BTS POSITION STATEMENT

INTEGRATED RESPIRATORY CARE 2019

1. Summary

1.1 Integrated care requires a move away from responsive fragmented care given to patients by separate individuals in separate organisations to co-ordinated, pro-active continuous care in which healthcare professionals in different organisations work across boundaries, forming a single team which includes the patient. The NHS Long Term Plan for England has recognised the importance of integrated care and highlighted this as a key element of future service design to enable high quality care to reach the whole population [1].

1.2 To enable this change, team members require additional knowledge and skills concerning the care of patients with Long Term Conditions. It requires specialists (doctors or other professionals in specialist roles) to think more in terms of their responsibility to the whole population of patients within their local health care economies. This requires a change in the way we train specialists, ensuring they gain experience of integrated healthcare models during their training and are given the opportunity to implement their own strategies locally.

1.3 This is not about specialists just carrying out clinics in the community, but leading and working within teams, using well defined components of care to deliver high quality respiratory care across populations as well as to individuals.

1.4 Our aim is to provide a guide to help teams nationally create models that work locally. There is no structure that will work for all, but we hope this will help us all work towards our goal whereby patients are able to take control and self-manage their own long-term conditions. Patients require support from a team of healthcare professionals to improve their wellbeing, knowledge around their condition and how to effectively self-manage. The specialist integrated team should also be able to support clinically appropriate patients at times of ill health in their usual residence to prevent avoidable hospital admissions.

2. Introduction

2.1 British Lung Foundation data from 2012 shows that approximately 12.7 million people in the UK (approximately 1 in 5) have a history of asthma, COPD or another longstanding respiratory illness. Half of these (about 6.5 million people) report taking prescribed medication for lung disease in the last year. During 2008-12, lung diseases were responsible for 20% of all deaths in the UK each year [2]. Lung diseases place a heavy burden on health services with particularly high levels of Respiratory admissions to hospitals in the winter months.

2.2 The UK has higher rates of death from respiratory-related illnesses compared to Europe, the US, and Australia[3]. Respiratory disease is the third leading cause of death in the UK, and respiratory disease (most commonly pneumonia) accounts for nearly 700,000 annual hospital admissions (> 6.1 million bed days) in the UK [4]. However, although it has one of the highest rates of disease, there are fewer respiratory specialists per head of population than most other European countries [5]. It is therefore particularly important to consider how to make best use of this specialist resource.

2.3 Respiratory disease accounts for a substantial expenditure and resources, both to the National economy and the NHS. Respiratory illness cost the UK £11.1 billion pounds in 2014, through direct and indirect costs [6]. The NHS spends around £1billion a year treating and caring for people with asthma alone [7, 8]. There is also considerable variation in in the accessibility and quality of care - where people live significantly affects morbidity and mortality, with worse outcomes in areas of high socio-economic deprivation [8].

2.4 People are living longer often with one or more chronic diseases. This has caused a shift from an acute and episodic model of care to one of health promotion, disease prevention, early intervention and chronic care. This along with the increasing cost of healthcare, rising expectations, changing disease profile, an aging society, and health inequalities means our current model of service care is no longer able to care appropriately for these patients.

2.5 In 2007 BTS produced a discussion paper on Integrated Care, what was at that time a newly

emerging phenomenon. The paper concluded that *"consultants in integrated respiratory care represent an exciting way of enhancing the care of those with lung disease"* [9]. Today, as the drive towards healthcare integration in the United Kingdom gathers momentum as laid out in the NHS Long Term plan, BTS has identified a need to further clarify the purpose and role of integrated respiratory specialist posts.

2.6 This document outlines the Society's vision for the role of respiratory specialists in the provision of integrated care. We will define what we mean by integrated care and suggest examples of existing models of care that have been successfully implemented. Integrated care services should enable patients with chronic, long-term respiratory conditions to be cared for in the community, enable early access to specialist respiratory input when required, and improve access to care for the most vulnerable in our society.

2.7 In 2014, we surveyed all members of the Society to gain insight of their understanding of integrated care. Some already work in an 'integrated' way and we used in depth interviews to determine their experience, whilst others provided smaller scale examples that are equally important to the local communities. In 2017, we undertook a scoping survey of integrated respiratory services as well as a survey of respiratory trainees on integrated care. The results of both can be found on the Respiratory Futures website which also has a wealth of information on the successful delivery of integrated care to enable the rapid adoption of this model of care [10].

2.8 There are already many examples of successful integrated respiratory specialist activity throughout the UK. There are some commonalities between these posts however there are also some significant differences in areas such as the source of funding of these roles, programme setup, design and the core components of theses posts.

2.9 We wish to promote change to a system where the patient is at the centre of a system of care and where organisations work as one, without clinical boundaries, to improve care and give better value for the healthcare communities they serve.

3. What is integrated care and why should we strive to achieve it

3.1 Integrated care can be defined as the best possible care for the patient, delivered by the most suitable health professional, at the optimal time, in the most suitable setting.

3.2 The steady rise in acute medical admissions linked with poor care for those with chronic illnesses led to a number of ideas suggesting ways to promote a shift of care into the community. These ideas started with 'Transforming Community Services' which promoted structural change, but omitted the role of specialist care and also the need for change in the culture of the various organisations involved [11].

3.3 Patients with chronic illness need the separate organisations that care for them to act as one. This requires those providing care in all settings - primary, secondary, community, social, mental health services, private providers and voluntary/third sector – to find ways of working in a 'joined –up' integrated way.

3.4 People with Long Term Conditions can lack 'joined up' care. In some areas, patients are passed between separate organisations, each with different workers, separate management structures, different budgets and often very different agendas. To stay within budget, they often pass costs and patients from one to the other, creating waste and poor care.

3.5 The NHS and Social Care Model in 2005 gave sound advice regarding the cultural and system changes required for the integration of services and care [12]. In some areas fantastic, new services have been developed with improved health outcomes. This change has not been universal and unfortunately the changes advocated in that model were not followed in all areas, leading to significant unwarranted variation in care delivered to patients.

3.6 With a renewed focus on preventing ill health, laid out in the NHS Long Term Plan [1], the NHS will be required to become more joined up and co-ordinated. The traditional barriers between health care providers, social care and mental health services will need to be removed to provide seamless care to patient with long term conditions. Organisational enablers for a more co-ordinated approach include the development of integrated care systems (ICS) and primary care networks

which will increasingly focus on population health and local partnerships.

3.7 Key components in this "integrated model of care"[13] include:

a) **Education,** including patient self-management through written and digital information along with pulmonary rehabilitation and group-based education.
b) **Decision support systems**, including discharge and care bundles, treatment guidelines, care pathways and integrated digital systems.
c) **System design,** including early supported discharge services, urgent community based rapid response services and commissioning to incentivise integrated working between organisations. Sharing information. Providing services that effectively reach the most vulnerable
d) **Clinical information,** including ways of using disease registers to risk profile populations. Use of data to measure outcomes, produce audit, measure variation.

3.8 The culture change at the heart of a move to integrated care advocates moving from the present system of fragmented care to a pro-active, co-ordinated model achieved through integration of clinical systems across organisations. The core elements revolve around organisational changes in health care delivery, better connected teams with clinical informatics and decision support, proactive planned evidenced based care and patient and carer support and education

3.9 Patients, service users and carers want continuity of care, a smooth transition between care settings, and services that are responsive to all their needs.

3.10 Healthcare providers must work for the healthcare community as a whole, taking some responsibility for the whole population it serves to ensure that care is delivered to those who need it the most and health outcomes are improved. We know that primary care and community services cannot care for patients with chronic illness alone and require input from specialists. Specialists in integrated care teams are a bridge between long term condition management and acute care as well as community teams, primary care, secondary care and social care.

4 Why respiratory specialists have a key role to play in integrated care

4.1 Respiratory disease encompasses over 30 different lung conditions, which combined with the fact that the most common symptom of breathlessness is shared with dysfunction of other systems, (e.g., cardiovascular disease, or systemic disease) can make the diagnosis of lung disease difficult. Respiratory medicine is multifaceted and requires a level of skill and knowledge in order to effectively manage these patients.

4.2 Pneumonia, COPD and asthma are the most frequent causes of acute hospital admissions and primary care consultations. Acute exacerbations of COPD are the second most common cause of emergency admission and also carry one of the most costly tariffs. In addition, half of these admissions are in people below retirement age. Sadly, 12% are readmitted within 30 days for the same condition [7].

4.3 Acute medical admissions continue to rise year on year and although the increase in the ageing population is an important contributor this accounts for only a half of the overall increase [14].

4.4 Repeated studies have demonstrated that primary care, community services and social care, working alone, cannot improve this situation. It is clear that secondary care specialist should be more aware of our responsibility for the welfare of populations, not just the patient before us. It is common to find that diagnostic registers looking to confirm the diagnosis of COPD show that between a quarter and a third of the time, that the diagnosis and treatment are incorrect. This leads to waste, poor value and harm [15].

4.5 Most management of disease is in the community and it is no longer acceptable to 'squirrel away' knowledge in hospitals. Best care comes from teams working together and sharing expertise to a common aim, specialists supporting the community they serve [16, 17].

4.6 Our aim is to provide a structured model of care with commissioned components that deliver pro-active care given by a well-trained team to educated patients, able to self-manage their illness.

4.7 Although this document reflects the challenges for Respiratory specialist working in this new way, it is not unique to respiratory medicine. Integration of care impacts similarly on other specialist areas working in an

integrated role, e.g. gerontology etc. There is a lot we can learn/share with other specialties to ensure this new role works to benefit the lives of patients and the overall healthcare community.

5. Next Steps

5.1 Develop Integrated Respiratory specialist job descriptions with core skills, responsibilities and roles.

5.2 Use the NHS Long Term plan as an enabler for change, developing Respiratory Strategic Clinical Networks across the country to drive change and share good practice.

5.3 Develop and promote our recommendations about specific model(s) of care for people with respiratory chronic illness and at the end of life.

5.4 Encourage cross-cutting skills which Respiratory specialists wishing to engage in integrated care will need to acquire.

i. Training in diagnostic registers, risk profiling and self-management
ii. Use of national data to support audit, measurement of variation in outcomes across a healthcare community. Work with Rightcare and GIRFT to improve care delivery and health outcomes
iii. Methods of commissioning care using 'value chains' or other similar ways which incentivise providers to work together within a team. E.g. lead provider models, or an alliance of provider models
iv. Training in chronic disease management
v. Training in health delivery to populations, population healthcare.

5.5 Actively engage members and others using social media, targeted messaging, the Respiratory Futures website and the Respiratory Futures mailing list.

5.6 Support the Respiratory Futures Integrated Clinicians Network via which clinicians are sharing experiences and expertise.

Respiratory Futures hosts a collection of integrated care case studies, relevant materials and links to other significant sources of information which will be regularly expanded and updated.

BTS is a membership organisation and a registered charity. We have over 3,500 members in respiratory medicine and allied health professions (August 2019) and can lay claim to being the professional voice of respiratory medicine in the UK. Our objectives are to develop and promote the best evidence-based standards of care for patients with respiratory and associated disorders; to disseminate knowledge and learning about their causes, prevention and treatment; and to raise the profile and provide information about prevention of respiratory diseases.

6. References

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7 Additional Resources:

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