GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS
Greater Manchester and Eastern Cheshire Strategic Clinical Networks

Improving Respiratory Care in Greater Manchester

Friday 30 November 2018
Held
10:00am – 3:30pm
Crowne Plaza Manchester - Oxford Road, 55 Booth Street West, Manchester, M15 6PQ

Contents

1. Introduction

The purpose of the event is to update stakeholders on emerging proposals for Greater Manchester and to obtain wide stakeholder input on Greater Manchester initiatives.

Our aims are:

- To inform stakeholders of the planned Greater Manchester approach to tackling respiratory disease.
- To obtain wider stakeholder views on emerging priorities.
- To obtain wider input in to proposed solutions.
- To obtain details of people who would like to be involved/should be involved moving forward.

2. Brief background & rationale

Respiratory disease is second only to circulatory disease when it comes to total spend, bed occupancy and non-elective admissions. Unplanned admissions and prescribing expenditure are high and hospitals often struggle to accommodate respiratory demand especially during winter.

Following some initial scoping work carried out by the Health and Social Care Partnership, it was concluded there are a number of challenges across the broad spectrum of respiratory disease and despite a number of initiatives being proposed:

- It was unclear if the initiatives would address the main challenges and;
- It was clear current and planned initiatives could be co-ordinated more effectively

With this in mind, the Executive Lead for Quality in the Health and Social Care Partnership (H&SCP) asked the Strategic Clinical Network (SCN) to begin work identifying what needed to be done in addition to what is already being done (or planned to be done) across GM and outlining what a GM respiratory programme might look like.

Key Points

The SCN has begun liaising with a wide range of respiratory stakeholders and has set up a GM Respiratory Steering Group consisting of clinicians, commissioners, Taking charge leads and patient/public representation.

The aims are to:

- Identify GM priorities based on the biggest impact
- Review existing initiatives against the priorities
- Propose (where necessary) a set of new existing initiatives where there are gaps/opportunities and;
- Make recommendations as how to co-ordinate respiratory initiatives more effectively.

Through wider consultation the proposals and recommendations will form the GM Respiratory programme.

3. The programme

Time	Title	Presenter
9:30 – 10:00am	Arrival registration, networking and refreshments	
10:00 – 10:10am	Welcome and introductions and purpose of the event	Peter Elton, Clinical Director, GMEC SCNs
10:10 – 10:35am	Emerging priorities and the view from secondary care	Dr Jennifer Hoyle, Consultant Physician and Respiratory Lead, Pennine Acute Hospitals NHS T and Clinical Lead, GMEC SCNs
10:35 – 11:00am	Emerging priorities and the view from primary care	Dr Murugesan Raja, GP Member, Manchester Health & Care Commissioning and Clinical Advisor for Respiratory in Primary Care, GMEC SCNs
11:00 – 11:15am	Refreshment break and networking	
11:15am – 12:45pm	Workshop 1 ¦ Views on emerging priorities (stakeholder discussions and input on the emerging priorities and proposals)	All
12:45 – 2:00pm	Lunch, networking and respiratory market place	
2:00 – 2:20pm	The role of health innovation	Dr Binita Kane, Consultant Chest Physician and Respiratory Lead, Manchester University NHS FT, Health Innovation Manchester
2:20 – 2:40pm	Experiencing respiratory care ¦ A patient's perspective	Ian Kenworthy, Respiratory care service user
2:40 – 3:05pm	Workshop 2 ¦ Cradle to grave management pathways (stakeholder input)	All
3:05 – 3:20pm	Workshop 3 ¦ Things we need to consider table top discussions (stakeholder input)	All
3:20 – 3:30pm	Wrap up and close	Dr Peter Elton

4. Speaker biographies

Dr Peter Elton

Peter has been the Clinical Director of the Strategic Clinical Network since their inception five years ago. He has been in public health for 41 years and was a director of Public Health for 18 years. He has a long-standing interest in tobacco, having set up a smoking cessation service in North Manchester in 1984 and was the Greater Manchester public health lead on smoking. He is a member of the Joint Committee of Vaccination and Immunisation (JCVI) and chairs a voluntary organisation for people with learning disability and chronic mental illness.

Dr Jennifer Hoyle

Dr Jennifer Hoyle is a Consultant Respiratory Physician and Occupational Lung Disease Lead at Pennine Acute NHS Trust, based at North Manchester General Hospital. She has run a busy Occupational Lung Disease department there since 2004, is a member of GORDS UK (Group of Occupational Respiratory Disease Specialists) and the British Thoracic Society SAG. Dr Hoyle is an Honorary Lecturer at Manchester University and is a member of the SWORD Committee there. Dr Hoyle has numerous publications in Occupational Lung Disease including Interstitial Occupational Diseases. Jennifer has been the Clinical Lead for Respiratory at the Greater Manchester and Eastern Cheshire Strategic Clinical Network since June 2018.

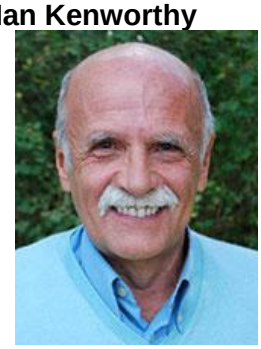
Dr. Murugesan Raja

Dr Murugesan Raja is a General Practitioner with special interest in Respiratory Medicine. Dr Raja works as the Lead GP for Hope Citadel at John Street Medical Practice, and Hawthorne Medical Centre. He has been the Clinical Lead for Respiratory Medicine for Central Manchester CCG since 2014 and in 2017 the role became citywide. He is currently also Clinical Lead for Quality and Performance and a GP Governing Board Member (Central) for Manchester Health and Care Commissioning. His other roles include GP Trainer, Speaker, Member of Health and Wellbeing Board for Manchester and on the GP Reference Panel for National Institute of Clinical Excellence. Since June 2018, he is the Clinical Advisor for Respiratory in Primary Care at Greater Manchester and Eastern Cheshire Strategic Clinical Network.

Dr. Binita Kane

Dr Binita Kane is a Consultant Respiratory Physician at Manchester University Foundation Trust with an interest in airways disease. She is currently the clinical lead for Integrated Respiratory Care for Manchester University Foundation Trust and a member of the GM Respiratory Steering group. She is the clinical lead for Health Innovation Manchester's COPD Programme and strategic lead for the North West Severe Asthma Network which provides specialised asthma services across the region. National roles include; Royal College of Physicians QI Faculty, PCRS Service Development Committee and Board member for the National Audit for COPD and Asthma.

Ian Kenworthy



Ian was diagnosed with severe COPD over 20 years ago. He has lived with chronic asthma all his life and more recently discovered he has bronchiectasis. He is a strong advocate of self-management and pulmonary rehabilitation and believes that HCP's should do more to encourage patients to self-manage their disease by supplying information and directing patients to education. He is a member of the respiratory board Tameside hospital and was a member of the NHS North West Respiratory Board.

Ian is founder and chair of Breathe Easy Tameside and was the first patient to be invited onto the board of trustees of the British Lung Foundation

5. Setting the scene

Dr Peter Elton outlined the aims of the day, provided a brief background and explained the role of the Strategic Clinical Network.

Dr Elton also provided period prevalence and mortality data for Asthma, COPD and Lung Cancer highlighting that whilst Asthma has the highest morbidity, it has relatively low mortality; compared with Lung Cancer. Whereas, COPD is the cause of considerable morbidity and mortality which is one of the reasons it should be considered an appropriate starting point to address first.

Dr Jennifer Hoyle explained why change was needed and shared GM level data on unwarranted variation, spend, admissions and mortality.

Dr Hoyle also explained how the Strategic Clinical Network set up GM Respiratory Steering to review respiratory data and to determine the emerging priorities:

- Improving early detection and diagnosis
- Helping to prevent flu and subsequent pneumonia
- Helping to reduce tobacco addiction
- Preventing/reducing avoidable hospital presentations

These priorities inform the scope and cover; all ages, prevention of disease, progression and complications, Influenza, pneumonia, COPD, Asthma, and people with or at risk of other lung diseases affected by smoking, influenza that could benefit from improved self-management (all ages).

Dr Murugesan Raja gave a talk on the emerging priorities and the view from primary care.

Dr Raja shared stories on the difficulty in living with diseases such as COPD and how initiatives such as detecting and diagnosing conditions early would improve the quality of a person's life.

He highlighted that co-ordination with other initiatives such as Long Term Condition IAPT, tobacco addiction strategies, GM Moving, localities neighbourhood models and plans etc. would be key to our success.

6. Workshop 1: Views on the emerging priorities

After the morning presentations delegates were split in to 4 groups and invited to partake in discussions around each of the 4 emerging priorities (a different discussion every 20 minutes) allowing all groups input on all priorities.

Following a 2-3 minute brief on an emerging priority delegates were asked to:

- Give views on whether they think what is being proposed a good / bad /right / wrong with regard to addressing the current problems in the system
- Offer ideas on additional opportunities and approaches
- Offer alternative ideas where suitable, and
- Express interest in being involved, or leave details of those who would need/like to be involved

Improving early detection and diagnosis

All groups approved an approach to improving early detection and discussions generated a number of considerations that can be taken back to both the early detection and the COPD pathway task and finish groups. These included:

- The use of FEV6 to identify possible COPD (although concerns over diagnosing over 35's (by not taking in to account reduced lung capacity due to age)
- Algorithms / flags on EMISS / and use of PINGR
- Using an evidence base to convince clinicians
- Focus on those that show symptoms first

- Annual spirometry for smokers
- Better use of community pharmacy (inhaler technique, spirometry, smoking cessation, FEV6)
- Identifying and capturing those coming in through non GP routes (i.e. walk in centres, out of hours).
- Drugs and alcohol service screening
- Complexity of primary care coding e.g. there are lots of codes for chest infections
- Lack of spirometry provision (dedicated spirometry hubs have been tried before and have significant DNA rates). Ultrasound has lower DNA rates.
- Does an increase in quality assured spirometry equate to a decrease in its provision?
- Shorter DNA recall times

In addition, there was suggestion a Public Health campaign for lung health would be useful telling people that breathlessness and persistent cough is not a sign of age. This can be discussed with our colleagues in Public Health.

Helping to prevent flu and subsequent pneumonia

There was strong support for opportunistic vaccinations (flu and pneumococcal) in secondary care.

Considerations included:

- Any proposal to have vaccinations in outpatient clinics (or even A&E) being communicated back to primary care.
- Vaccinations starting as early as possible (ideally September)
- Nurse training

There was general agreement that current seasonal flu guidance could be simpler and that:

- A simple version of the guidance would be helpful
- It would be good to have an alert system for paediatrics
- There needs to be clearer communication to those at risk patients
- A GM hub for algorithms or algorithms on an app would be useful
- An EMIS flu template with information for would be helpful

There was general confusion around swabbing i.e. what, how and where to order etc. and that the process could be made simpler.

Discussions included suggestions on:

- Targeting at risk groups i.e. >65 years first
- Use of charcoal swabs
- Website/ access point electronically and;
- Education

Finally, point of care testing was thought useful in primary care especially in children as an early warning but it was thought to have high costs compared to CRP.

These views will be discussed at the flu task and finish group.

Helping to reduce tobacco addiction

There was strong support and enthusiasm for the CURE programme currently in place for inpatients at Wythenshawe hospital. However, this led to concerns about further support in primary care.

It was felt there was some confusion in the system about what's available out there and there was a view we could do with GP's and nurses in community knowing what to continue treating with. This would be helped by a parent pathway for primary and secondary care standardised across localities. The Making Smoking History team are scoping what is currently out there and plan to look at the gaps in provision across GM.

Having strong locality support in primary care following hospital discharge would help, as would a primary care training programme on treating people with tobacco addiction (especially one that involves pharmacies as first line).

Other considerations include:

- Tackling smoking before asking people to attend pulmonary rehabilitation
- Addressing outpatients, and;
- Telling people in appointments that pre-op surgery is a high risk group that has different waiting times

Preventing/reducing avoidable hospital presentations

Discussion featured two themes:

1. Reactive (addressing people currently presenting at hospital), and
2. Proactive forward planning to address people who are at risk of presenting in future

Reactive measures

a) Stakeholder agreement there needed to be a reactive approach to address those that frequently attend hospital. There was no agreement as to how to address this but there was agreement to explore the reasons and to 'address the person'.

Proactive measures

a) The need for consistent education and self-management tools, with appropriate signposting to services.
b) There should be mechanisms in place to address anxiety and depression
c) There should be community follow up in primary care following presentations to hospital

d) There needs to be NWAS involvement as protocol dictates they have to take people to hospital
e) And in an ideal world there should be a 24 hours dedicated breathlessness service (or out of hours) featuring district nurses and equipment that is available in secondary care such as lung ultrasound, tomography etc.

Some of these themes will be addressed by proposed projects such as the cradle to grave COPD pathway which will also cover the information/education to be provided; the identification and management of those at high risk of admission/presentation and the data packs to help localities stratify their approach.

However, feedback from stakeholder groups suggests further considerations are needed. Whilst the data packs may help identify areas of high admissions from practices, local data will be needed to investigate presentations to the emergency department. And although clinicians will develop the ideal COPD pathway on which to base future models of care, future models of care and the choice of provision will be determined by each locality. Therefore, there is a need to ensure we have locality buy-in and system leaders early.

7. Experience and innovation

In the afternoon, Dr Binita Kane explained how the role of innovation and technology could help drive change moving forward. Health Innovation Manchester currently have a COPD programme aligned to the emerging priorities and have a number of initiatives that work toward making improvements.

Dr Kane talked of how MyCOPD app could help with education and reported on the positive changes made through virtual clinics being piloted across Manchester (see slide)

Ian Kenworthy talked openly about his experience of living with COPD since his 'bleak' diagnosis over 20 years ago.

Ian talked about having to deal with exacerbations, being told there was little anyone could do and how he tackles the daily challenge of COPD through effective self-management.

A huge advocate of pulmonary rehabilitation, Ian explained the virtue of patient information and education

8. Market place

Pulmonary Rehabilitation Team (Pennine Care Team) –
Information on the benefits of PR (see above)

Community Pharmacy –
Effective inhaler technique, information about inhaler disposal and flu vouchers

Health Innovation Manchester –
Technological solutions and information on their current COPD programme.

British Lung Foundation –
Information on their initiatives and breathe easy groups.

Lung Health Checks –
Information on the lung health checks pilot for lung cancer

Children's SCN –
Information relating to work on children's Asthma

CURE Programme –
Information about the tobacco addiction programme at Wythenshawe Hospital (see below)

9. Workshop 2: Cradle to grave management pathways

For the second workshop delegates were in invited to comment on an early draft pathway developed for COPD patients and discuss what education, advice and support a person with COPD should receive.

There were some incredibly helpful and thought provoking views from diagnosis through to end of life care. The following section encapsulates some of the themes.

At diagnosis:
The view of a patient:

- What is wrong with me?
- What do I need to do?
- Why is it important?
- Who can I contact? Website and details in and out of hours.

The view from the HCP:

- What is important to you now? (This question challenges the culture and current thinking by identifying a patient agenda through a standard question that enables the right information to be given by the right person(s) at the right time).

Education and information:
Many suggested education needs to happen before the 'care processes' and at diagnosis or immediately after.

There needs to be constant re-enforcement of education throughout a patient's journey.

It would be helpful to have standard information packs.

One group suggested re-ordering the care processes to ensure key education was given as priority.

That education includes flu vaccine, and advice around the use of e-cigarettes with signposting to services.

There was also wide agreement that 'pulmonary rehabilitation' needed renaming /rebranding.

Further considerations:
The inclusion of:

- Social isolation
- Social prescribing
- Social assessment OT/SW
- Chest physio for breathing exercises
- Peer support
- Mental health support (referral for CBT, psychiatrist)

There was wide agreement Palliative care needed to be discussed much earlier in the pathway with advanced care planning

Many found the draft pathway too confusing and that there needs to be a clear distinction between primary and secondary care roles including who carries out annual reviews, the role of high impact teams, supportive discharge and MDT's.

There was suggestion the pathway should be supported with an IT standardised template (coding), algorithms and directory of services and be available to all clinicians including pharmacists.

All views will be fed back to the pathway task and finish groups for further revision.

10. Workshop 3: Further considerations

The final workshop asked delegates 'What things do we need to consider in the development of a respiratory programme of work moving forward to get the best out of the system?'

Views were grouped in to themes:

1. Barriers
2. Ideas to help success
3. People and key links
4. Approach to enable success
5. Other considerations

1. Barriers

Pulmonary rehabilitation:

- Multiple referral forms for multiple services
- Lack of capacity
- Silo working / needs improved communication between primary and secondary care / better GP, pharmacy and community communication
- Buy in across the system
- Infrastructure / lack of clinical leadership / incomplete buy in from localities
- Different rules for different post codes

- Resistance to change / old fashioned ideas / traditional health care systems
- Workforce recruitment / lack of trained professionals
- Funding / commissioning

2. Ideas to help success

Information technology (IT)

- Smarter use of technology
- A degree of automation
- Patient hand held records
- National IT support
- Database needed for PR – know who has been referred / attended / completed / DNA
- Single printable EMISS information sheet

Portal that has links/forum with other clinicians and that answers questions and

- where clinicians can securely discuss patient cases, and
- includes a directory of services

Effective networking / single teams

Better collaboration across primary and secondary care
Working as a single service and embedding pharmacy as part of the pathway

Education and pulmonary rehabilitation

- Patient led development of resources
- Patient led programme of education
- Involving carers and clinicians in attending
- Group consultations
- Expert patients selling PR
- Referral at point of discharge
- Referral through pharmacy and other services
- Different models of PR – one size does not fit all (i.e. mini exercise groups, peer support etc).
- Psychological support / awareness of anxiety and depression (co-located with IAPT).

3. People and key links

- Networking of the respiratory teams / MDT including PR, social services
- Mental health services / commissioners / psychological therapy practitioners
- Pharmacists and smoking cessation teams
- Palliative care teams
- Breathe Easy groups of patients / young people
- Housing
- Public transport
- CPPE (develop education programme for pharmacies)
- Involve the mayor for potential support

4. Approach to enable success

- Effective communication / consistent message / include CEO's and commissioners and getting them on board
- Working collaboratively – primary and secondary care and at GM level not just locality
- Sharing evidence based best practice / shared learning / small wins
- Sharing data and the health record

5. Other considerations

- Not all localities starting from the same point
- Future workforce
- Disseminating initiatives for guidelines in a clear, precise way
- Consider outpatients
- Joint training opportunities – MH and respiratory
- Shared patient records

11. Moving Forward

The importance and education was highlighted throughout the day. Whilst there was strong advocation for PR for those who may benefit, it was generally agreed PR should not be considered in isolation. Information and education with effective sign-posting to local services should be provided throughout the patient journey, starting at diagnosis or in those at high risk of developing a condition, before.

Innovation needs to be used to drive changes where traditional methods have had little success, and technology used to support the change and aid consistency.

As for integration; a topic repeated amongst questions, barriers and ideas to help success. This needs to be embedded within our programme and its outputs by promoting effective evidence based methods. And given localities are at different stages in delivering respiratory care, the programme team need to continue to work closely with both clinical and commissioning leads so we develop an approach that suits both the interest of the emerging priorities and on the going plans in each locality.

In the meantime, all input from the day will be used by the teams to aid and shape the programme of work.

The SCN Respiratory Support Team: (from left to right):
Peter Elton, Jennifer Hoyle, Gareth Lord, Murugesan Raja

On behalf of the team – Thank you for your input.

If you would like to be involved in the respiratory work or have any enquiries, please email:

Gareth Lord (Programme Manager) – Gareth.lord@nhs.net

12. Appendix A: Presentations

Dr Peter Elton - Welcome and introductions and purpose of the event

Peter Elton Slides.pptx

Dr Jennifer Hoyle - Emerging priorities and the view from secondary care

Jennifer Hoyle slides.pptx

Dr Murugesan Raja - Emerging priorities and the view from primary care

Murugesan Raja slides.pptx

Dr Binita Kane - The role of health innovation

Binita_GMCOPD stakeholders event.p

Ian Kenworthy - Experiencing respiratory care - A patient's perspective

Manchester Oct 2018.ppsx