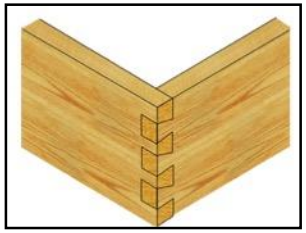
# Using ‘value’ & collective clinical leadership to change what we do in respiratory care



The Kings Fund
Center for Creative Leadership

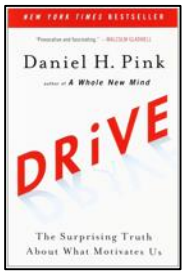
**Developing collective leadership for health care**

Authors
Michael West
Regina Eckert
Katy Steward
Bill Pasmore

May 2014

Dr Louise Restrick
integrated consultant respiratory physician
Whittington Health & Islington CCG
London Respiratory Network 2010-16
London Senate Helping Smokers Quit Programme 2014-16*

# What makes me 'tick' as a (respiratory) clinician? Motivation and Values

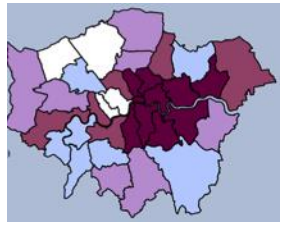



- ✓ Delivering best outcomes possible for 'my' patients*
- ✓ Improving outcomes for 'my' patients*
- ✓ Affirmation from patients and families
- ✓ Peer opinion and respect
- ✓ Quality of days & being well
- ✓ Learning and using (new) skills
  - **treating tobacco dependence**
  - **evidence-based conversations:**
  - **shared decision making & behaviour change**
- ✓ New challenges?

Autonomy, mastery and purpose …

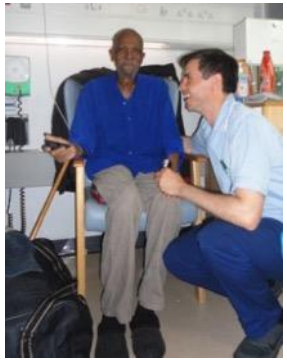

** 'Under **my** care' …local population/all patients … with respiratory disease*

# What are the needs of Londoners admitted to hospital with respiratory illnesses?

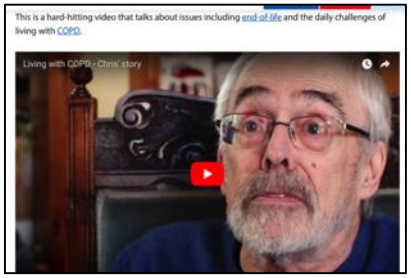


- Tobacco dependent
- Multi-morbidity and poly-pharmacy
- Mix of physical & mental illnesses including
  - Drug and alcohol dependence
  - Diagnosed and undiagnosed dementia
  - Morbid obesity
- Difficult life situations including
  - Alone, homeless & from prison
- Specific communication needs
  - Learning Disabilities
  - Not able to speak or understand English
  - Not able to read
- **High risk of premature mortality**

Low health literacy
Low mastery & activation



# What respiratory patients and families in London 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.

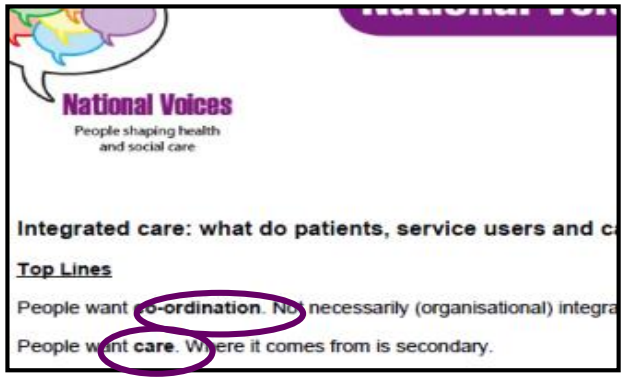
My mind is trying hard to keep calm, but I am stiff with anxiety

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'


National Voices

People shaping health and social care

**Integrated care: what do patients, service users and c**

**Top Lines**

People want **co-ordination**. Not necessarily (organisational) integra

People want **care**. Where it comes from is secondary.

'I want 'better' conversations with those involved in my care'

http://www.nationalvoices.org.uk/realising-value-person-centred-care

https://www.blf.org.uk/your-stories/copd-affects-every-part-of-my-daily-living

# Addressing what patients want us to change: key challenges & enablers

How are we going to:

- Delay death
- Improve the experience of living with breathlessness?
- Have conversations that ‘work’ better for patients
- ‘Make’ care feel more joined up to those experiencing it

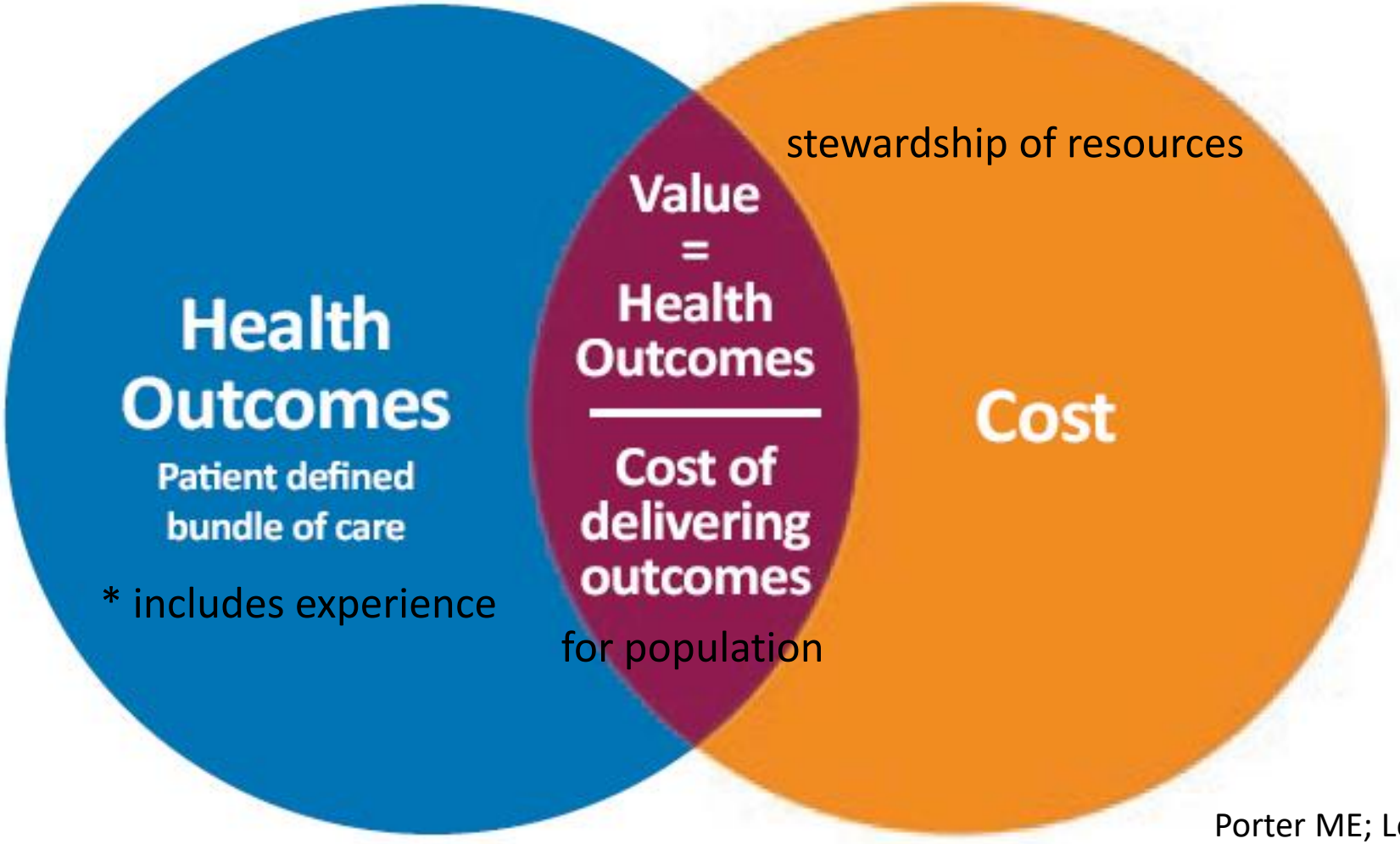
We need to work out what are the ‘right’ things to do

Co-design models of care with patients & families

Use systems to make doing the ‘right’ things easier

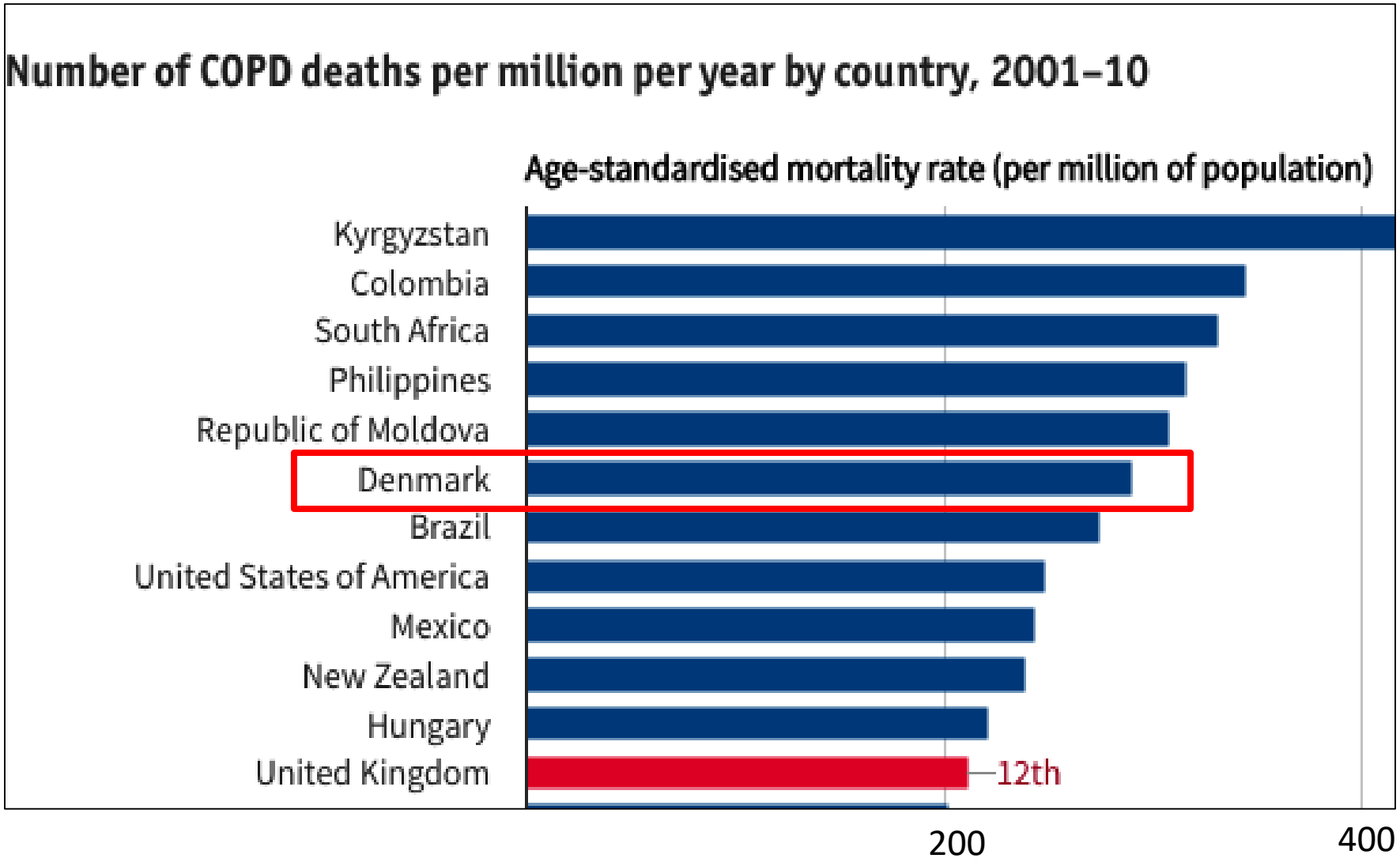
Integrated Care and Collective Clinical leadership

# Working out the ‘right’ things to do: using a Value framework




Porter ME; Lee TH
**NEJM** 2010;363:2477-2481; 2481-2483

# Why might using a ‘value-based’ approach be useful in COPD?: ‘I don’t want to die”



# Why might using a 'value-based' approach be useful in COPD?

Common disease caused by smoking

Patients die from it & often 'young'

High costs to patients & society

Causes disabling breathlessness

Causes respiratory failure

Frightening for patients & families

Variation in treatments offered

Variation in outcomes …

COPD increasingly described as 'young frailty'…

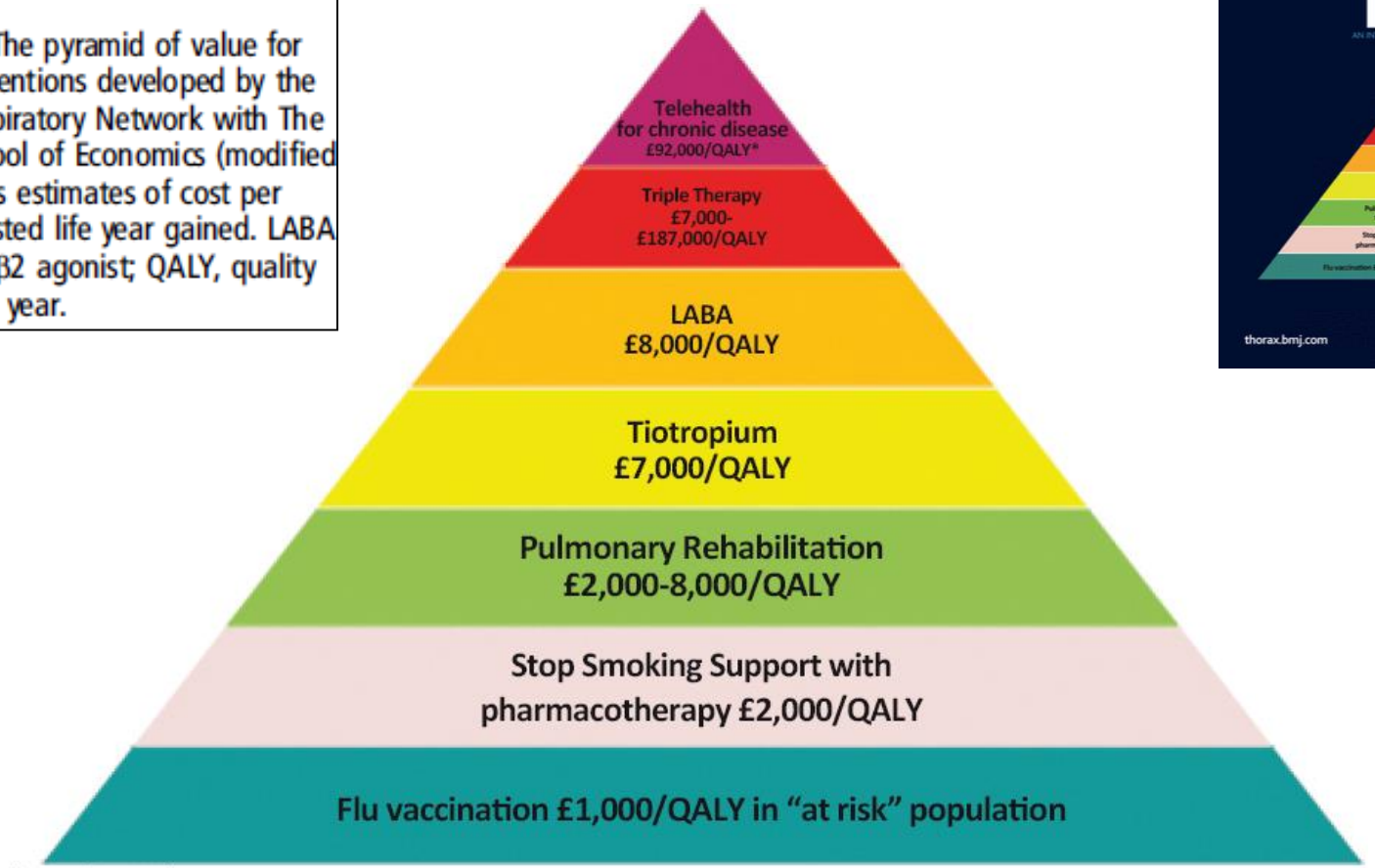
COPD
=
**C**an **O**nly **P**lan **D**aily

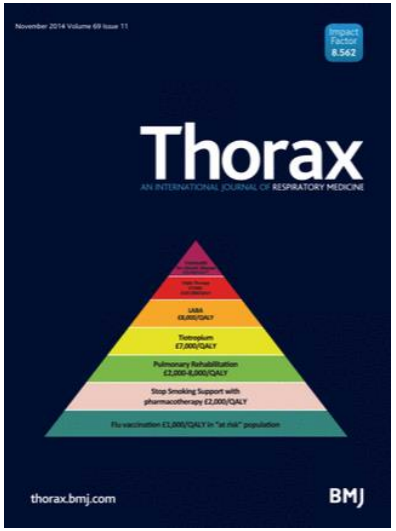
1.2 million people in the UK living with diagnosed COPD
30,000 deaths due to COPD each year

# What is High Value Respiratory Care? COPD 'Value' Pyramid 2011-

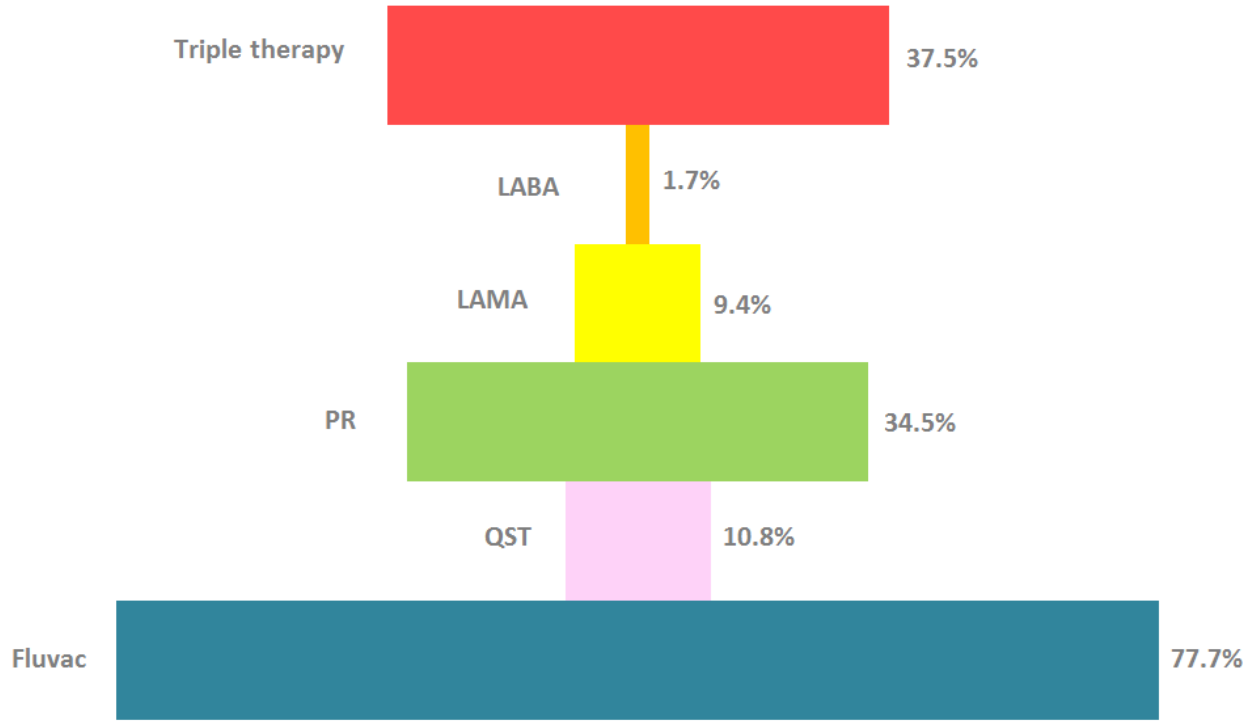
**Editorial**

**Figure 1** The pyramid of value for COPD interventions developed by the London Respiratory Network with The London School of Economics (modified from[19]) gives estimates of cost per quality adjusted life year gained. LABA long-acting β2 agonist; QALY, quality adjusted life year.



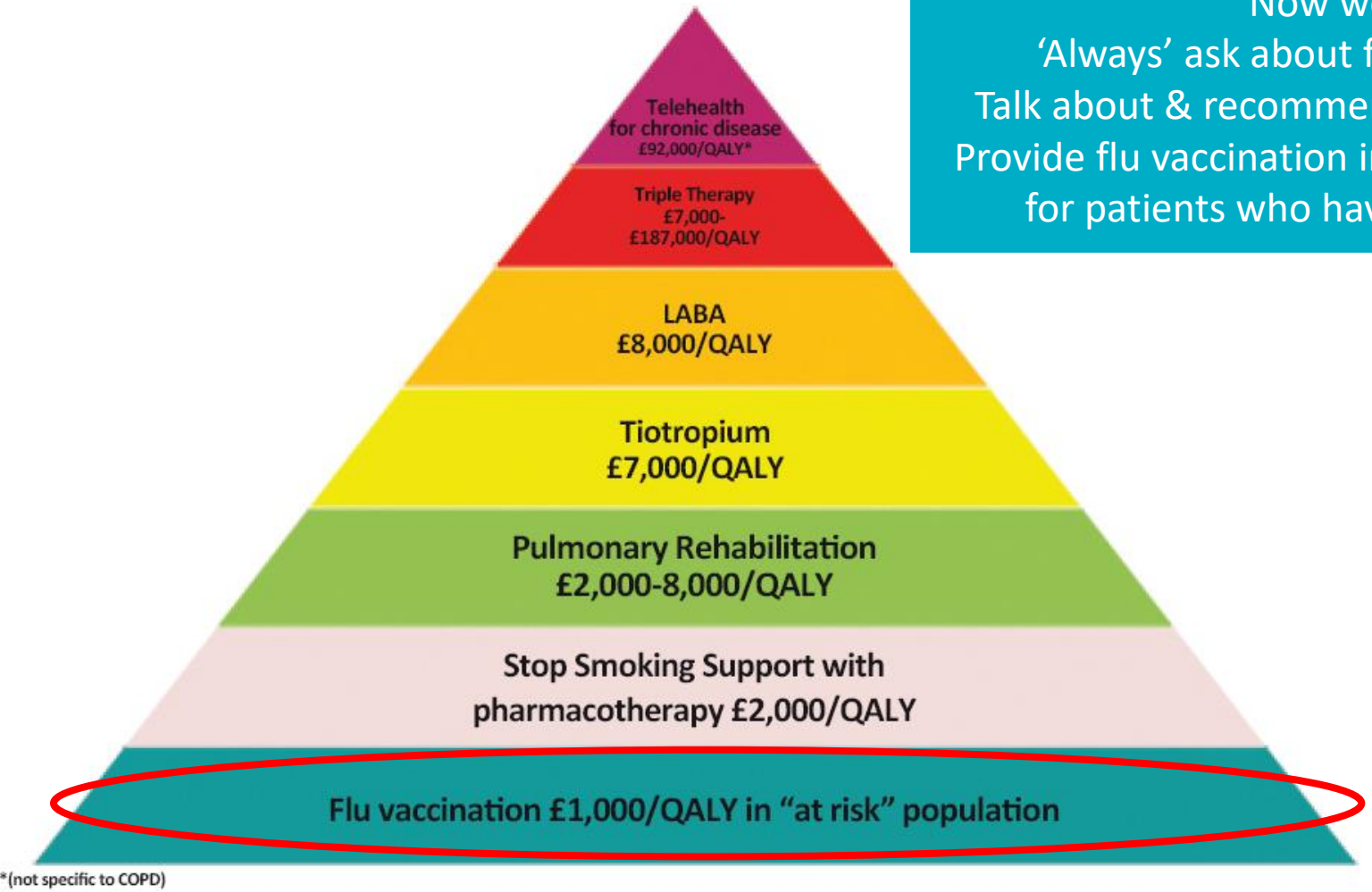



# High value interventions in COPD
## Are we delivering them?




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

# Using the COPD 'Value' Pyramid to start to think about relative value .... Flu vaccination




*(not specific to COPD)

Now we:

'Always' ask about flu vaccination

Talk about & recommend flu vaccination

Provide flu vaccination in clinics & on ward for patients who have 'missed' out

# Staff influenza vaccination:
## Beliefs, behaviours and variation

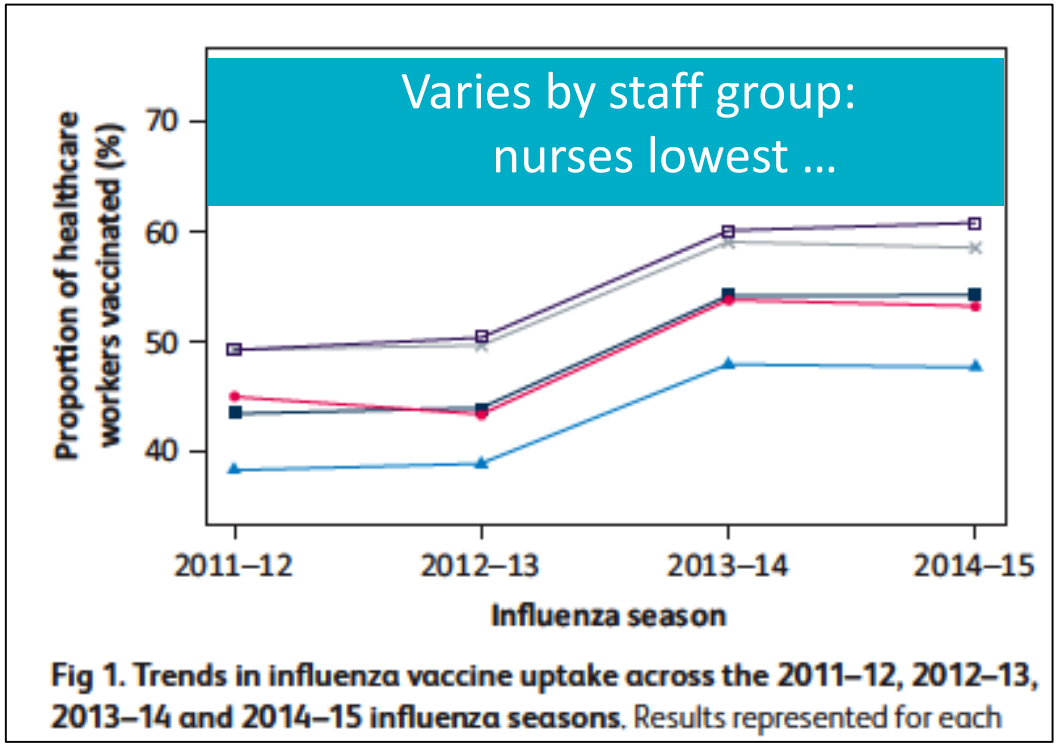
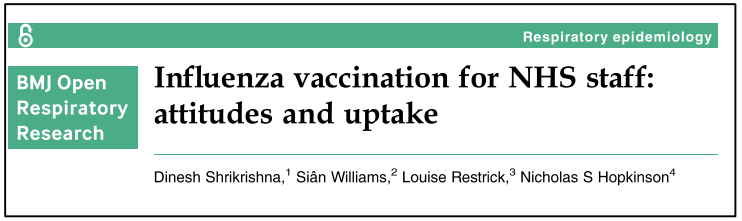



**Fig 1. Trends in influenza vaccine uptake across the 2011–12, 2012–13, 2013–14 and 2014–15 influenza seasons.** Results represented for each




Varies by NHS Trust:
36% to 86%


'… recent publication* suggesting that a 10% increase in staff vaccination reduces healthcare worker sickness absence by about 10%.'

Healthcare worker influenza vaccination and sickness absence – an ecological study
Pereira M, Williams S, Restrick L, Cullinan P, Hopkinson NS for London Respiratory Network
**Clinical Medicine** 2017 Vol 17, No 6: 484–9

# Whittington staff flu vaccination leadership: Sharing values and value …

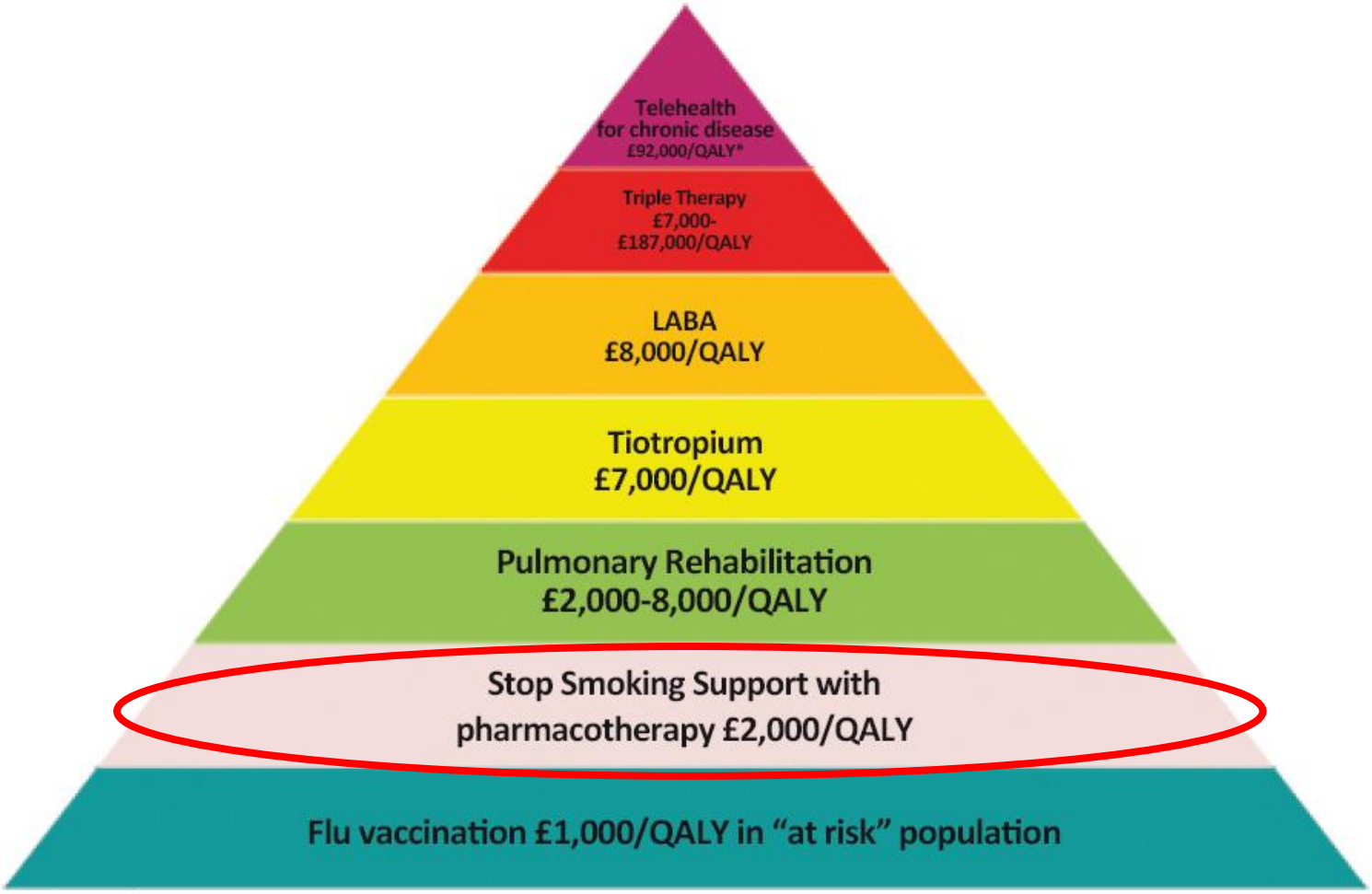
Keeping patients safe from harm and using our resources effectively


We expect all staff (& students) who work on our respiratory ward and all staff who work with respiratory patients to have and have had flu **vaccination every year**

We ask new staff at interview 'do you have flu vaccination every year?'

All medical students get 'free' flu vaccination.

# Using the COPD 'Value' Pyramid to start to think about … smoking differently




*(not specific to COPD)

# What does smoking have to do with hospital admission?

HELPING SMOKERS QUIT

NHS London Clinical Senate

**Table 1** Smoking status by speciality, adjusted ORs relative to patients not treated, and estimated number of national FCEs for patients a 15+ in England in 2010/2011 in current and ex-smokers (ranked by % current smokers)

| Speciality | Number of patients in study dataset | % current smokers | % ex smokers | Adjusted OR for current smoking, 95% CI, p value* | Total number of FCEs in patients aged 15+† | Number of episodes where patient current smoker‡ | Number of episodes wh patient ex-s |
|---|---|---|---|---|---|---|---|
| Not admitted | 469 971 | 14.7 | 19.8 | | | | |
| Admitted | 80 007 | 17.0 | 30.2 | | | | |
| Adult mental illness | 472 | 51.7 | 10.6 | | | | |
| Neurology | 435 | 23.2 | 28.0 | | | | |
| Oral surgery | 1501 | 22.3 | 20.7 | | | | |
| Thoracic medicine | 1178 | 21.9 | 37.4 | | | | |

Smoking responsible for
~500 000 adult admissions
>1 million smokers treated in hospital
2.6 million episodes of care

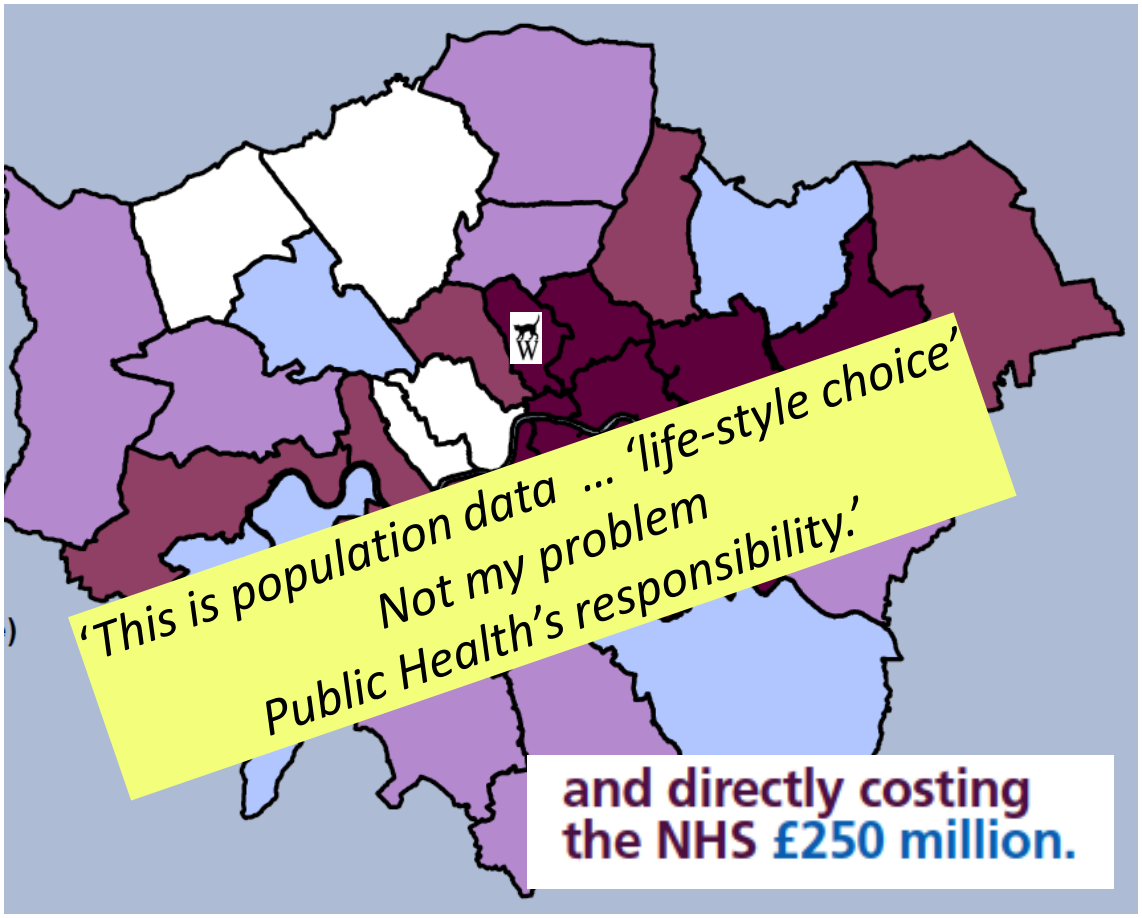
40% people admitted with COPD in England remain tobacco dependent
Unchanged over 10 years

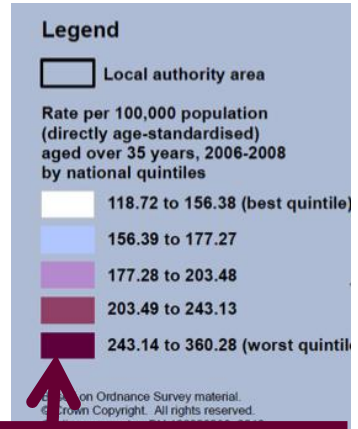
NB Smoking status:
Known in only 74% of admitted patients - from GP data!

*Szatkowski L, Murray R, Hubbard R, et al.* ***Thorax*** *2015;70:498–500.*

# Londoners' dying from smoking


1,125,000 smokers in London and smoking causes 8,175 deaths/year*



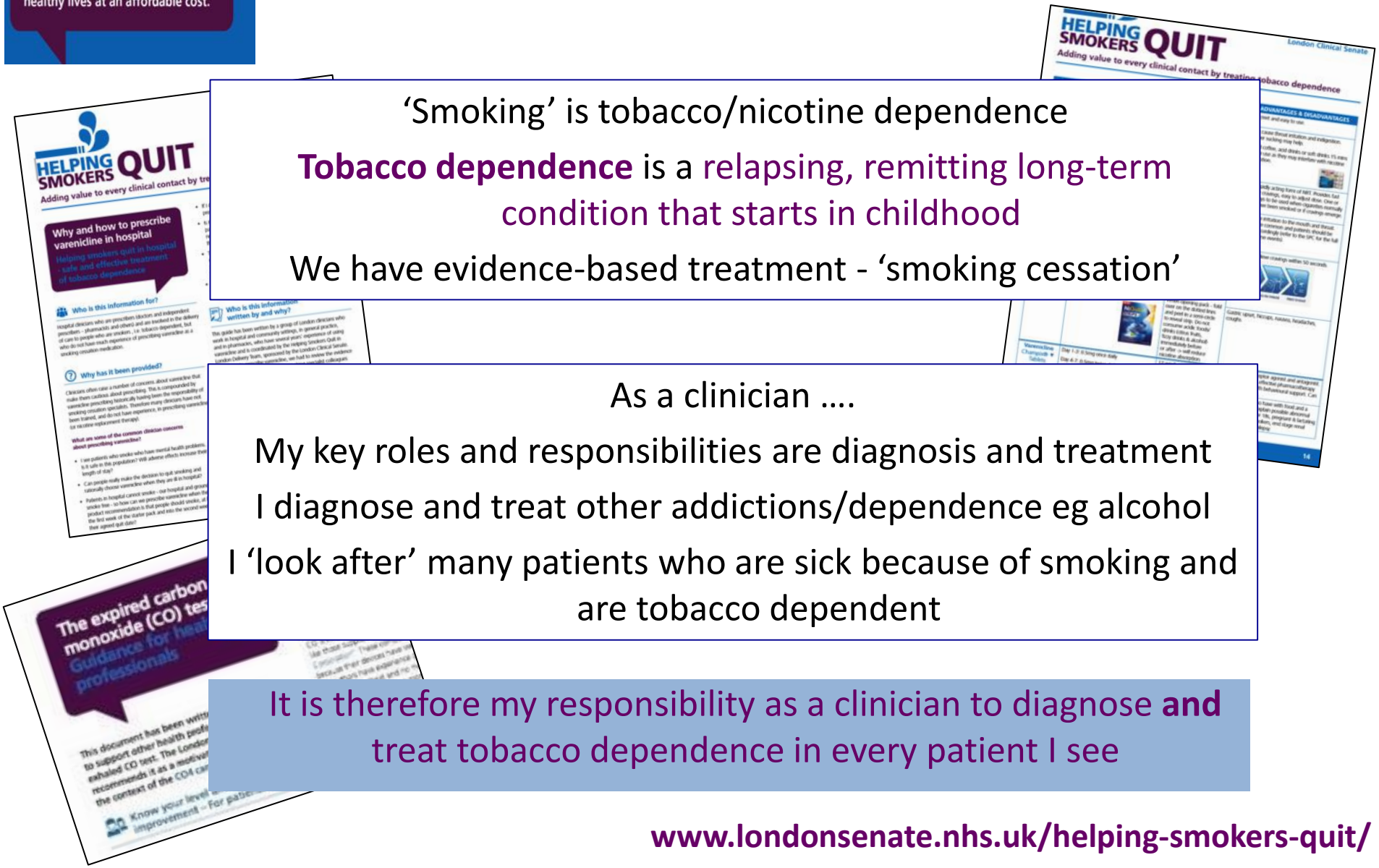

*'1 in 5 deaths due to smoking'*

*London Senate Helping Smokers Quit Programme Report 2016

Tobacco dependency is a long term and relapsing condition that usually starts in childhood; treating it is the highest value intervention for today's NHS and Public Health system, saving and increasing healthy lives at an affordable cost.

# Changing how we think about smoking

NHS
London Clinical Senate




'Smoking' is tobacco/nicotine dependence

**Tobacco dependence** is a relapsing, remitting long-term condition that starts in childhood

We have evidence-based treatment - 'smoking cessation'

As a clinician ….

My key roles and responsibilities are diagnosis and treatment

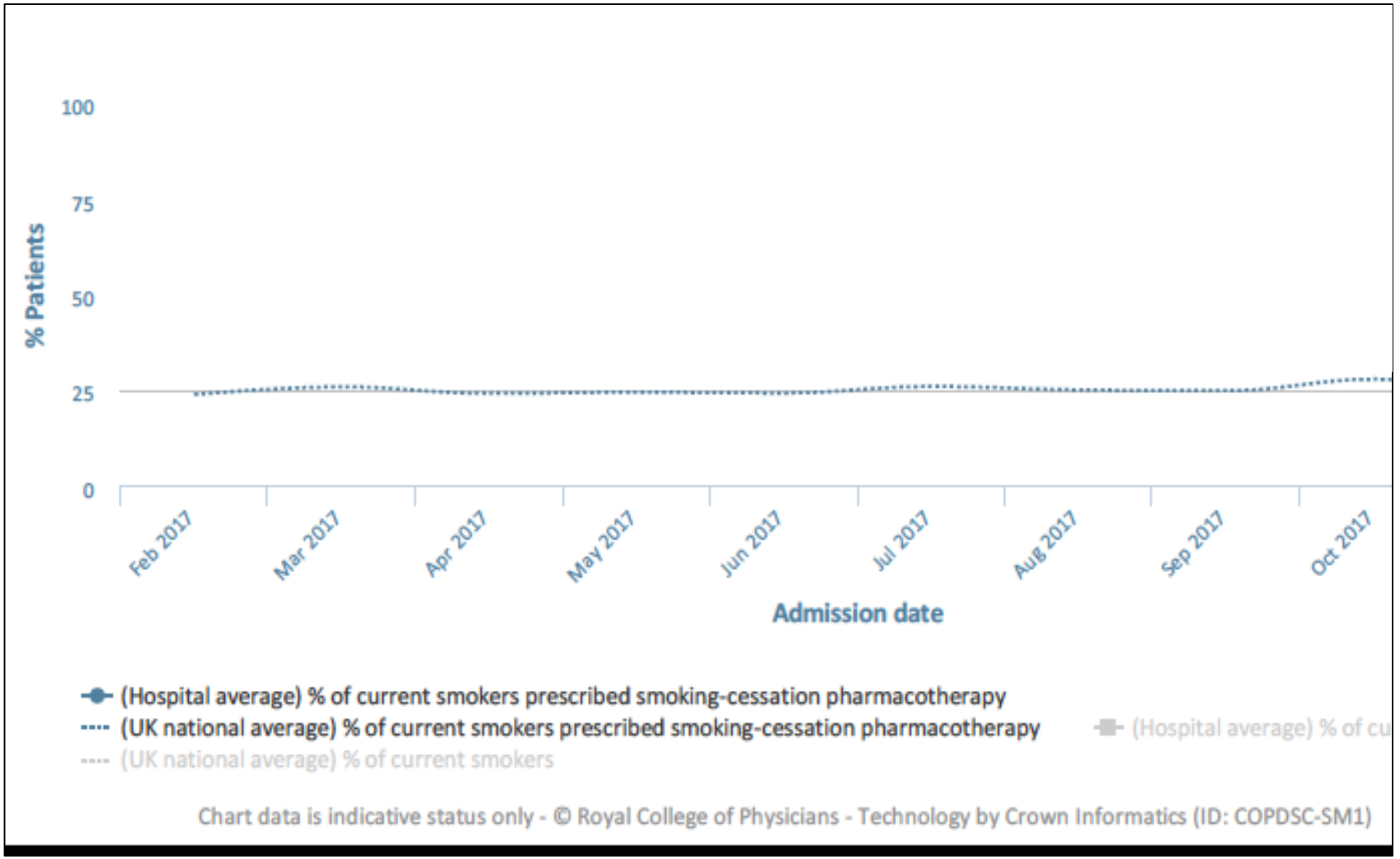
I diagnose and treat other addictions/dependence eg alcohol

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/**

# Treating tobacco dependence
## How effective are we as in-patient teams?



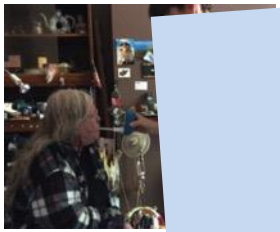
# Changing what we do:
## Diagnosing & treating tobacco dependence 2004-2017

Whittington Health NHS

Consultant led - all team members responsibility

Quit smoking **specialists** key members of MDT

SKILL TRANSFER & **training**




**Why do it as a clinician?**

High value treatment

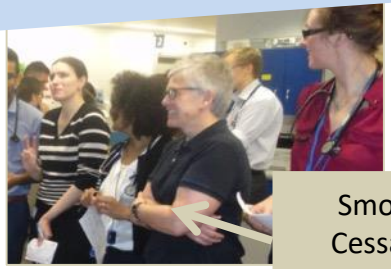
'Works'

Makes an 'obvious' difference to patient outcomes

Like using new skills, doesn't take long

'Rewarding'

*



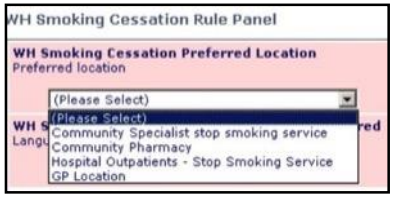
Smoking Cessation Specialists

*Ruiz J et al **Nicotine and Tobacco Research** 2011

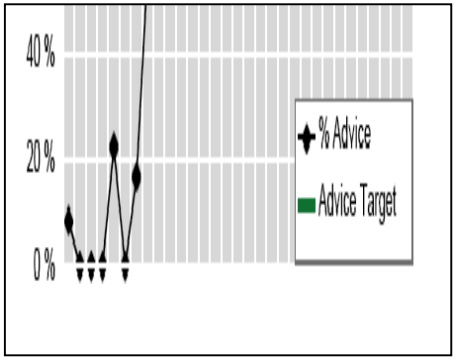
# Treating tobacco dependence: Do incentives help & does it work?

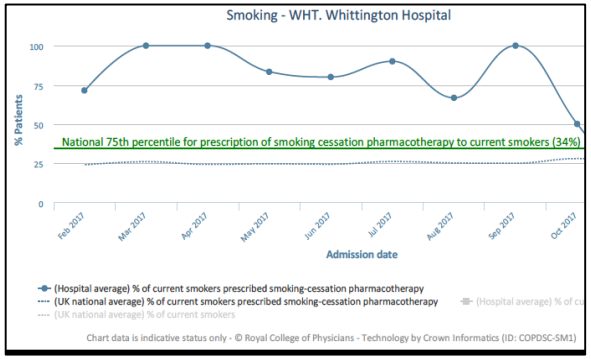
Whittington Health NHS

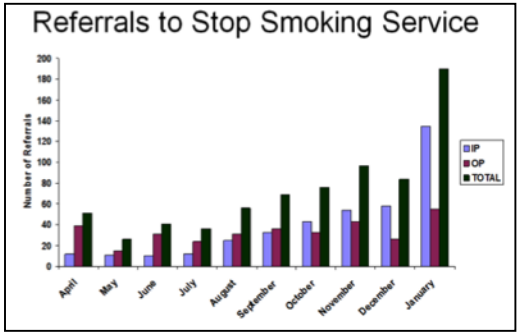
- ✓ Document the smoking status of every adult inpatient
- ✓ Offer Brief Advice to smokers
- ✓ Offer and prescribe NRT & varenicline
- ✓ Refer to Stop Smoking Services
- ✓ **Training front line medical staff**








## Whittington Health Respiratory Ward Outcomes
## 50% 6 month quit rates
## with varenicline and intensive support*

*Ainley A, Pang E, Coleman B, Stern M, Restrick LJ **Thorax 2014**;69 (Suppl 2):A199 10.1136/thoraxjnl-2014 206260.404

# Treating tobacco dependence in hospitals: Change at scale and pace in Canada

2-group effectiveness study - Ontario, Canada.
Impact of 'Ottawa Model' for Smoking Cessation cf 'usual care'
Adult smokers admitted to hospital

Systematic approach to tobacco dependence treatment in healthcare

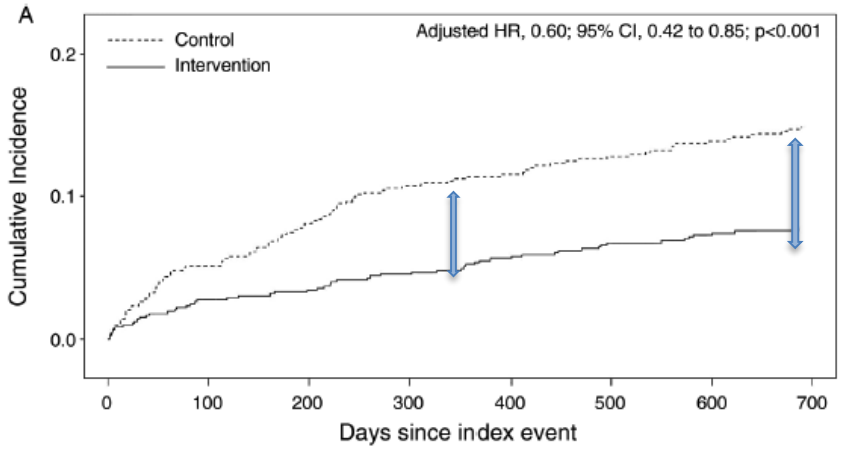
- ✓ identify and document the smoking status of all patients
- ✓ provide brief counselling **and**
- ✓ in-hospital pharmacotherapy
- ✓ offer follow-up support post-hospitalisation to all 'smokers'

OPEN ACCESS

Effectiveness of a hospital-initiated smoking cessation programme: 2-year health and healthcare outcomes

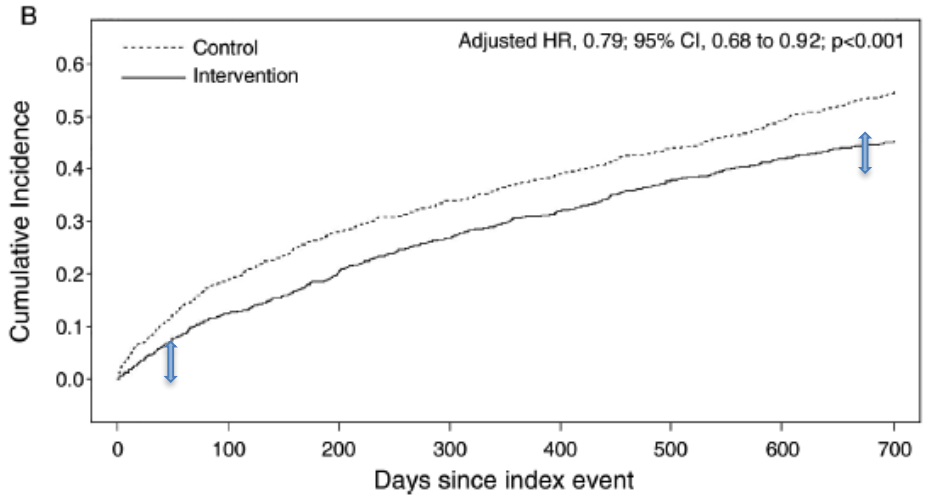
Kerri A Mullen,[1] Douglas G Manuel,[2] Steven J Hawken,[2] Andrew L Pipe,[1] Douglas Coyle,[3] Laura A Hobler,[1] Jaime Younger,[2] George A Wells,[1] Robert D Reid[1]

# Treating tobacco dependence in hospitals: Impact on mortality & re-admissions




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

# Coming back to what patients want us to change: key challenges & enablers

How are we going to:

- Delay death
- **Improve the experience of living with breathlessness?**
- **Have conversations that 'work' better for patients**
- 'Make' care feel more joined up to those experiencing it

We need to work out what are the 'right' things to do

**Co-design models of care with patients & families**

**Use systems to make doing the 'right' things easier**

Integrated Care and Collective Clinical leadership

# High value care for breathlessness: keeping patients safe

Care at home provided correct diagnosis made, correct treatment started AND patient feels in control of breathlessness

**Respiratory failure = diagnosis and treatment in hospital**

Breathlessness (symptom)

Respiratory Failure (low oxygen saturation)

Breathless and low oxygen saturation

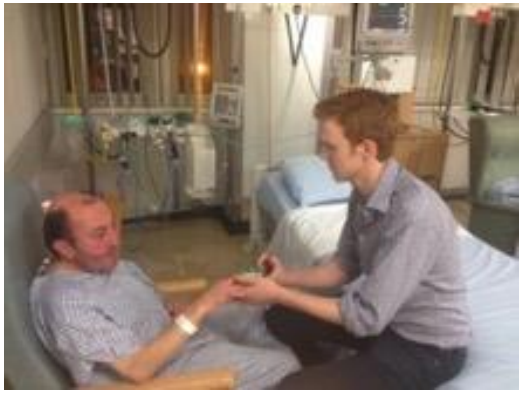
Low oxygen saturation but not breathless

Breathless with normal oxygen saturation


Ask and listen

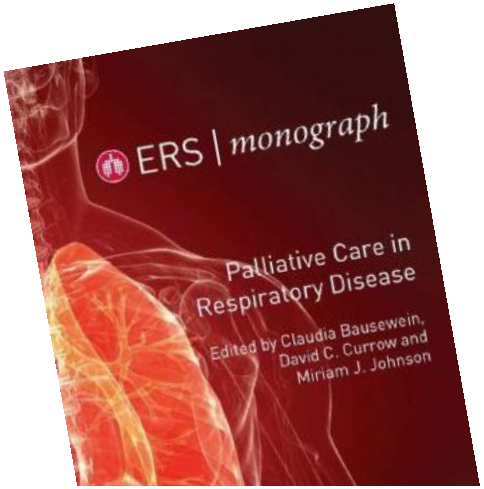
Measure

# Enabling safe care in **all** settings: Clinicians who have & use oximeters to assess breathless patients


# Breathlessness complicated & frightening

Need better ways to assess, diagnose & treat breathlessness …




It's 1:30am in the morning and I an
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.

"didn't go the GP because I'd
ot used to being breathless"

Chapter 11

## Service planning and delivery for chronic adult breathlessness

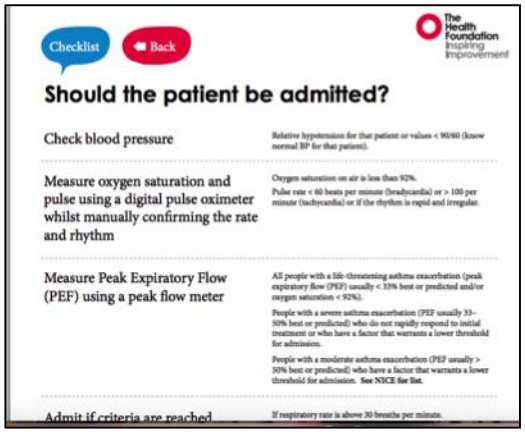
Siân Williams[1] and Chiara De Poli[2]

The diagnosis and management of the symptom and underlying causes of ch
breathlessness challenge current health service organisation and delivery, as evidenced b
diagnosis or misdiagnosis, underuse of effective treatments and resource waste in tim
health service austerity. A new approach that builds on the evidence and experien
managing complexity in healthcare is needed. This chapter summarises where we are now in terms of the scope and scale of the problem and offers some options to tackle it. It describes how to improve diagnosis and treatment in all settings by using a decision support tool derived from multidisciplinary case-based discussion and the literature on heart failure, COPD, asthma, obesity and anxiety interventions. It also describes how to set up specific cardiorespiratory services, and how to extend the learning from the best palliative care services for breathless patients. For the longer term, it offers the vision of a population-based approach, describing aims, objectives and criteria to evaluate the impact of a breathlessness system.

It sounded an excellent plan, no doubt, and very neatly and simply arranged. The only difficulty was, she had not the smallest idea how to set about it.

Lewis Carroll, *Alice in Wonderland*.

"They looked at my lungs not who they belonged to"




Listen to, & design breathlessness pathways with, patients & families?

# Breathlessness pathways: what works? Pulmonary Rehabilitation

Do you want to 'breathe better, feel good, do more?'

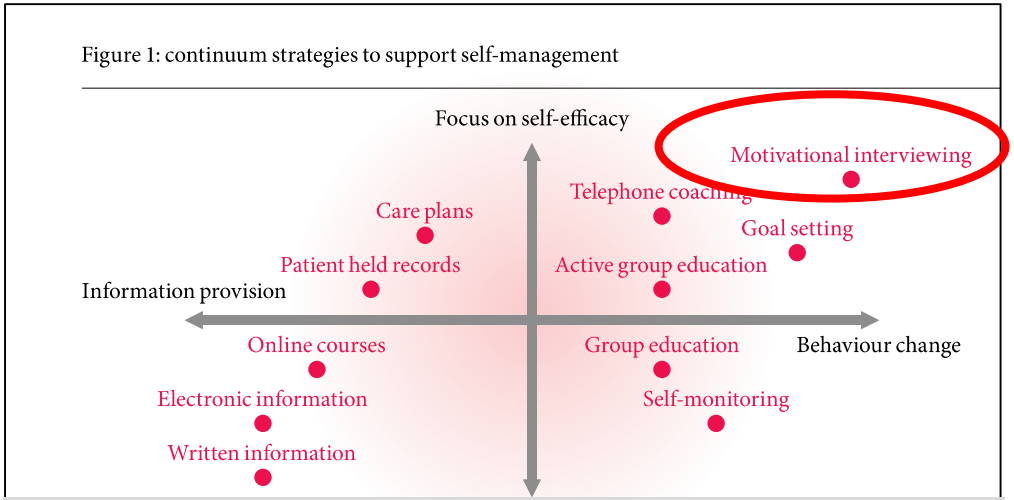



PR in Denmark; photo courtesy of Margrethe Smidth

# Breathlessness pathways: Skills to enable mastery …

*'Better conversations'*

*'plan my care with people who work together to understand me and my carer(s), **allow me control**, and bring together services to achieve the outcomes important to me.'*




Shared decision making & motivational interviewing skills

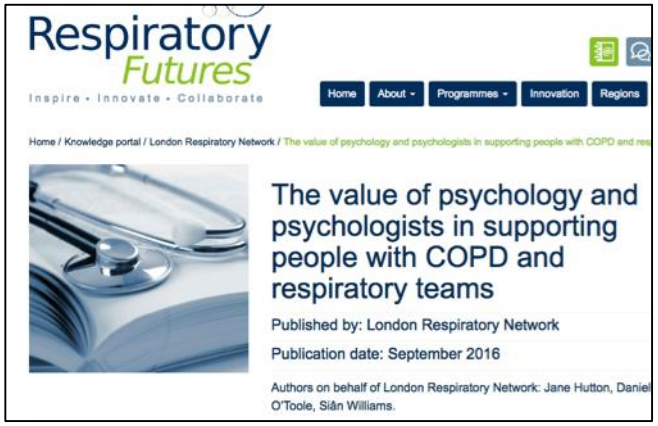
Do we think we need these skills?How are we going to learn these skills as clinicians?

Going on 'courses'?

Learning from, and working with, psychologists in teams

www.health.org.uk/publications/evidence-helping-people-help-themselves

# Psychologists in respiratory teams
# One enabler of higher value COPD care?


Respiratory Futures
Inspire • Innovate • Collaborate

Home | About | Programmes | Innovation | Regions

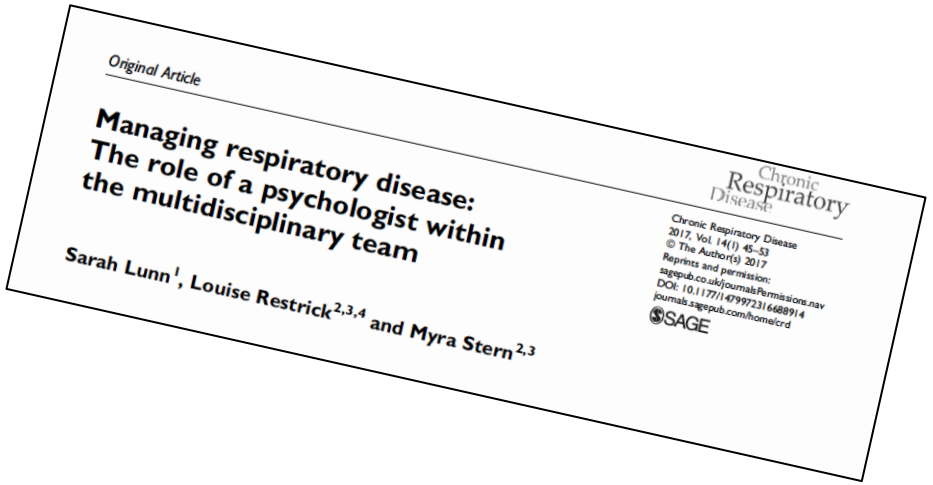
Home / Knowledge portal / London Respiratory Network / The value of psychology and psychologists in supporting people with COPD and res

The value of psychology and psychologists in supporting people with COPD and respiratory teams

Published by: London Respiratory Network

Publication date: September 2016

Authors on behalf of London Respiratory Network: Jane Hutton, Daniel O'Toole, Siân Williams.


Original Article

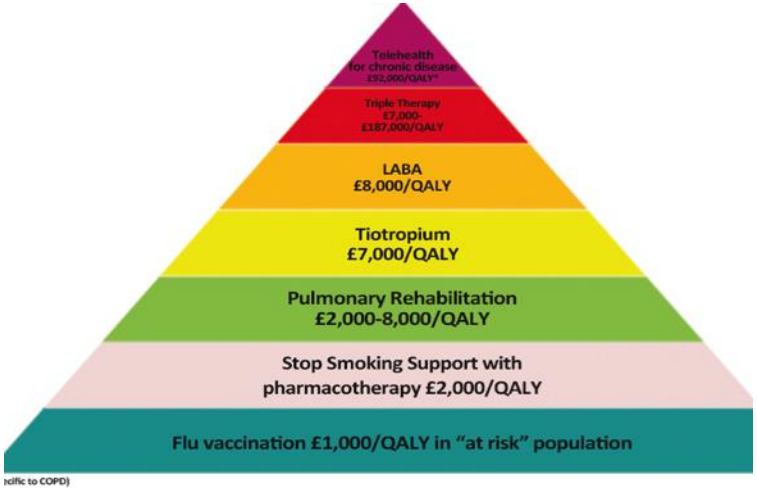
Managing respiratory disease: The role of a psychologist within the multidisciplinary team

Sarah Lunn[1], Louise Restrick[2,3,4] and Myra Stern[2,3]

Chronic Respiratory Disease

Chronic Respiratory Disease 2017, Vol. 14(1) 45–53
© The Author(s) 2017
Reprints and permission: sagepub.co.uk/journalsPermissions.nav
DOI: 10.1177/1479972316688914
journals.sagepub.com/home/crd

SAGE




Potential psychologist role in:

- ✓ Increasing flu vaccination rates
- ✓ Delivering evidence-based support as treatment for tobacco dependence
- ✓ Enabling patients to benefit from pulmonary rehabilitation
- ✓ Reducing waste in NHS inhaler spend
- ✓ Supporting patients to live better with disabling & frightening breathlessness

http://www.respiratoryfutures.org.uk/knowledge-portal/london-respiratory-network/the-value-of-psychology-and-psychologists-in-supporting-people-with-copd-and-respiratory-teams/

# ‘COPD Discharge Bundle’: One enabler of higher value COPD care?

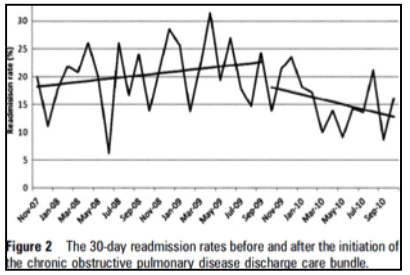


Figure 2 The 30-day readmission rates before and after the initiation of the chronic obstructive pulmonary disease discharge care bundle.

## COPD Discharge Bundle to be completed by Ward Staff

Inform the COPD CNS or Respiratory Physiotherapist of all COPD p
discharged from the ward. CNS: (NPH only) Extension 2508 or Bleep 47

**CARE BUNDLE STEPS**
All required documents are included in packa

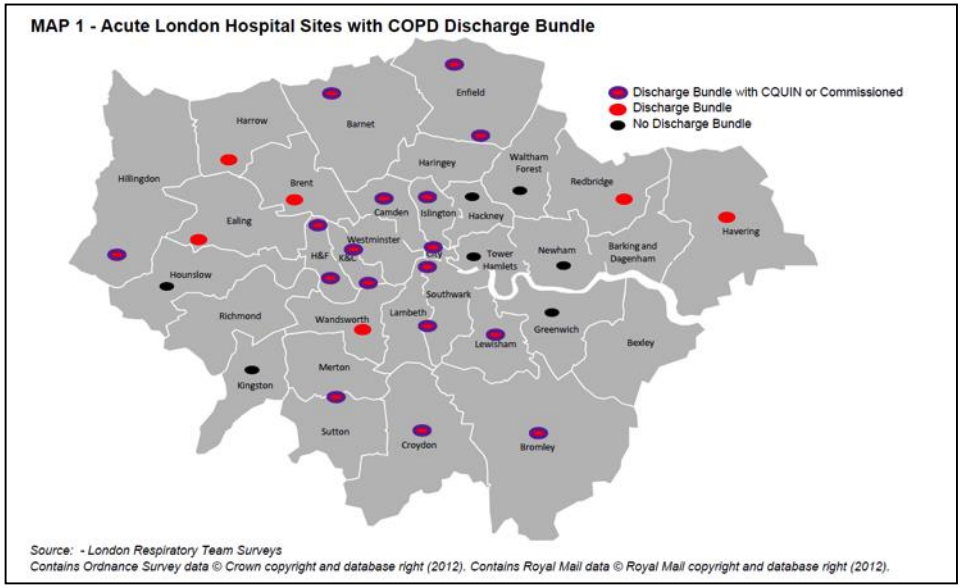
PRIOR TO DISCHARGE

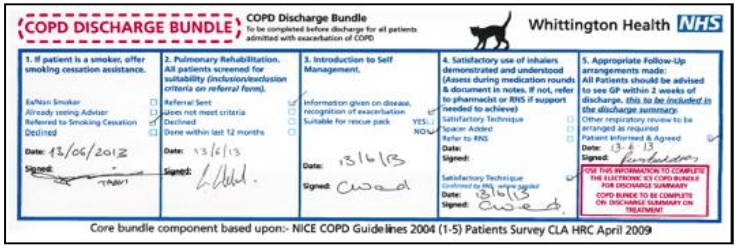
1. If patient is a smoker offer smoking cessation assistance — Completed ☐
   Refer 02089661008 (Harrow)
   Refer 02087956669 (Brent)
2. Pulmonary rehabilitation: screened for suitability — Completed ☐
   CNS and Physiotherapist will identify suitable patients, and follow appropriate referral pathways for each PCT
3. Self Management: Yes / N/A
   Written disease information given ☐
   Rescue packs recommended by HCP: ☐ ☐
   Individualised self management plans supplied ☐ ☐
4. Satisfactory use of inhalers demonstrated and understood
   Please assess during medication rounds. Observe the patients using the de
   and document adequate technique demonstrated if not (Refer to CNS, Phar
   or Physiotherapist if support needed).
5. Appropriate follow up arrangement made — Yes ☐
   Respiratory OPD consideration for LTOT, after NIV / first presentation
   Respiratory Community Services if **severe** COPD (follow guidance) and seen by
   If already under community respiratory team, inform team of discharge — OPD ☐
   If above not applicable, follow up with GP

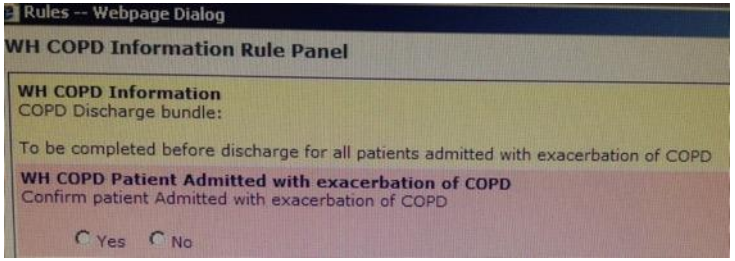
| Pre Bundle % | With Bundle % |
|---|---|
| 18 | 100 |
| 14 | 68 |
| 55 | 98 |
| 59 | 91 |
| 41 | 39 |

Designing and implementing a COPD discharge care bundle Hopkinson et al **Thorax** 2012: 67:90-92

# COPD Discharge Bundle: Does it work?
## Incentivised London experience 2011-14




Impact of a COPD Discharge Care Bundle on Readmissions following Admission with Acute Exacerbation: Interrupted Time Series Analysis

Anthony A. Laverty[1]*, Sarah L. Elkin[2], Hilary C. Watt[1], Christopher Millett[1], Louise J. Restrick[3], Sian Williams[3], Derek Bell[4], Nicholas S. Hopkinson[5]

Hospitals introducing the bundle had increasing readmission rates pre-implementation & falling post

| Readmissions ≤ 28 days | per annum % |
|---|---|
| Pre-Bundle | +2.13 |
| Post-Bundle | -5.32<br>p for difference in trends = 0.012 |

Laverty et al **PLOS ONE** 2015
DOI:10.1371/journal.pone.0116187

# Addressing what patients want us to change: key challenges & enablers

How are we going to:

- ✓ Delay death
- ✓ Improve the experience of living with breathlessness?
- ✓ Have conversations that ‘work’ better for patients
- **‘Make’ care feel more joined up to those experiencing it**

We need to work out what are the ‘right’ things to do

Co-design models of care with patients & families

Use systems to make doing the ‘right’ things easier

**Integrated Care and Collective Clinical leadership**

# What do we mean by ‘integrated care’?
# Not where it happens but what …


Person-centred

Evidence-based

High ‘Value’

Feels ‘joined up’ to the person experiencing it

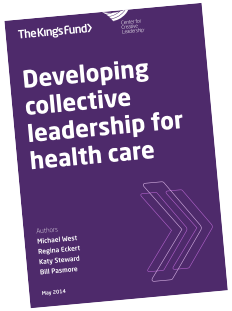
Inpatient Respiratory MDT

Home

Community Respiratory MDT

Primary Care Teams

Across pathway




Collective clinical leadership

Colleagues with shared values and priorities

Effective communication and shared information

Focus on ‘transitions’

# ‘Integrated Care’:
# One enabler of higher value COPD?

NHS Innovation Challenge Prizes

25% increase in diagnosed COPD prevalence; 2010-13
93% increase in referrals to pulmonary rehabilitation; 2010-12
72% of people on COPD register with self management plan
16% decrease in COPD emergency admissions


Person-centred, evidence-based, high ‘value’
Feels ‘joined up’ to the person experiencing it
Collective clinical leadership & shared values & priorities
Effective communication & shared information
Focus on ‘transitions’