

CHANGING LIVES

BREATHE at BEST

Mark Longshaw

Consultant Physician

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Learning outcomes

- Understand the role of the BREATHE Service
- Understand how to refer a patient
- Understand the strategy for improving lives of patients with COPD in Barnsley



Declarations of interest

- Barnsley NHFT
- North Manchester Care Organization
- Manchester University
- (CQC)
- No Industry Sponsorship

1. In Barnsley, there are approximately this number of patients with COPD

- A) 2000
- B) 4000
- C) 8000
- D) 12000
- E) 16000

2) In 1 year, how many Barnsley patients are admitted to hospital with COPD?

- A) 1000
- B) 1200
- C) 1400
- D) 1600
- E) 2000

3) In Barnsley, we spend the following on oral aminophylline each year

- A) £10 k
- B) £20k
- C) £30k
- D) £40k
- E) £50k

4. In Barnsley, we spend the following on Biologic treatment for asthma each year

- A) £0
- B) £20k
- C) £50k
- D) £100k
- E) £500k

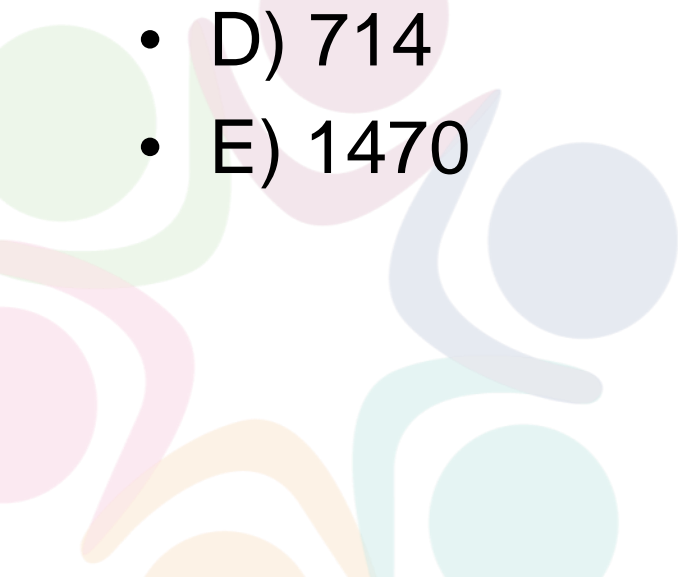
5) The following are on the “red list” for prescribers in Barnsley

- A) Roflumilast
- B) Ellipta device inhalers
- C) Monteleukast
- D) Serevent (for patients with COPD)
- E) Azithromycin

6) The following are cost effective interventions in COPD

- A) influenza vaccination
- B) smoking cessation
- C) pulmonary rehabilitation
- D) screening spirometry
- E) inhaled steroids

7) This number of patients in Barnsley are on home oxygen therapy

- A) 217
 - B) 317
 - C) 417
 - D) 714
 - E) 1470
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8) In patients with occupational COPD, the following history is notifiable

- A) working as a coal miner
- B) working underground as a coal miner
- C) working for 20 years as a coal miner
- D) working underground for 20 years as a coal miner
- E) coal mining does not cause COPD

9) In Barnsley, the actual number of patients completing PR annually is

- A) 100
- B) 150
- C) 250
- D) 300
- E) 400

10. In Barnsley, the following proportion of COPD patients are on the EOL register

- A) 1 in 200
- B) 1 in 100
- C) 1 in 50
- D) 1 in 40
- E) 1 in 10

BREATHE Service

- 01226 431 673
- Right Care Barnsley
- Breathe.service@nhs.net



Commissioned as a new service

- Operational since 2017
- Consultant in post since May 2018

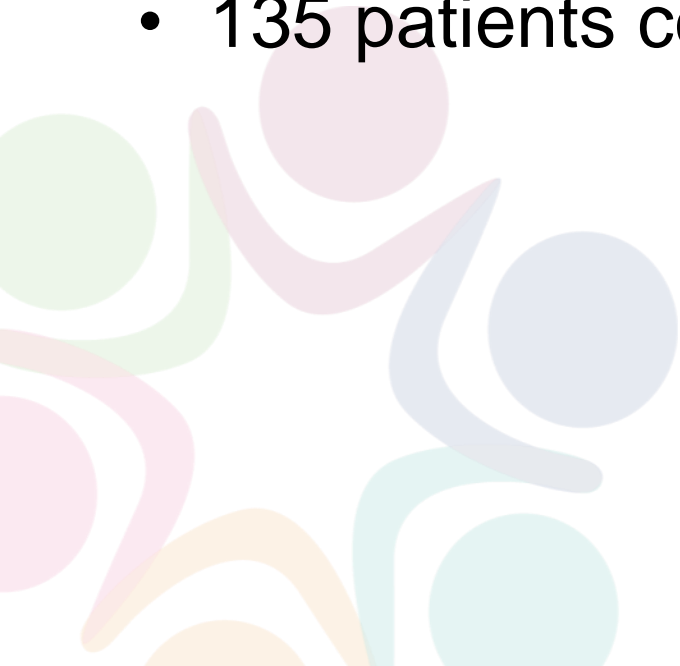


Outcome measures

- Reduction of patients admitted to hospital with exacerbations of COPD
- Meeting CQUIN standards for management of patients admitted with acute exacerbation
- Increase number of patients completing pulmonary rehabilitation

Current task

- 8000 + patients
- 1200 hospital admissions (target 800)
- 135 patients completing PR (target 400)



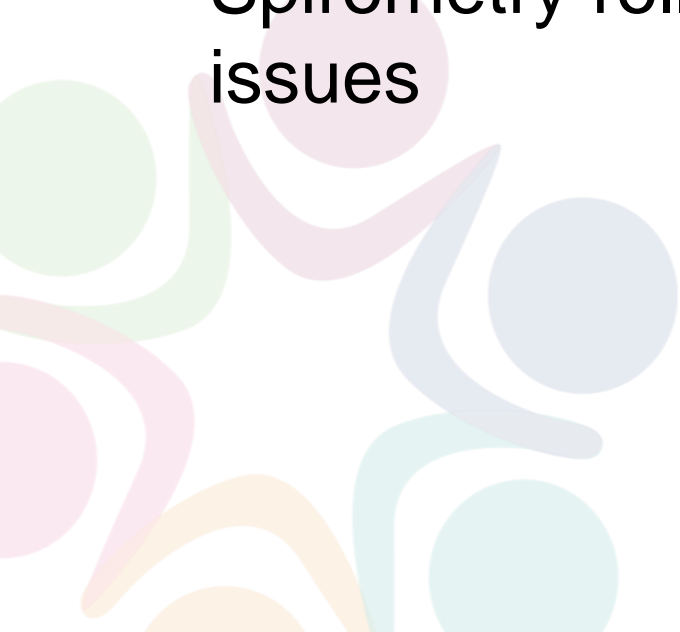
Smoking prevalence

- Overall 23% (nationally 15.1%)
- Particularly high in some areas of Barnsley
- Particularly high in young adults



“Unknown unknowns”

- Prevalence of COPD may be an underestimate
- Primary care registers may not be accurate
- Spirometry rollout complete, but ongoing training issues



Breathe Service

- Early supported discharge
- Hot clinics
- Home oxygen assessment
- Case review

Strategy

- “Tinkerbell”
- Can we actually prevent an admission once the patient is exacerbating?
- Evidence so far.....probably not

Barriers to change

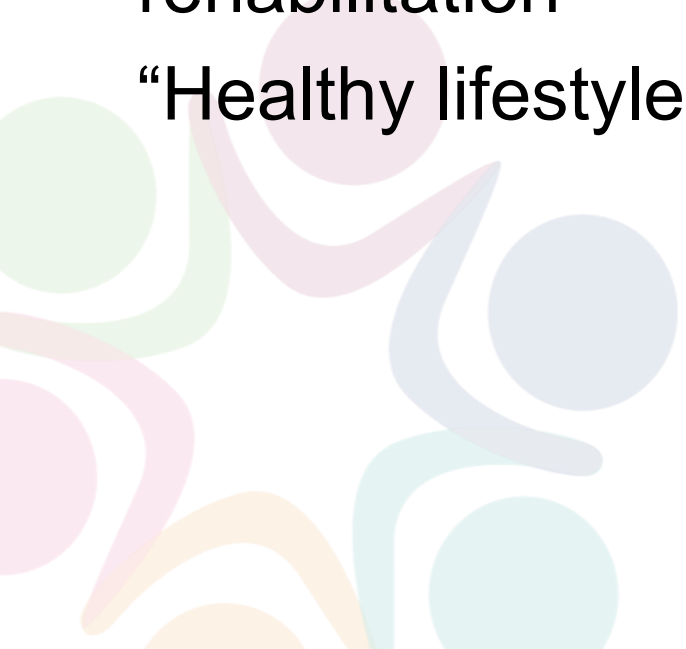
- Patients are referred or self refer to A+E
- Patients are admitted due to 4 hour target
- Patients are mis-diagnosed (in secondary care)
- Revolving door
- Patient and staff expectations

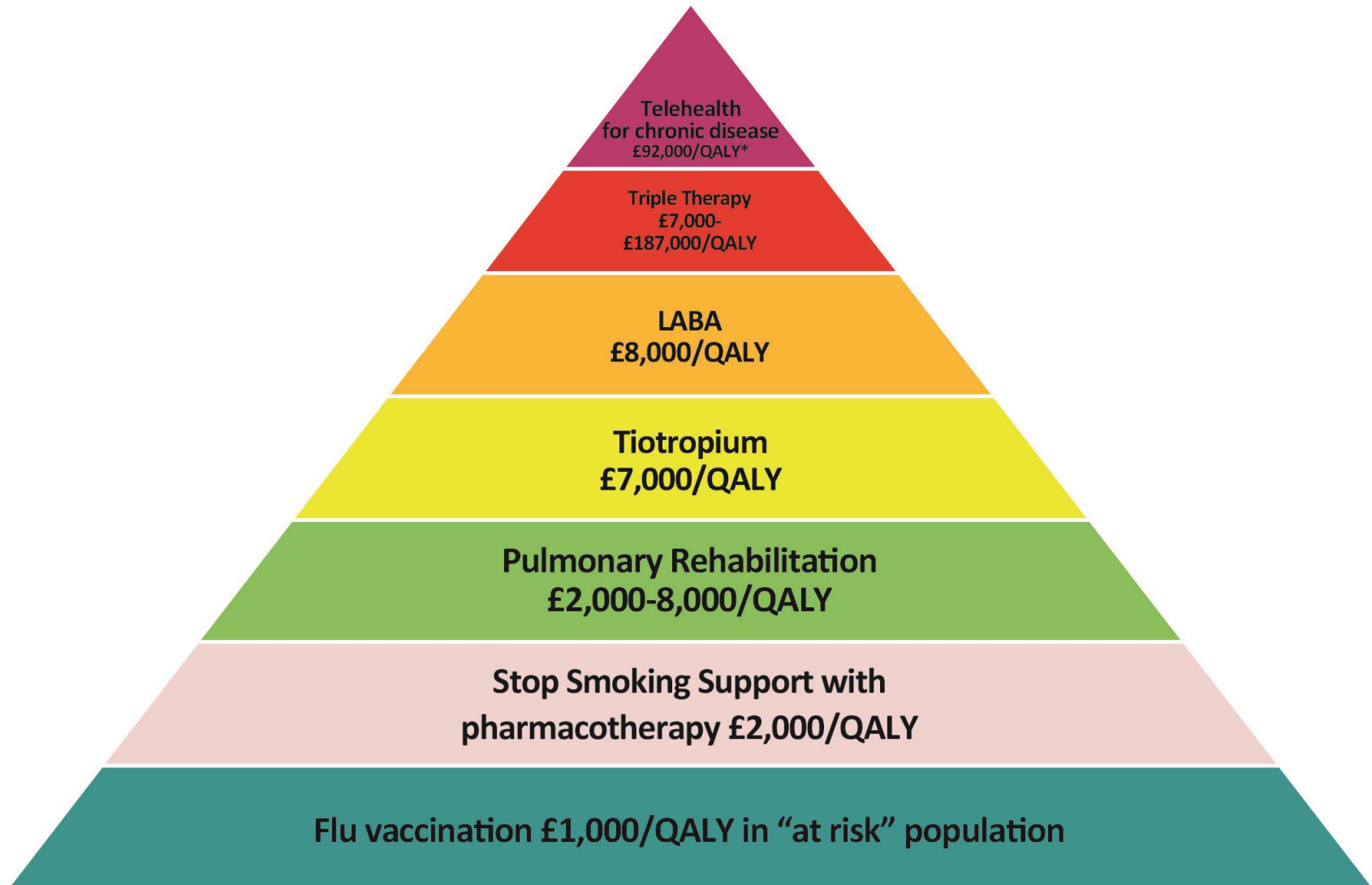
So what does work?

Early diagnosis

Smoking cessation, Flu vaccination, pulmonary rehabilitation

“Healthy lifestyle” and maintenance of activity





Reducing exacerbations

- Done by better long term control of disease
- Patients will exacerbate: only question is whether that leads to an admission



The long tail

- 30% of hospital admissions with COPD are presenting with new diagnosis
- 50% have 2-4 admissions per year
- Small number of patients have high frequency of admissions
- Consequently different strategies required for each of these groups

Precision of diagnosis

- Over-diagnosis of COPD in secondary care
- Under-diagnosis of asthma
- Lack of stratification of severity
- Lack of detailed occupational history

EOL register

- 1% of patients “should” be on a EOL register
- COPD patients: less than 0.5%
- Consequently, lack of advanced care planning, multiple admissions in last year of life, death in hospital

New strategy

- Early support and identification of patients
- Community based clinics rather than hospital based setting
- High quality review in Hot Clinic: one stop
- Detailed occupational history
- Cost effective interventions
- Advanced care planning

In parallel with

- Improving asthma service
- Improving referral pathway for patients requiring home NIV
- Developing a Sleep Service
- Improving access to Palliative Care
- Improving relationships with contiguous CCGs

Any questions?

