Respiratory OGIM - 2021

Why change is needed

- Respiratory disease affects one in five people and is the third biggest cause of death in England (after cancer and cardiovascular disease). Lung cancer, pneumonia and chronic obstructive pulmonary disease (COPD) are the biggest causes of death.
- Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally.
- Respiratory diseases are a major factor in winter pressures faced by the NHS, most respiratory admissions are non-elective and during the winter period these double in number.
- The annual economic burden of asthma and COPD on the NHS in the UK is estimated as £3 billion and £1.9 billion respectively. In total, all lung conditions (including lung cancer) directly cos the NHS in the UK £11 billion annually.
- Incidence and mortality rates from respiratory disease are higher in disadvantaged groups and areas of social deprivation, with the gap widening and leading to worse health outcomes. The most deprived communities have a higher incidence of smoking rates, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards.

From:https://nhs.sharepoint.com/sites/msteams_431e61CountyDurhamPlanningGroup/Shared%20Documents/County%20Durham%20Planning%20Group/OGIM%202021%20%20NEW/Respiratory/OGIM%20Respiratory%202021.docx

Objectives

- Improved services and outcomes for respiratory disease.
- Provide an integrated approach to delivery which involves communities, voluntary organisations and the health and care system.
- Focus on prevention, early detection and diagnosis and optimal treatment options, concentrating interventions initially on populations at greater risk.
- Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities.

Goals

- Enable early and accurate diagnosis of respiratory diseases, by supporting the training of staff to deliver tests such as spirometry.
- Expand pulmonary rehabilitation services across the country so that patients who would benefit complete treatment in a good quality service.
- Improve appropriate prescribing of medicines and the way they are reviewed, and support patients to use their inhalers properly.
- Design and develop tools and programmes that will support patients to manage their condition themselves and receive personalised care.
- Impro the treatment and care of people who present with community acquired pneumonia.

COVID - 19

- A new cohort of patients affected by COVID-19; who have a plethora of physical and psychological symptoms that require an integrated approach (including respiratory)
- Our existing patient groups, many who have multi-comorbidities (including respiratory); they may also have now suffered an episode of COVID-19
- Develop working groups across the Health and Care System – involving public health, DCC and voluntary services to develop community pathways for respiratory, pulmonary, cardiac and other LTCs.
- Support our workforce to work differently, ensuring they have the skills required (understand the training needs) Develop new roles to support innovative pathways.
- Continue to prioritise and implement the "Living Well With" Strategy (using Living Well With COVID-19 to influence the processes, pathways and MDT approach).
- Home blood pressure monitoring (HBPM) was identified as a priority for CVD management during and after the COVID-19 pandemic to ensure that patients who are vulnerable to becoming seriously ill, can manage their hypertension well and remotely, without the need to attend hospital or GP Practice appointments.
- The COVID Oximetry @ Home Service is to enable enhanced self-management by patients discharged from a hospital setting, presenting at practice or notification from 111 with likely or confirmed COVID, who are clinically stable at presentation, but remain at risk of deterioration because of their age, co-morbidities or other concerns identified at the initial clinical assessment. Enhanced self-management support, including the use of oximetry, will enable early identification of deterioration, in particular silent hypoxia, so that appropriate action can be initiated as quickly as possible.

Focus on the four key points to ensure interventions are evidence based, integrated and community focused.

I. **Redesigned evidence based trans-diagnostic pathways**
   a. Current single diagnostic pathways will not adequately meet the physical, psychological and social needs of patients.
   b. A trans-diagnostic pathway would enable allow a wider cohort of people to access appropriate rehabilitation. This is of particularly important during the current pandemic due to anticipated escalating rehabilitation demands with multiple presenting symptoms.

II. **the development of integrated and cross-organisational roles**
   a. to address patient specific trans-diagnostic needs including.
   b. Redesigning current roles for qualified clinicians (e.g. nurses, physiotherapists).
   c. Working with Public Health and County Council (e.g. Wellbeing for Life).
   d. Working with Mental Health Organisations (TEWV).

III. the use of the Patient Activation Measures (PAMs) [1]
   a. Targeting appropriate people/ care.
   b. Shared decision making.
   c. enablement to self-management approach.

IV. **A programme of training for upskilling the current and future workforce for psychologically informed care**.
   a. CBT training already embedded within Respiratory Team.
   b. Workshops and training which could enhance PAMs.

Triple Aim Outcome Measures

Health Outcomes	Patient Experience Outcomes	Workforce Outcomes
1. Number of annual COPD health checks in primary care	1.Patient hospital attends resulting in a non-elective admission	1. Number of nurses trained and competent in delivering diagnostic spirometry treatment

Initiatives

Project Gantt Chart	20/21	21/22	22/23	23/24	24/25	BRAG
1. Health Inequalities						
Respiratory Clinical Advisory Group reviewing national and local guidelines and ensuring these are embedded in our services and pathways.						
Ensure adequate provision of Pulmonary Rehabilitation is commissioned and funded by CCGs, and that pathways into community physical activity provision ensure this element is sustained.						
Increasing flu vaccine uptake for adults and children. (Children's Public Health Flu campaign this year is "Protectorsaurus" *dinosaur themed).*						
2. Health Behaviours (Alcohol, Tobacco, Nutrition and Physical Activity)						
Development of a diagnostic spirometry service across County Durham, either to be delivered by CDDFT alone or with support from PCNs. Need to rationalise who does this. Must be ARTP trained to carryout test. Needs to have clear screening guidelines/referral criteria into the service and consideration of staffing required/skill mix.						
Address the backlog of patients who are waiting for diagnostic spirometry testing for those without a confirmed COPD or Asthma diagnosis. (The backlog is due to there being no service provision in the community during the COVID pandemic.						
To implement a FeNO service for newly diagnosed asthmatics (adults and paediatrics).						
Reduce the prevalence of harm caused by smoking through tobacco control measures and redesigning the stop smoking service to improve the services to tackle tobacco-related ill health						
Increase the use of active travel to encourage physical activity (including cycling and walking) to reduce traffic emissions related respiratory illness and carbon emissions						
3. Personalised Care						
Continue to meet the needs of people with Covid-19 through the integration of Personalised Care approaches are supporting people within the Post / Long Covid pathway.						
Education plan for patients at point of diagnosis, including education on correct inhaler techniques.						
Implement Blood Pressure monitoring@home with a focus on shared decision making.						
Continue to deliver COVID Oximetry@Home, an enhanced self-management pathway giving power to the patient to manage their own care.						
Help people to manage their own long-term conditions including diabetes and respiratory conditions through self-management programmes through a range of methods, including digitally, to access advice, self-help in minor illnesses and health (including mental health) promotion						
4. Mental Health and Learning Disabilities						
Access to CBT for patients with breathlessness with history, examination & investigation to be completed prior to referral.						
Continue to provide MDT support (including Mental Health Support) for people suffering with Long COVID through the Long COVID Clinic.						
Ensuring people with respiratory problems whose emotional wellbeing has suffered as a direct impact of COVID (including those who have not actually suffered an episode of COVID) are signposted to the Durham COVID Resilience Team (CRT) for additional psychological support.						
5. Children						
Encourage the use of the Little Orange Book app for parents when launched in September 2021.						
Promote the Little Orange Book to parents – given to all pregnant people at "booking appointment" by the midwife, electronic version sent out via Badgernet (maternity app). Promoted by Health Visitors, nurseries and schools.						
Invest in training and equipment for Primary Care accurately measure oxygen saturation in babies and those aged under 2 to enable care at home when clinically appropriate preventing secondary care admission or A&E attendance for RSV related illness.						
Primary Care and Secondary Care clinicians working in collaboration to set up a direct advice telephone line for GPs who have a young baby in practice presenting with an RSV related illness to offer advice.						
Primary Care and Secondary Care clinicians working in collaboration to identify and help practices target families frequently walking into A&E for their children. Assertive outreach and targeted education.						
James Carlton and Godfrey Nyamugunduru to produce a 5 minute online refresher/training video for GPs and Secondary Care Clinicians in relation to RSV illness in patients aged 2 and under, so everyone in the system is giving the same consistent message and are aware of what each other are doing.						
Communications and education to our voluntary and community sector (VCS) providers on infection prevention and control for respiratory hygiene and where families should be signposted to have their needs met appropriately within the health system - County Durham - Jo Laverick from Durham Community Action.						
6. Digital						
Consider alternatives for current Pulmonary Rehabilitation classes, such as myCOPD App/videos at home, days & times of sessions and venues. Engagement with patients.						
Implement the use of Health Call in the Long Covid service to support data collection and evaluation.						
Continue the use of Health Call in the COVID Virtual Ward service to support data collection and evaluation.						
Continue the use of AccuRx to support BP@Home.						
7. Finance						
Review/intervention of over/under use of patient's inhaler prescriptions - Work with Meds Ops and Local Pharmacy committee.						
Invest in Diagnostic Spirometry Service to ensure sustainable and safe service delivery.						
8. Integration						
Increased use of community resources for people who are unable to commit to the intensity of pulmonary rehabilitation, or because of days & times of sessions and venues.						
Continue integrated approach to deliver Long Covid service and use this approach as a basis to deliver the Living Well With Strategy for other Long Term Conditions.						
9. Cultural Change						
Increase focus on preventing respiratory ill health including smoking cessation or switching to vaping.						
Focus on changing inhalers to those that are CSE friendly in line with the green strategy.						