The greatest pleasure in life is doing what people say you cannot do. Anonymous

Wendy Fairhurst
Nurse Partner Marus Bridge Practice
Clinical Director Health First ALW
Community Interest Company
Commissioning a breathlessness service

- PBC (2009)
- Germ of idea
- Commissioning plan
- Health First
- Delivery
- Evaluation
- Rollout
Developing a commissioning plan

- Starts with an idea
- Research and gathering evidence
- Identification of issues
- Stakeholder involvement
- Map out current pathway
- Patient journey
- Cost analysis
- Design future pathway
- Cost analysis
- KPIs
- Evaluation
Your idea

- If you think you are too small to be effective, you have never been in the dark with a mosquito

- Knowledge of area
- Clinical knowledge
- Knowledge of client group
Research and gathering evidence

- Local information
- National/international research
Approximately 15–20% patients misdiagnosed
Local projects (COPD Salford and Blackburn) 40–60% admissions prevented
RCT (COPD USA) 41% admissions prevented
CHD NSF (Heart Failure) 50% admissions preventable
Asthma UK – 75% of admissions avoidable
This chart shows the proportion of residents within England, the region and the local authority living in neighbourhoods belonging to each of the five national deprivation quintiles. These quintiles were derived by arranging all the small areas (Lower Super Output Areas) in England in rank order according to the deprivation scores in the Index of Multiple Deprivation 2007 and dividing them into five equal groupings. The resident numbers are based on the 2005 population figures.

<table>
<thead>
<tr>
<th>Quintile</th>
<th>Residents %</th>
<th>Residents Number</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>5.1</td>
<td>15,423</td>
</tr>
<tr>
<td>2</td>
<td>20.5</td>
<td>62,547</td>
</tr>
<tr>
<td>3</td>
<td>20.0</td>
<td>60,822</td>
</tr>
<tr>
<td>4</td>
<td>22.9</td>
<td>69,768</td>
</tr>
<tr>
<td>5</td>
<td>31.5</td>
<td>96,021</td>
</tr>
<tr>
<td>All</td>
<td>100.0</td>
<td>304,581</td>
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</tbody>
</table>
Deprivation

Smoking, Alcohol

COPD

Admissions and Mortality

Diet, Obesity

CVD -HF
Why breathlessness?

- COPD and HF cause of significant morbidity and mortality
- High rates of admissions and readmissions
- Misdiagnosis Common
- QoF process rather than outcome
- Wide Practice Variation
- Respiratory disease accounts for 21% excess deaths
- Low Quality
- Poor Experience
- High Cost

Co-morbidities Common but Disease specific approach
Problems with diagnosis between cardiac and respiratory causes of breathlessness

Multiple pathologies managed individually not holistically

Limited post-exacerbation follow-up in practice teams – many factors

No detailed personalised management plans
Case Review pilot (continued)

- COPD diagnosis covering other causes of worsening Breathlessness
- Haphazard medication regimes – medication not optimised
- Limited follow-up of patients on o2 therapy
- Poor servicing and technical problems identified with home nebulisers
- Patients who might benefit from o2 not being identified
Feedback from Primary Care

- Difficulties in the management of patients with multiple pathology
- Patients referred to multiple hospital consultants and specialist nurses – inconvenience and confusing for patients – delays in appropriate treatment
- Difficulties for some patients in accessing services
- Travelling is difficult for this group of breathless patients
- There are a high number of follow-up out-patient appointments. These are inconvenient for patients, result in a high level of DNAs and costly for the PCT
Under diagnosis of COPD and Heart Failure in ALWPCT when compared with expected prevalence resulting in poor control.

“Patients with poorly controlled heart failure are more likely to be symptomatic and therefore tend to utilize hospital services more often than those with well-controlled heart failure. As such, these patients are a significant source of ‘revolving door’ patients.”
Health Equity Audit – Heart Failure

The recorded prevalence of heart failure in ALWPCT is remarkably low

1. under-reporting
2. under-diagnosis
3. effect of increased cardiovascular mortality.

The poor detection rates, and conceivably treatment rates, will have implications on healthcare resource utilisation and therefore requires further scrutiny and intervention.

The reported proportion of heart failure patients in receipt of ACE-inhibitor or angiogenesis II antagonist therapy compares favourably with regional and national Figures.
Health Equity Audit COPD

- Reasons for under-recording include clinical cases being missed and because significant airflow obstruction may be present before individuals become aware of it.

- A significant proportion of patients with COPD are not being recognized
Higher numbers of admissions occurred in the winter months. There appeared to be marginally fewer admissions at weekends.
Identification of issues
Why is the Service Needed?

- For patients with asthma, COPD and heart failure in Ashton, Leigh and Wigan there is:
  - Mortality levels above national and SHA average
  - Admission levels above national and SHA average
  - Under diagnosis
  - High levels of multiple long term conditions
  - Fragmented services with lack of co-ordination
- Evidence from other projects
Stakeholder involvement/engagement

- Consultation and involvement
- Patient groups
- Gps and practice nurses
- Practice staff
- Secondary care
- Community services
- Public health
- Medicines management
Map out current pathway

- Patient journey
- Cost analysis
## Enhanced on-going care/case management

### Current Care

- **ALL with Established Disease**
  - GP: QoF Annual Review
  - Full Meds review
  - Pneumonia Flu jab
  - Spiro
  - MRC breathlessness score

### Case Management

#### Moderate – Severe:
- **QoF Annual Review +**

<table>
<thead>
<tr>
<th>History &amp; Examination</th>
<th>Full Meds review</th>
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</thead>
<tbody>
<tr>
<td>Request Chest X-ray</td>
<td>Pulse oximetry</td>
</tr>
<tr>
<td>Bloods</td>
<td>Inhaler technique</td>
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</tbody>
</table>

- **Exclusion of other pathology**
- **Exacerbations: History**
- **Review of equipment**
- **Ensure LTOT review performed**
- **Optimise treatment**
- **Management & Self care planning:**
  - Social support
  - Education re: exacerbations
  - Public health: Housing, environment, weather
  - Mental Health assessment

### Quality of care? Quality of life? exacerbations? unplanned care
Current Journey to Diagnosis

Current Journey

GP Appointment (History & Examination)

1. Diagnostic 1 (SPIRO or ECG)
2. Diagnostic 2 (Bloods)
3. Diagnostic 4 (ECG or SPIRO)
4. Diagnostic 2 (BNP)
5. Diagnostic 3 (ECHO)

Consultation

Consultant-led Care

On-going Care

1-Stop Diagnostics

GP Appointment (History & Examination)

1 Stop Diagnostic

On-going Care

Consultant-led Care
Future pathway

- The shortest distance between two points is under construction.
  Noeli Alito
Cost analysis

- I did not have three thousand pairs of shoes, I had one thousand and sixty.

Imelda Marcos
KPIs

- Objectives
- Ethos
Objectives

- Reduce unplanned admissions from these conditions
- Reduce excess bed days
- Reduce OPD appointments following echocardiogram
- Improve data collection in Primary Care
- Improve discharge notification to primary care
- Ensure that patients with moderate to severe disease have a personalised management plan
- Ensure that patients with moderate to severe disease are reviewed at least twice per year
- Increase referral to pulmonary re-habilitiation
- Increase referrals to stop smoking services
- Improve medicines management (appropriate inhaler use, beta blocker use, SBOT (short burst o2 therapy) use
- Increase the uptake of seasonal flu and pneumonia vaccinations (associated with reduced unplanned admissions)
- Review exception reporting in consortia practices
- Increase AWARM referrals (see public health report – fuel poverty associated with excess winter mortality and admissions) Add in core objectives from paper
Ethos of the Service

- Establishing the correct diagnosis
  - New or worsening breathlessness
- Co-ordination of care at all levels
- Patient centred
  - Practice and Locality based
  - Reducing attendances
- Post exacerbation assessment and prevention
- Focus on high risk patients
A government that robs Peter to pay Paul can always depend on the support of Paul.  

George Bernard Shaw

- Being political
- Understanding your stakeholders
- Finding allies
- Agendas and Drivers
Why Health First?

- Community Interest Company
- No shareholders
- Not for profit organisation
- GP Directors
- Distinct separation from commissioners
Evaluation

- At 12 months
Evaluation – ALPF Admissions

Breathlessness: Number Of Emergency Spells

<table>
<thead>
<tr>
<th>Year</th>
<th>Spells: ALPF</th>
<th>Spells: Other</th>
<th>ALFF: No Change Trend</th>
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<tbody>
<tr>
<td>2010/11</td>
<td>150</td>
<td>350</td>
<td>100</td>
</tr>
<tr>
<td>2011/12</td>
<td>400</td>
<td>450</td>
<td>200</td>
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</table>
Evaluation – ALPF Outpatients
## Evaluation – Diagnosis Service

<table>
<thead>
<tr>
<th>Referred to service</th>
<th>282</th>
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<tbody>
<tr>
<td>New COPD</td>
<td>88</td>
</tr>
<tr>
<td>COPD diagnosis confirmed treatment optimised</td>
<td>29</td>
</tr>
<tr>
<td>New asthma</td>
<td>27</td>
</tr>
<tr>
<td>Asthma diagnosis confirmed treatment optimised</td>
<td>13</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>35</td>
</tr>
<tr>
<td>Other</td>
<td>43</td>
</tr>
<tr>
<td>DNA</td>
<td>12</td>
</tr>
</tbody>
</table>
Cost of Service

- Total contracted price – £174k
- Diagnosis service – £20k
  - £70 per patient
- Underspend – £30k
- Net Cost of Review Service £124k
Savings (£000)

- Admissions – £75k
- Outpatients – £15k
- Prescribing – £31k
- Total verified savings £121k
- Potential savings on increase in admissions in practices not using Health First – £49k
“Nurses don’t generate income......... They generate care. For which we make no apology!”
Nurse Hathaway – ER