pilot will look to improve the care received and outcomes for patients with respiratory conditions, using a collaborative approach, connecting primary, secondary and community care partners.
- Longer term: The pilot aims to look at how we reduce the consumption of care for patients with respiratory conditions across the healthcare system.

Objectives

To review and develop the patient pathway for respiratory care conditions

To develop an integrated approach to chronic disease care, delivered in the patient neighbourhood, using an MDT approach

To develop a new model of care

Move away from transactional referral-based care pathways.

Proactive in our approach to managing patients with respiratory conditions, ‘address tomorrow’s patients today.’

Maximise the value of the workforce to deliver Integrated MDT care

To utilise a single shared care record, recording all patient care information in a single place.

Data led in our approach understanding and utilising

To share knowledge, skills and behaviours enhancing the care offer and empowering patients

To achieve consistent, high quality care for patients with respiratory health conditions

Reduce the demand across the healthcare system for patients with respiratory conditions

Sustainability and scalability (across the locality in other PCNs)

Care in the right time, at the right place

Searches run to identify patients (ILD, bronchiectasis, uncontrolled COPD)

Practices provide light touch clinical validation/prioritisation

Gpas arrange appointments

Clinical appt including health check, spirometry and consultant review

Care Delivered – Dr Oliviera @ Chandler house

- 65 unique patients seen in 84 appointment slots over 12 weeks
- 3 Did not Attend 4 % Vs 8-10% NHS clinics
- GP assistants (GPAs) employed through ARRS supported the administrative side of the pilot- patients were proactively identified for invitation & no practice time or resource was taken up for arranging appointments
- Patients were very engaged, and uptake was high

Holistic health check for all patients

- **All patients seen have had weight, heart rate, BP, smoking status and alcohol intake checked and entered into the GP record by GP assistants**
- COPD reviews were coded into the record by the consultant
- This avoids the need for an additional nurse led COPD review in practice
- Additionally, the GPA contact provided **an opportunity to proactively detect other health problems**
- Tasks sent back to practices to pick up new hypertension, low mood and unintentional weight loss
- This approach increased patient engagement with practice to address unmet needs

Outcomes

- **All patients had spirometry when indicated (56 of 65 patients) – 12 month waiting time**

- Respiratory specialist nurse, increasing the visibility of role within the community and allowing patients to understand the support available to them. Connecting PC + Secondary care

- **All patients had their current treatment reviewed and optimised**
- 52% had their prescriptions changed – No Delays
- 4 patients IPF for further treatment i.e. antifibrotics (Reducing 9 months)
- 1 was referred directly to virtual ward for acute treatment (Preventing A/E admission)
- 1 patient had an HRCT which showed a new primary lung cancer
- All COPD patients were signposted to community COPD nurses - Pul rehab, IAPT, Chest Physio.

For patients with more complex needs a personal *written* care plan

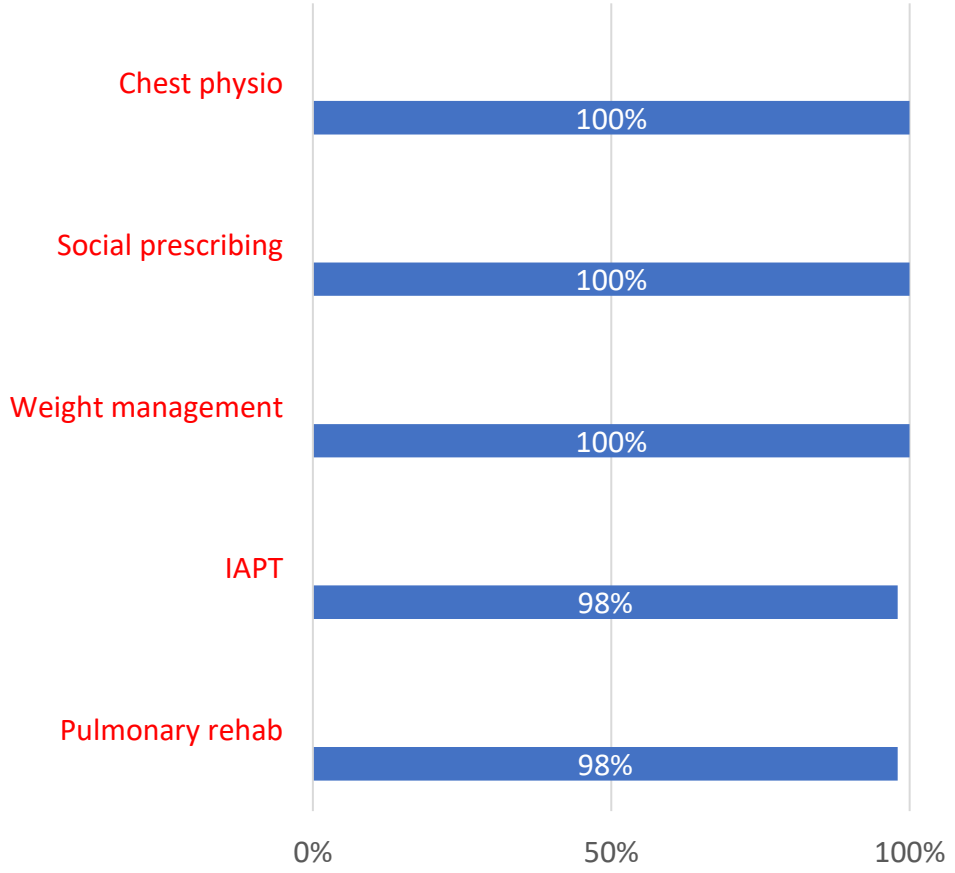
Smoking

- **All current smokers received smoking cessation advice and education, and were signposted to community smoking cessation services**

- Some patients who were perceived to be less motivated to stop smoking were started on NRT within the appointment to improve uptake and adherence

Onwards referrals to community services

- When indicated patients were referred on to community services for further management
- High levels of engagement with the pilot
- Proactive use of neighbourhood services likely to reduce morbidity over time and
- Reduce reliance on repeated presentation to primary care to access support



Patient feedback

At the time of booking patients were surprised and pleased to be contacted and there was a very high uptake of the offer

All patients who left written feedback said they were “very satisfied” and no potential improvements were suggested

All patients said the team worked well together and that the location was very convenient for them

All patients left the clinic feeling better equipped to manage their condition

Clinician feedback

Practices said there was no added workload for them but obvious benefit for patients

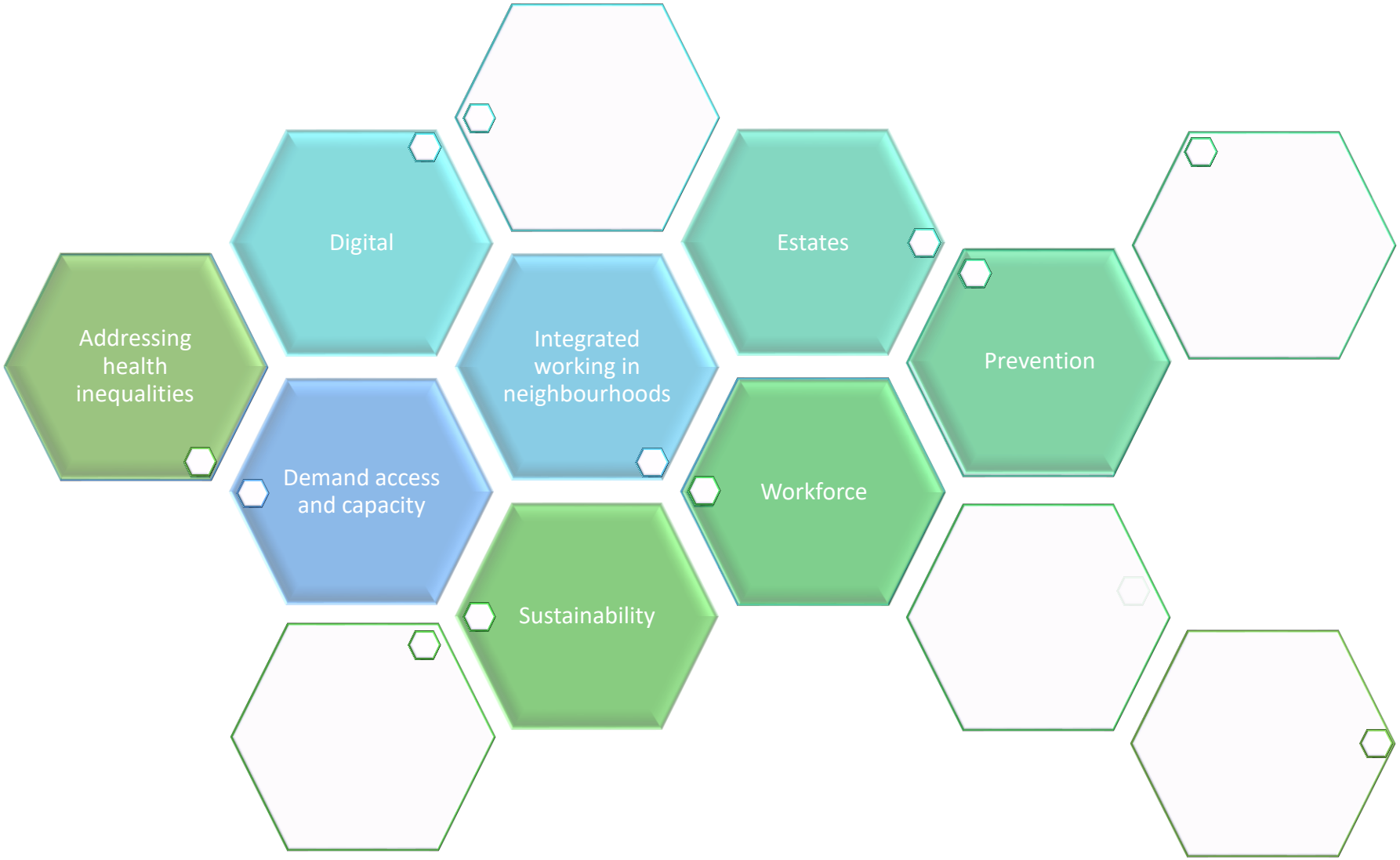
Respiratory nurse felt she benefitted from working at place and understanding local community

GPAs felt valued and integrated working as part of the broader team

Consultant felt clinic more efficient due to being able to make changes in record and avoiding dictation/letters

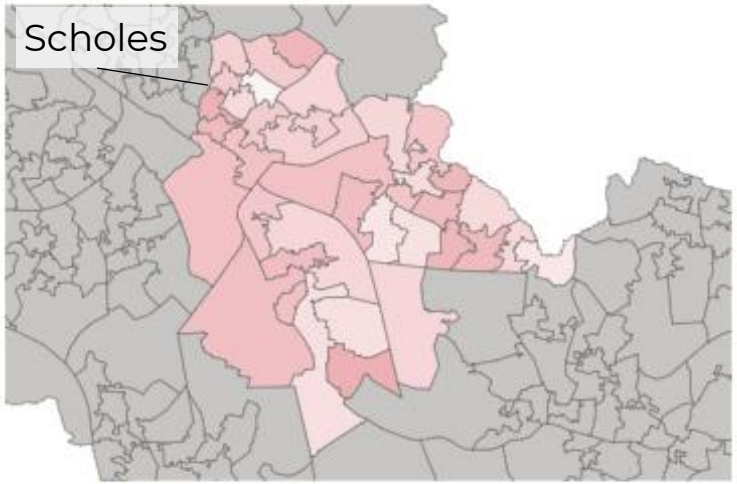
Aligning to Primary Care Blueprint

- Darzi
- Fuller
- Hewitt
- Messenger

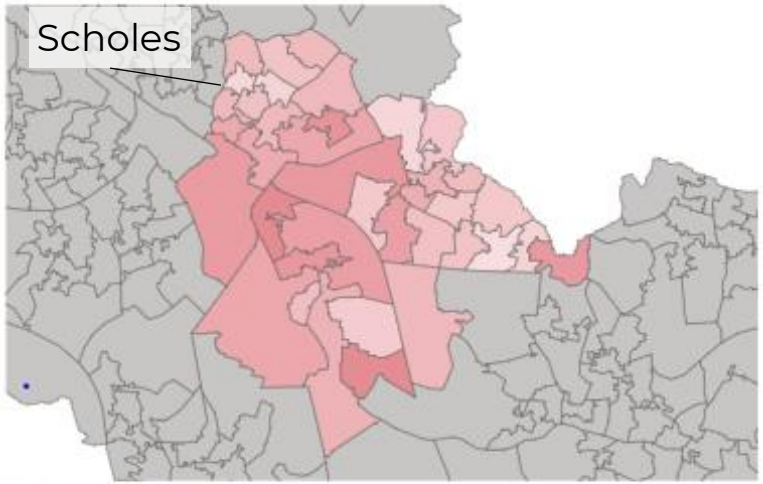


Hindley PCN (formerly PASHI)- joining the dots...where next

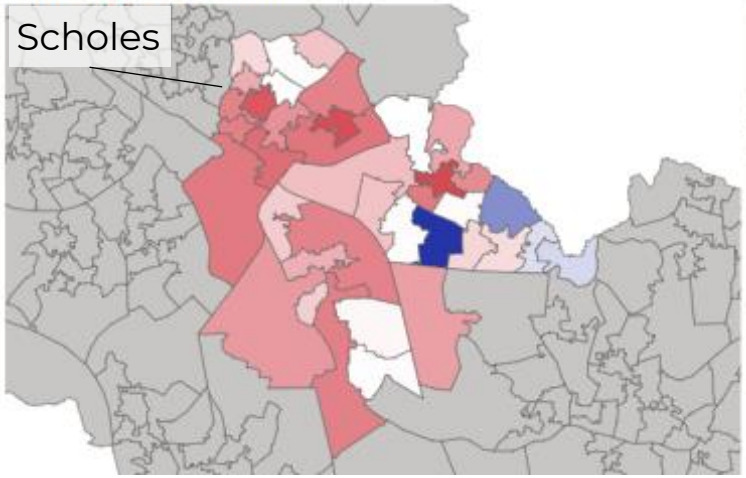
NEL Admission



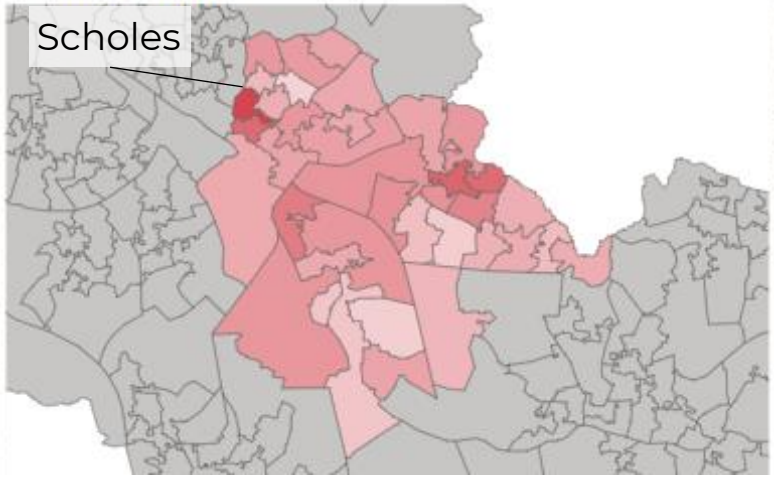
A&E Attendances



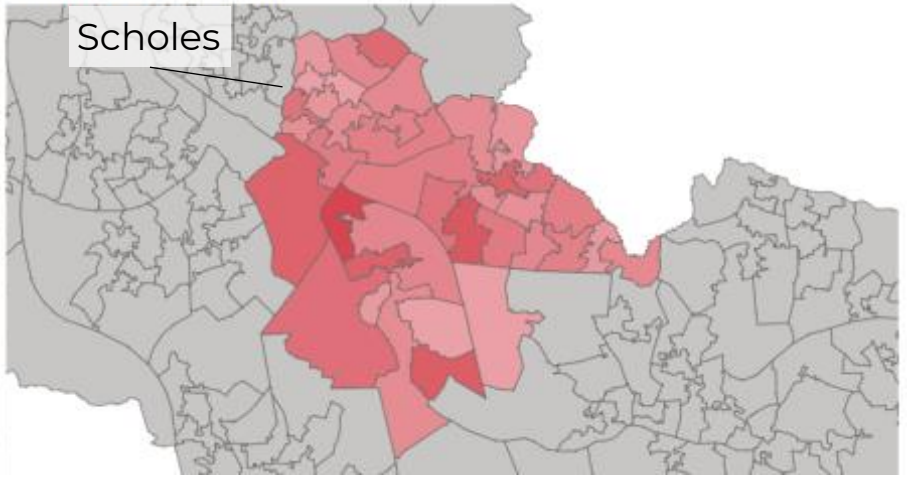
Smoking Prevalence



COPD Prevalence

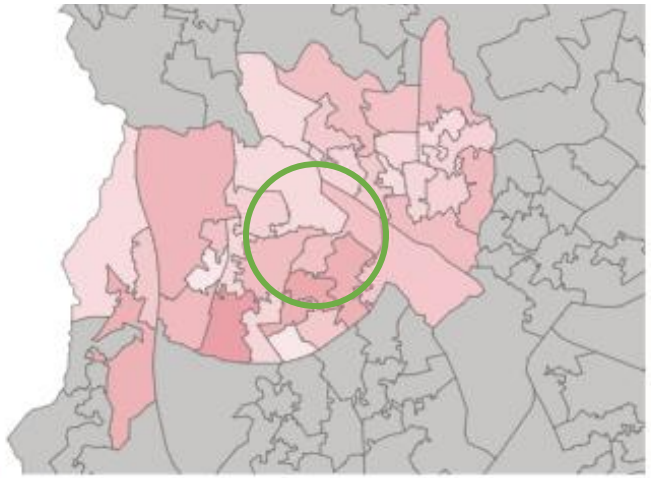


Asthma Prevalence

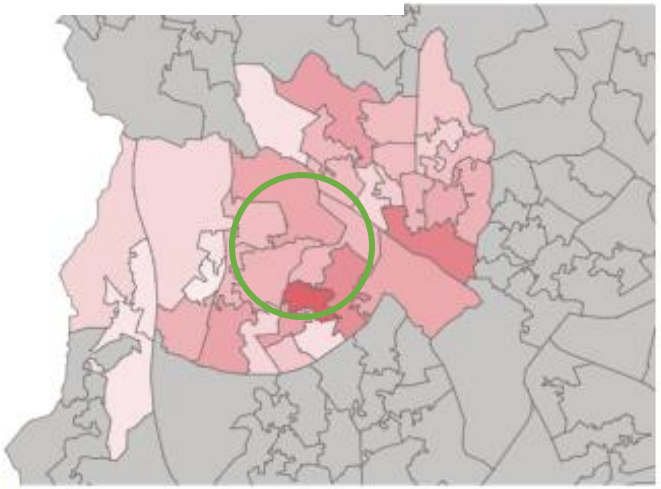


Wigan Central PCN

NEL Admission

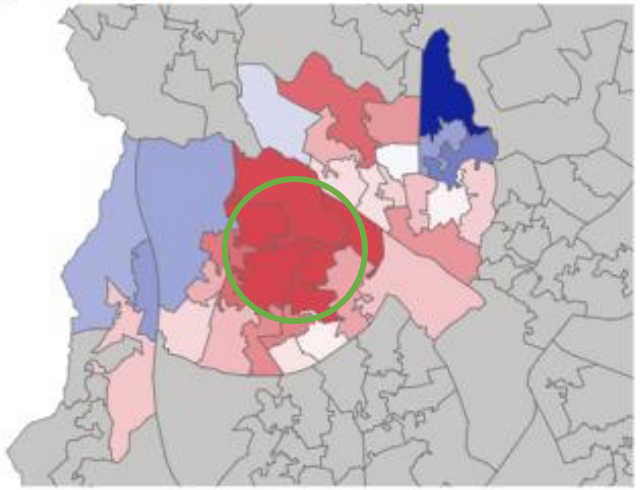


A&E Attendance

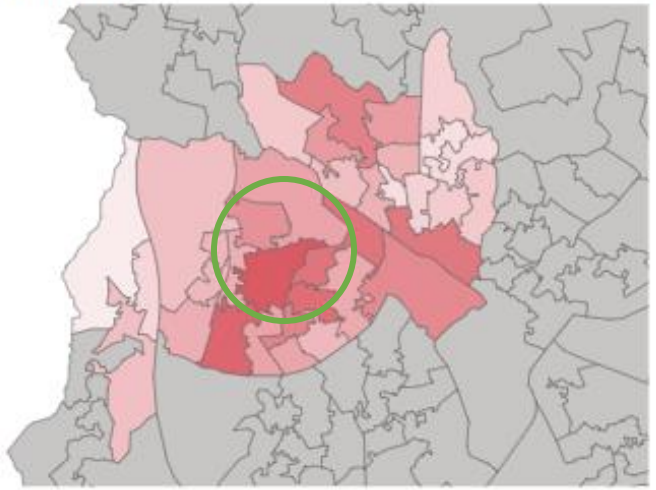


- The highest need areas of Wigan Central is the cluster including Marsh Green, Worsley Hall, Norley and Newtown.
- This cluster of areas has a particularly high smoking prevalence, COPD and Asthma Prevalence.
- Worsley Hall in particular has high number of A&E attendance.

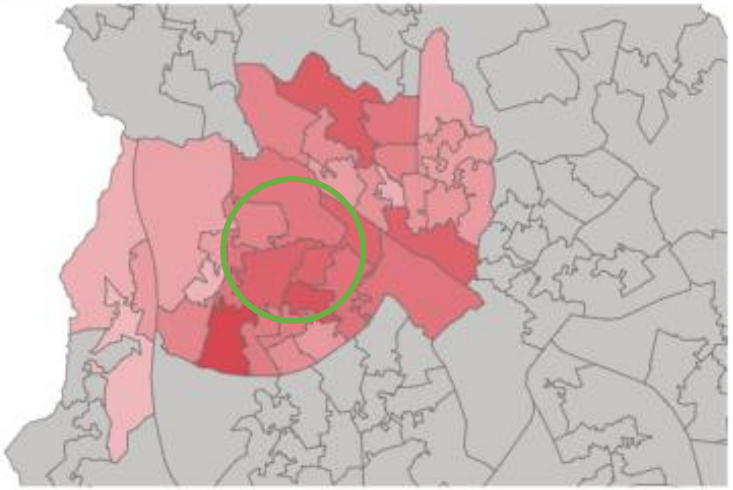
Smoking Prevalence



COPD Prevalence



Asthma Prevalence



Further Considerations

- Health Improvement Services
  - We are currently mapping the health improvement services (e.g. smoking cessation, alcohol services) closest to each suggested site
  - Given the complexity of differing needs between patients, we are investigating using Link Workers to help direct patients to these services
- Housing Quality
  - Poor quality housing worsens respiratory illness
  - But data on housing quality is sparse
  - And pathways to improve housing quality are more complex than other health improvement services
  - Link Workers may be able to help here as well

Aligning with Health research and learning from experiences

- Aligned with health care academics from edgehill
- Planning for scaling up
- Data collection & evaluation planning
- Simultaneous review of research possibilities
- Sharing of results with wider partners
- Research part of “business as usual”

Conclusion

- Integrated care at pace is an effective way of reducing duplication and strengthening connections between previously disparate areas of the wider health care system
- Proactive approach picks up patients before they become unwell and do not need to rely on unplanned care
- Integrating specialist consultant knowledge with hyper-local primary care knowledge and resource serves provide holistic care with greater patient engagement
- Provision of planned care at place reduces health inequalities across neighbourhoods
- This approach is sustainable and generalisable across localities with input at PCN level to support the service
- Engagement with wider educational / research partners and public health teams to improve research and care across the borough
- Research and improvement “part of usual business “

- Further PCN clinics in new year
- Guided by public health data
- Template for other specialist clinics

Glimpse into the future

- Care closer to home
- Digitally enabled Integrated teams
- Managing diseases upstream
- Reducing referrals to secondary care
- Healthier population

Acknowledgments

- Dr Shameen Oliveira (Consultant Respiratory physician)
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Thanks for your attention

Questions ?