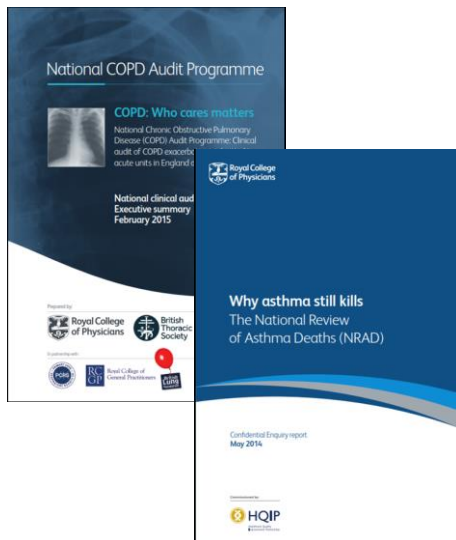


Healthcare Policy Update

Why is national respiratory policy relevant to me?



Accountable
care
organisations

Multispecialty
Community
Providers



Bronwen Thompson,
Policy adviser to PCRS-UK

De Vere Cranage estate workshop
November 11/12, 2017



Inspiring best practice in respiratory care

Overview

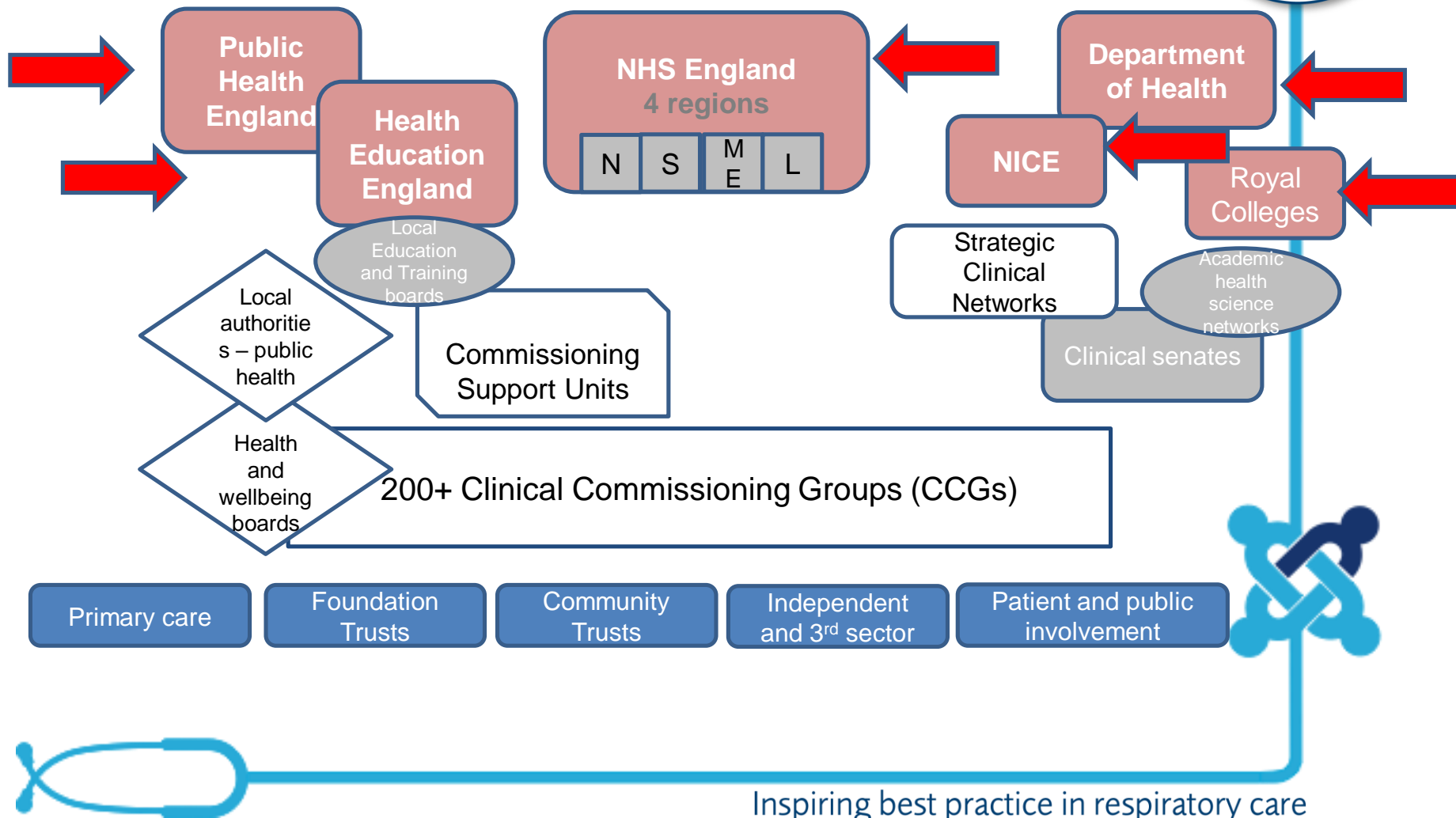


- Value of understanding healthcare policy for Respiratory Leaders
- Examples of using national policy to make change happen locally
- Where to access information at local level and at national level



Inspiring best practice in respiratory care

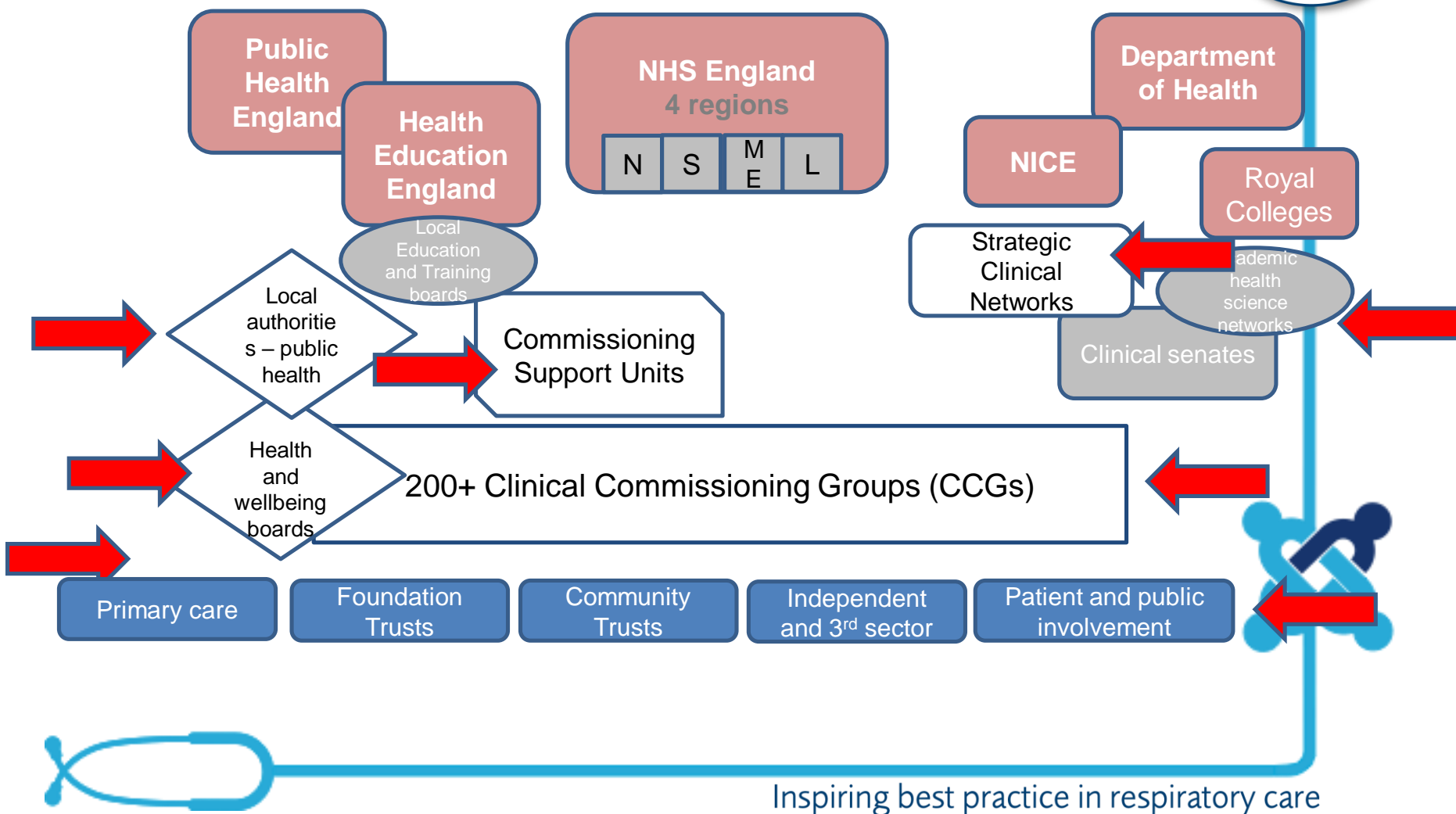
Influencing the development of policy



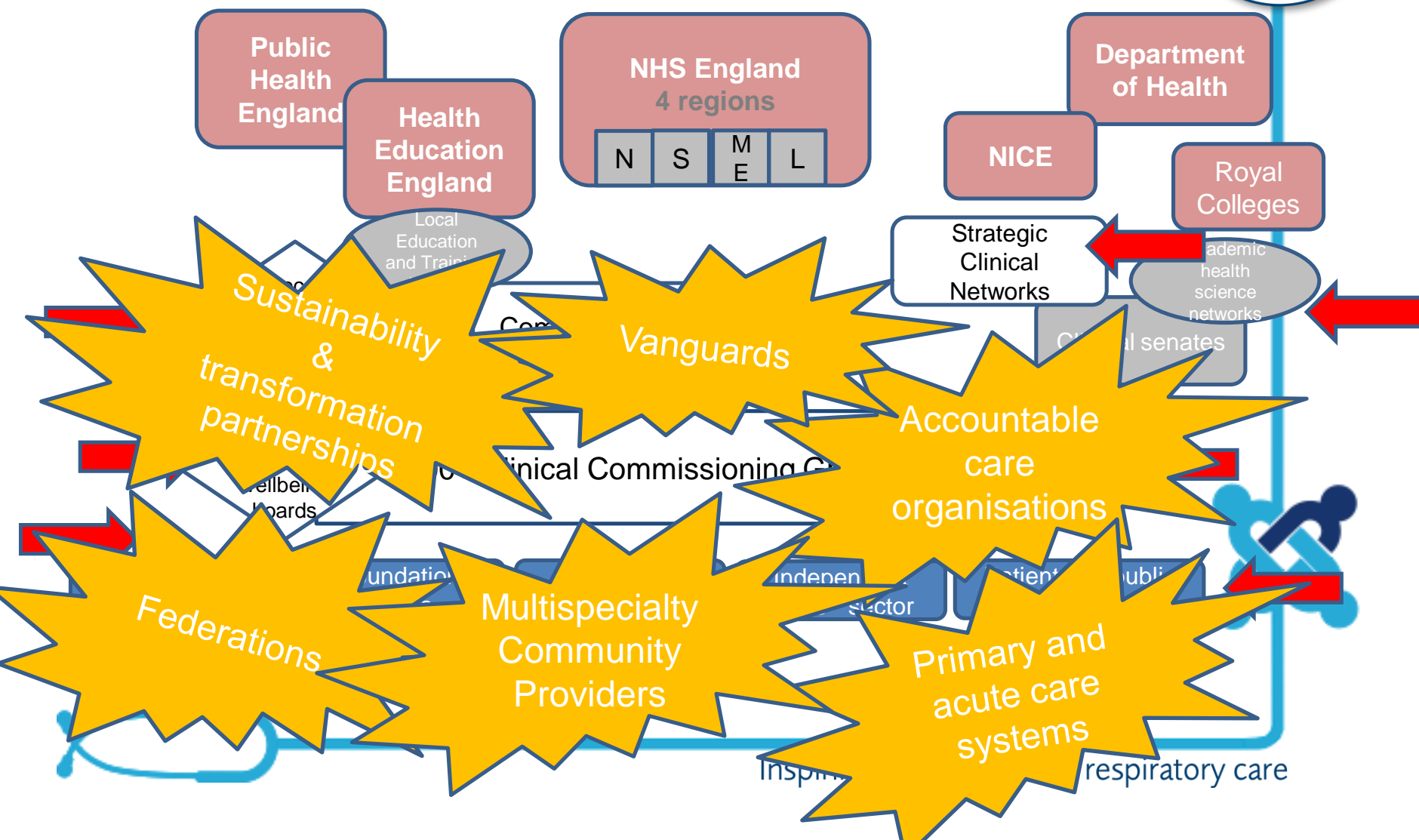
Seeking to create a positive environment for respiratory disease management



Influencing implementation of policy



Influencing implementation of policy





CCG area

Pharmacy

Primary care

Acute care

Community care

Mental health

Pharmacy

Primary care

Acute care

Community care

Mental health

Pharmacy

Primary care

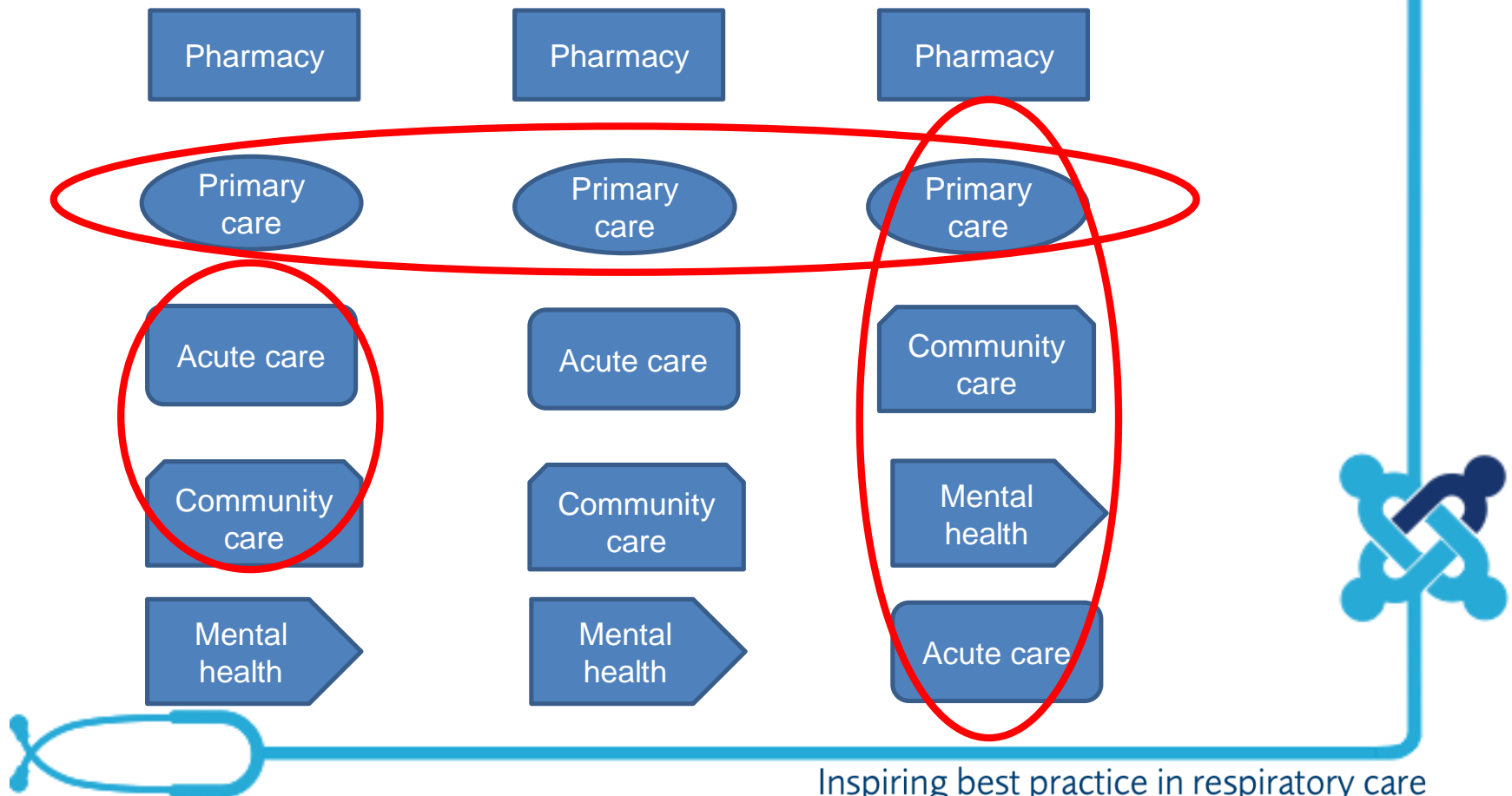
Acute care

Community care

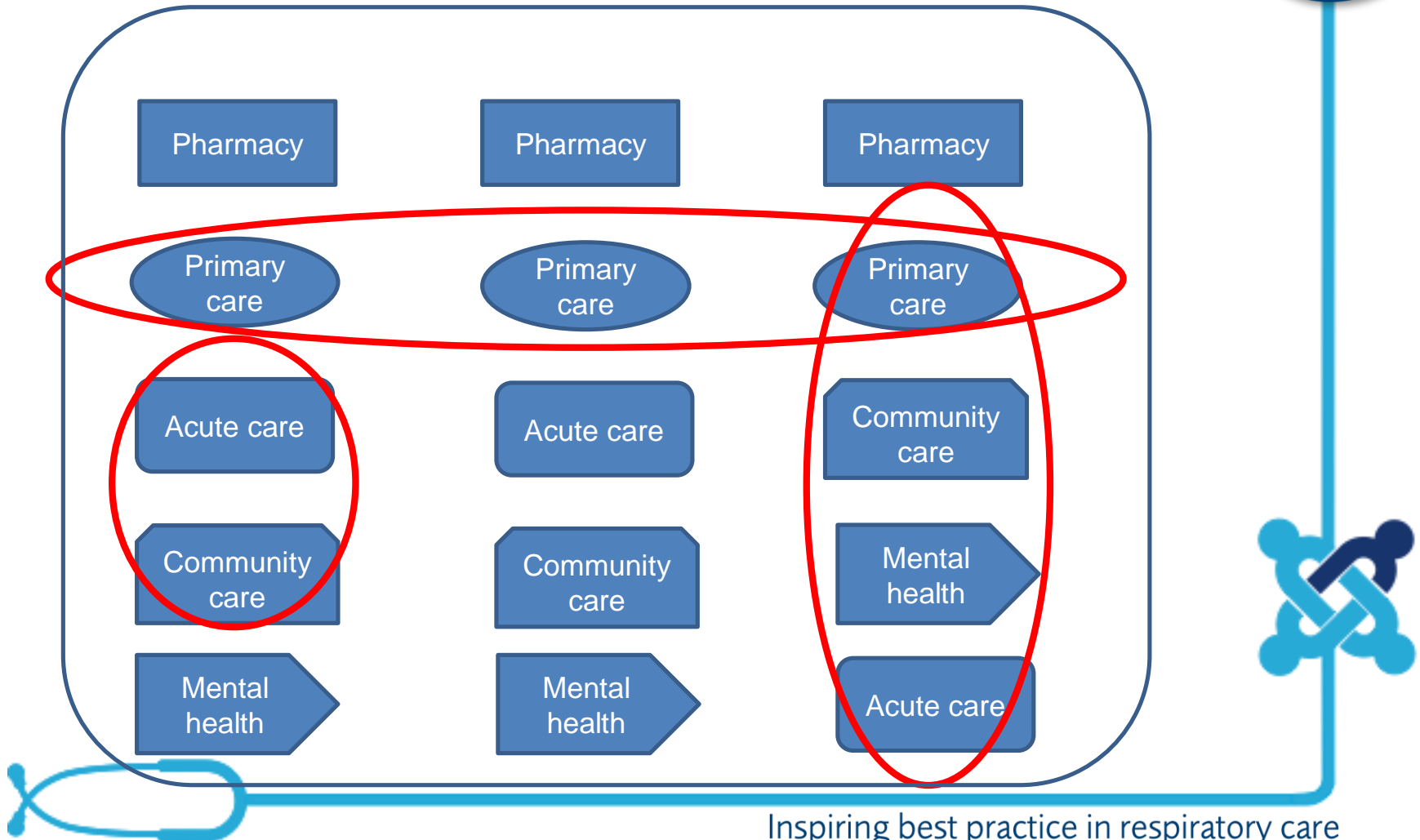
Mental health

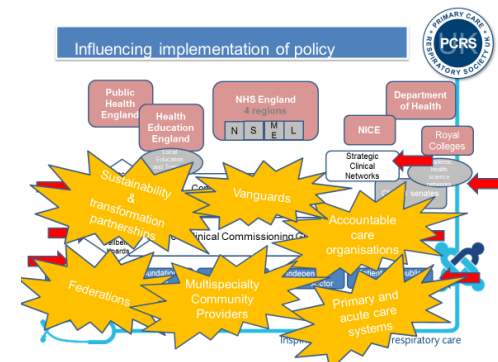
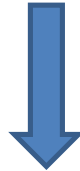
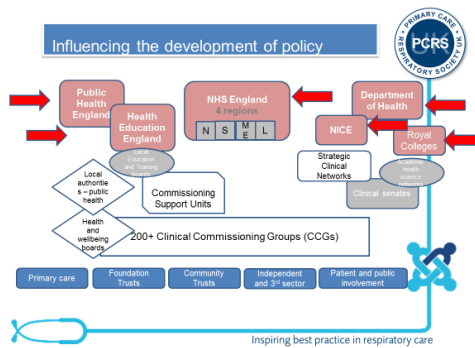


Inspiring best practice in respiratory care



Sustainability & Transformation Partnership STP or Accountable care organisation ACO



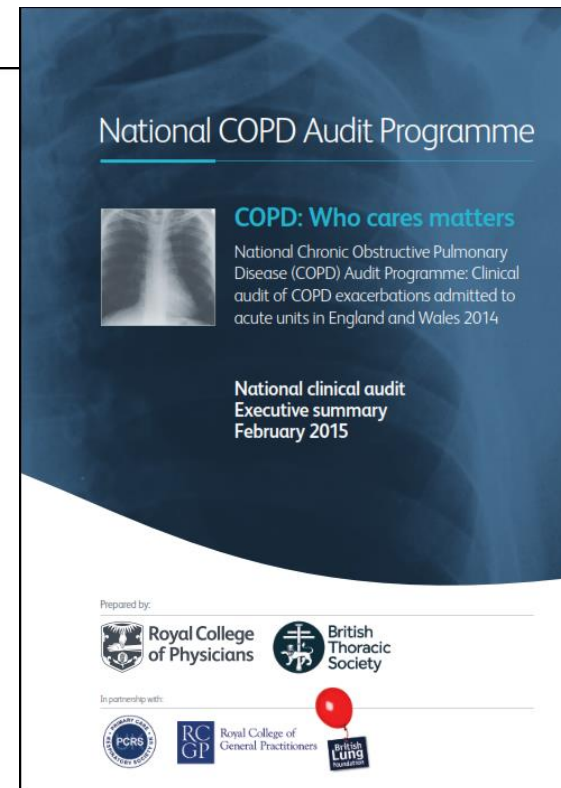




National enablers: Spirometry



National enablers: Spirometry



National enablers: Spirometry



NICE COPD quality standard

Quality statement 1: Diagnosis with spirometry

Quality statement

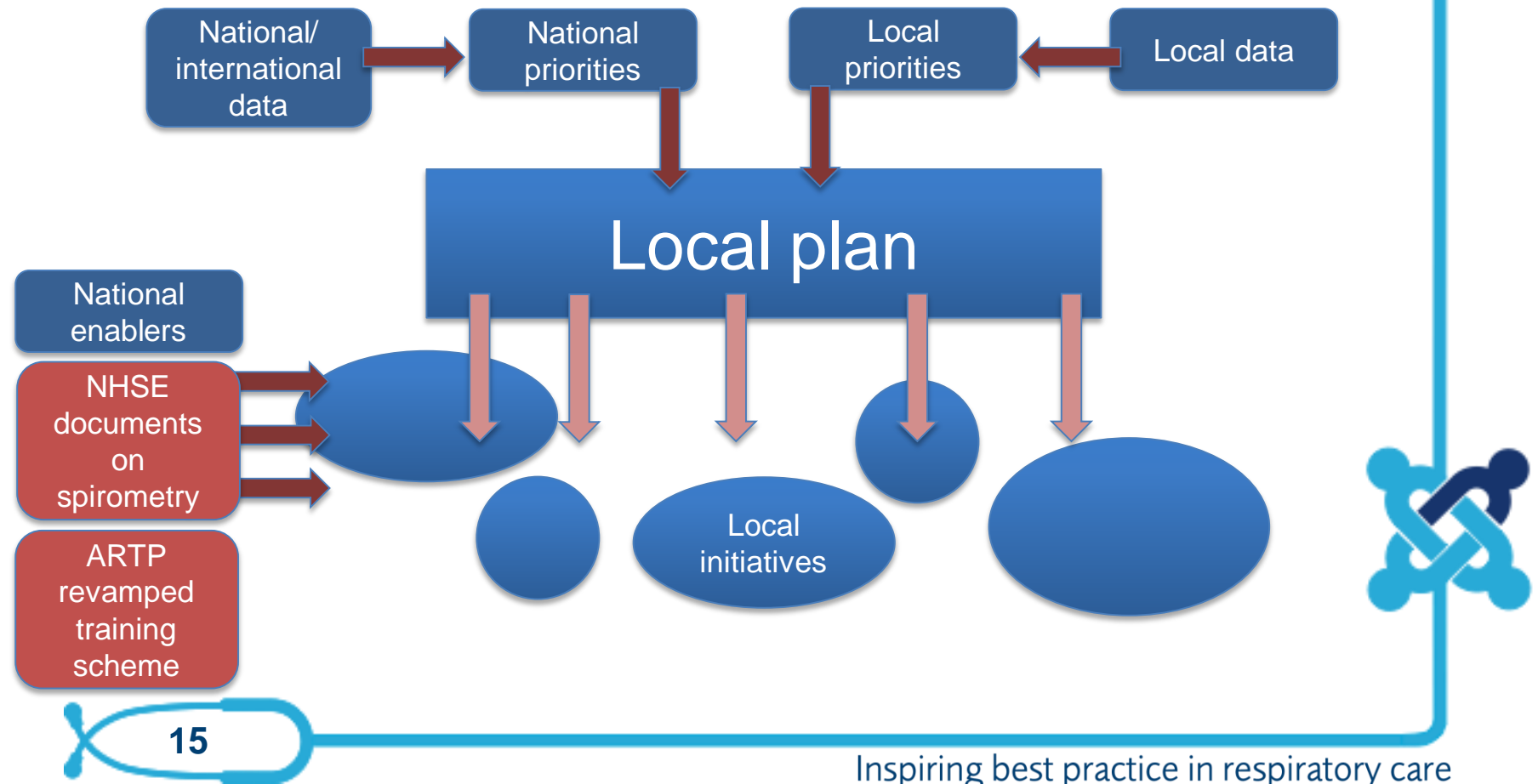
People aged over 35 years who present with a risk factor and one or more symptoms of chronic obstructive pulmonary disease (COPD) have post-bronchodilator spirometry. [2011, updated 2016]

programme

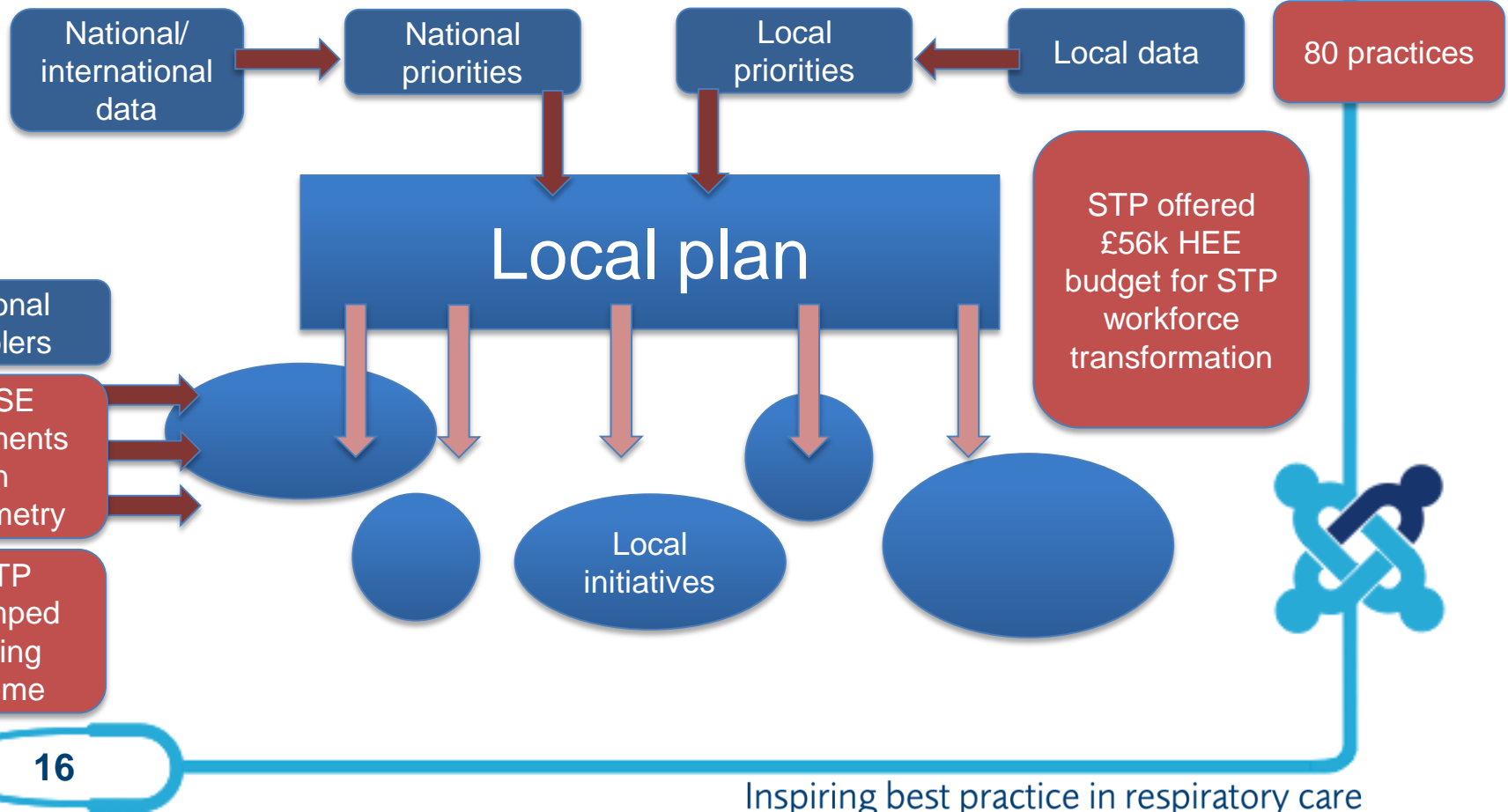
s matters

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Wales 2014

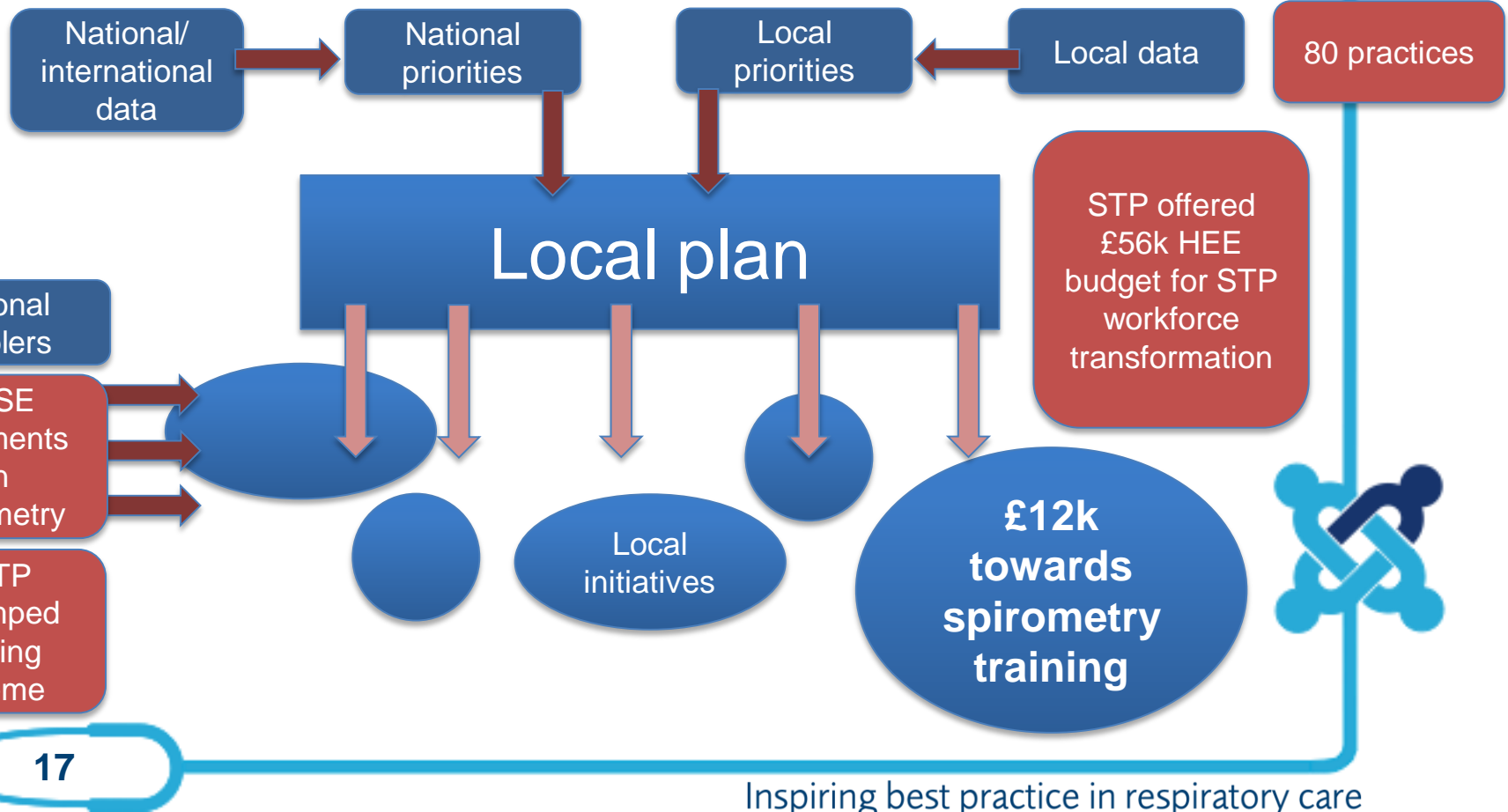
Example: Raising quality of spirometry



Short term opportunity for funding

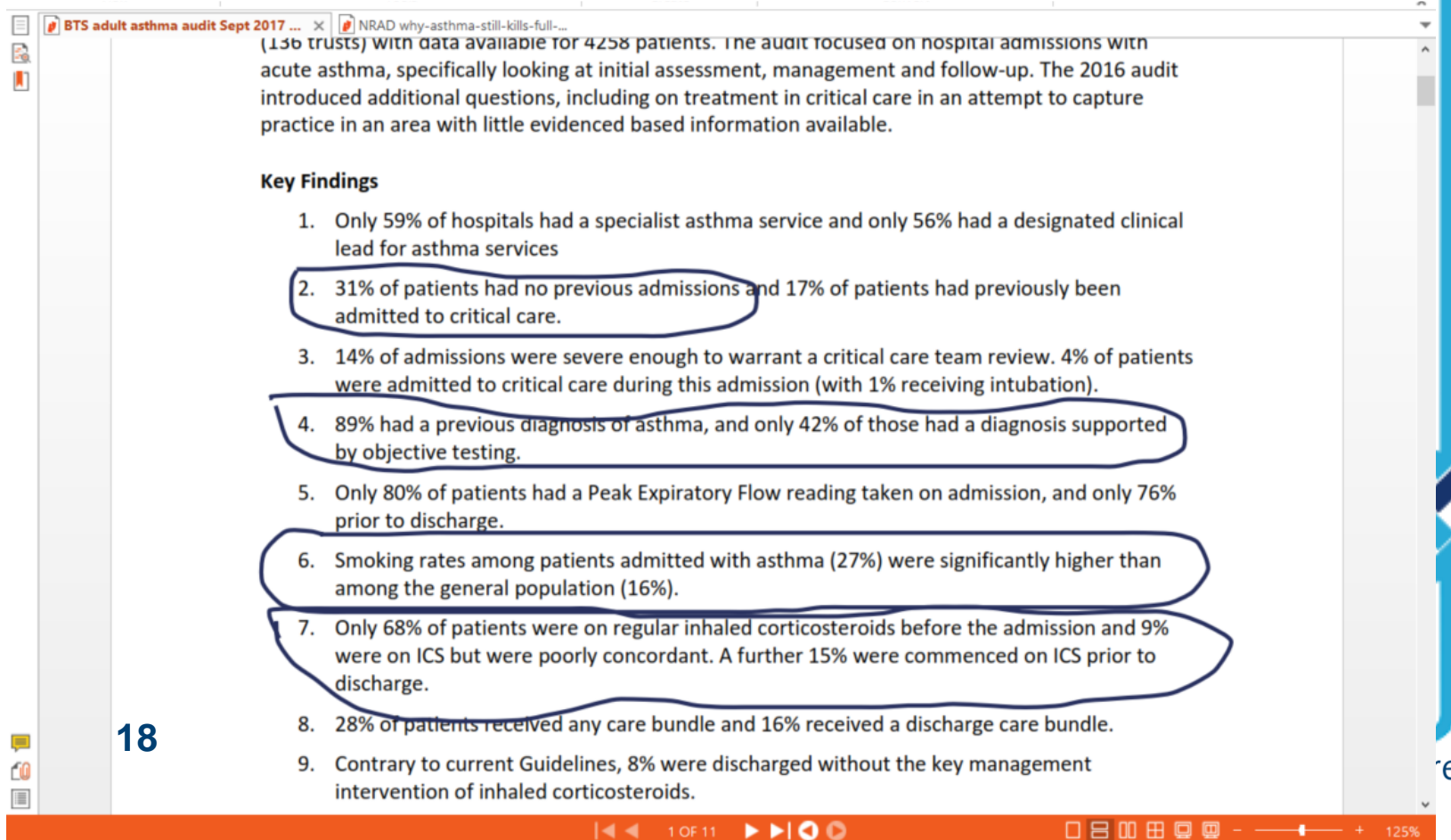


Start of a local initiative to train one person in every practice in spirometry



National enablers

BTS Adult asthma audit 2017

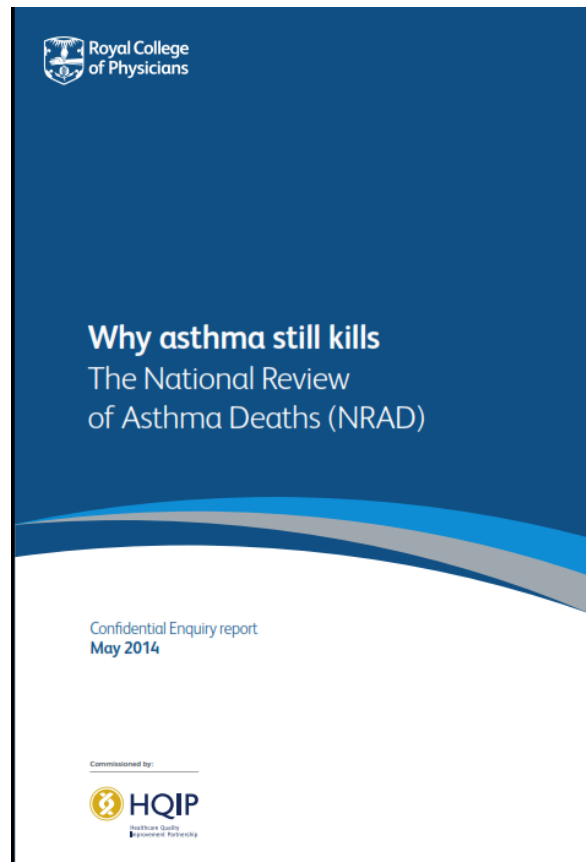


(136 trusts) with data available for 4258 patients. The audit focused on hospital admissions with acute asthma, specifically looking at initial assessment, management and follow-up. The 2016 audit introduced additional questions, including on treatment in critical care in an attempt to capture practice in an area with little evidenced based information available.

Key Findings

1. Only 59% of hospitals had a specialist asthma service and only 56% had a designated clinical lead for asthma services
2. 31% of patients had no previous admissions and 17% of patients had previously been admitted to critical care.
3. 14% of admissions were severe enough to warrant a critical care team review. 4% of patients were admitted to critical care during this admission (with 1% receiving intubation).
4. 89% had a previous diagnosis of asthma, and only 42% of those had a diagnosis supported by objective testing.
5. Only 80% of patients had a Peak Expiratory Flow reading taken on admission, and only 76% prior to discharge.
6. Smoking rates among patients admitted with asthma (27%) were significantly higher than among the general population (16%).
7. Only 68% of patients were on regular inhaled corticosteroids before the admission and 9% were on ICS but were poorly concordant. A further 15% were commenced on ICS prior to discharge.
8. 28% of patients received any care bundle and 16% received a discharge care bundle.
9. Contrary to current Guidelines, 8% were discharged without the key management intervention of inhaled corticosteroids.

National enablers



Chapter 8 – Key findings and advice for patients and carers

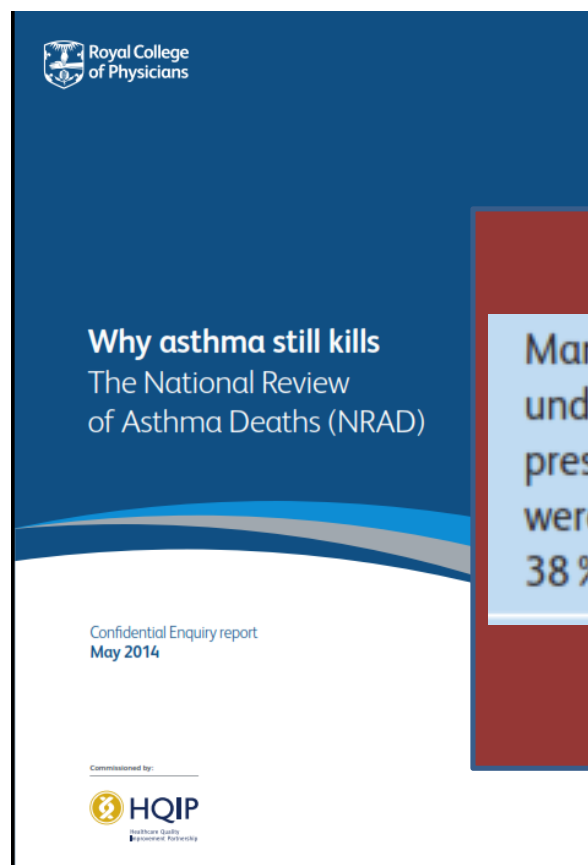
Key findings and recommendations for primary care by PCRS-UK

These key findings and recommendations were developed by the Primary Care Respiratory Society UK for inclusion in the report.

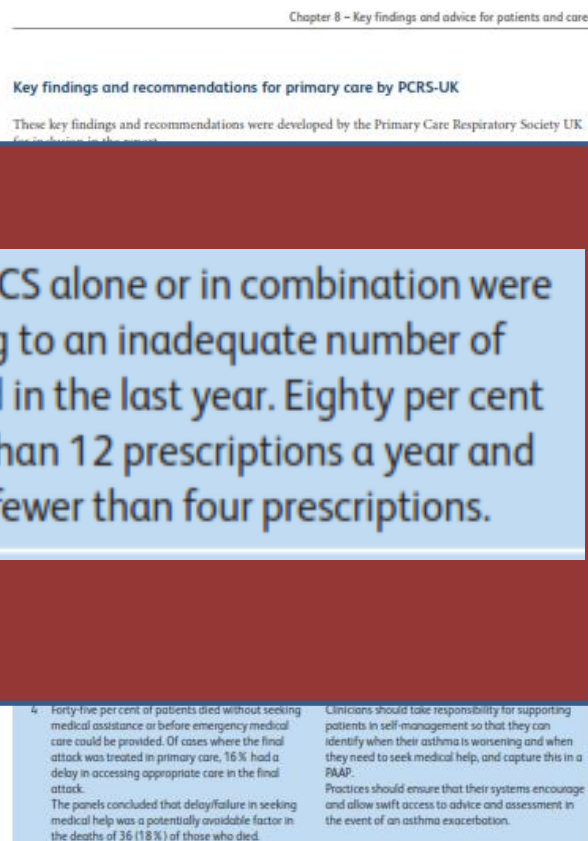
Key findings	Recommendations
1 For 43 % of patients, there was no evidence that the patient had had an asthma review in general practice in the last year before death. Twenty-two per cent had missed a routine GP asthma appointment in the previous 12 months.	Practices should have proactive methods of identifying and contacting patients who fail to attend for routine asthma appointments. A range of methods of engagement should be explored (eg telephone consultations – by clinicians not support staff, telephone follow-up if patients do not attend, personalised letters explaining possible risks of not attending, alerts on prescription screen limiting inhaler issue in future, opportunistic review of patients attending for other conditions, major alert on screen for all to see lack of asthma review).
2 Avoidable factors relating to the adequacy of asthma reviews were identified in 42 % of cases – in areas such as the provision of written self-management plans, and checking medication adherence and inhaler technique.	Reviews should be conducted by clinicians trained in asthma care and aware of the factors that place patients at higher risk of exacerbation and death. Practices should devise/acquire a standard template to raise the quality of the regular review, until a standard national template is available. QOF guidance states that an asthma review should include: <ul style="list-style-type: none"> • assessment of symptoms using RCP three questions • measurement of peak flow • assessment of inhaler technique • a PAAP.
3 Only 44 (23 %) of the 195 who died had been provided with a PAAP in primary or secondary care.	The BTS/SIGN asthma guideline has recommended personal asthma action plans for all patients for many years. The evidence for the benefits of such plans is grade A, and all patients with asthma should have a written plan and know how to respond in the event of deteriorating control.
4 Forty-five per cent of patients died without seeking medical assistance or before emergency medical care could be provided. Of cases where the final attack was treated in primary care, 16 % had a delay in accessing appropriate care in the final attack. The panels concluded that delay/failure in seeking medical help was a potentially avoidable factor in the deaths of 36 (18 %) of those who died.	Clinicians should take responsibility for supporting patients in self management so that they can identify when their asthma is worsening and when they need to seek medical help, and capture this in a PAAP. Practices should ensure that their systems encourage and allow swift access to advice and assessment in the event of an asthma exacerbation.



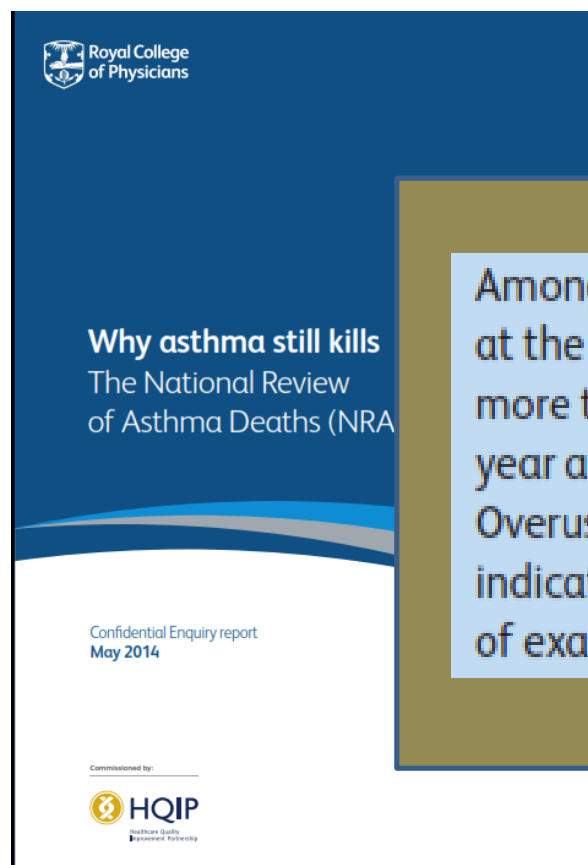
National enablers



Many patients on ICS alone or in combination were undertreated owing to an inadequate number of prescriptions issued in the last year. Eighty per cent were issued fewer than 12 prescriptions a year and 38 % (of 128) had fewer than four prescriptions.



National enablers



Chapter 8 – Key findings and advice for patients and carers

Key findings and recommendations for primary care by PCRS-UK

Among patients that were on short-acting relievers at the time of death, 39 % had been prescribed more than 12 salbutamol inhalers in the previous year and six individuals had had more than 50. Overuse of short-acting bronchodilators is a key indicator of poor asthma control and of higher risk of exacerbation and death.

4. Forty-five per cent of patients died without seeking medical assistance or before emergency medical care could be provided. Of cases where the final attack was treated in primary care, 16% had a delay in accessing appropriate care in the final attack. The panels concluded that delay/failure in seeking medical help was a potentially avoidable factor in the deaths of 36 (18%) of those who died.

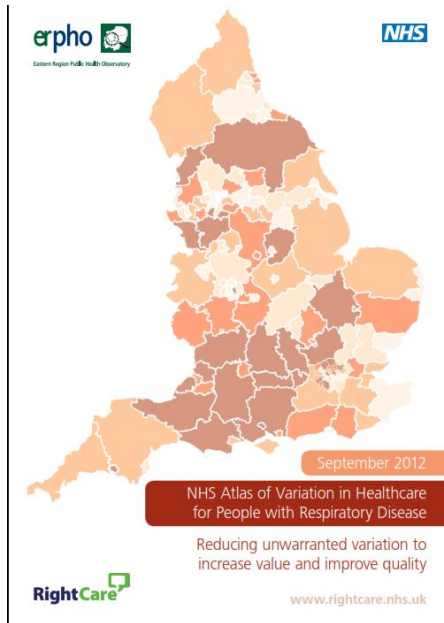
Clinicians should take responsibility for supporting patients in self-management so that they can identify when their asthma is worsening and when they need to seek medical help, and capture this in a PAAP. Practices should ensure that their systems encourage and allow swift access to advice and assessment in the event of an asthma exacerbation.



Local information?



Sources of local level information



Public Health England

NHS England

NHS RightCare
Commissioning for Value
Focus Pack

Respiratory
April 2016

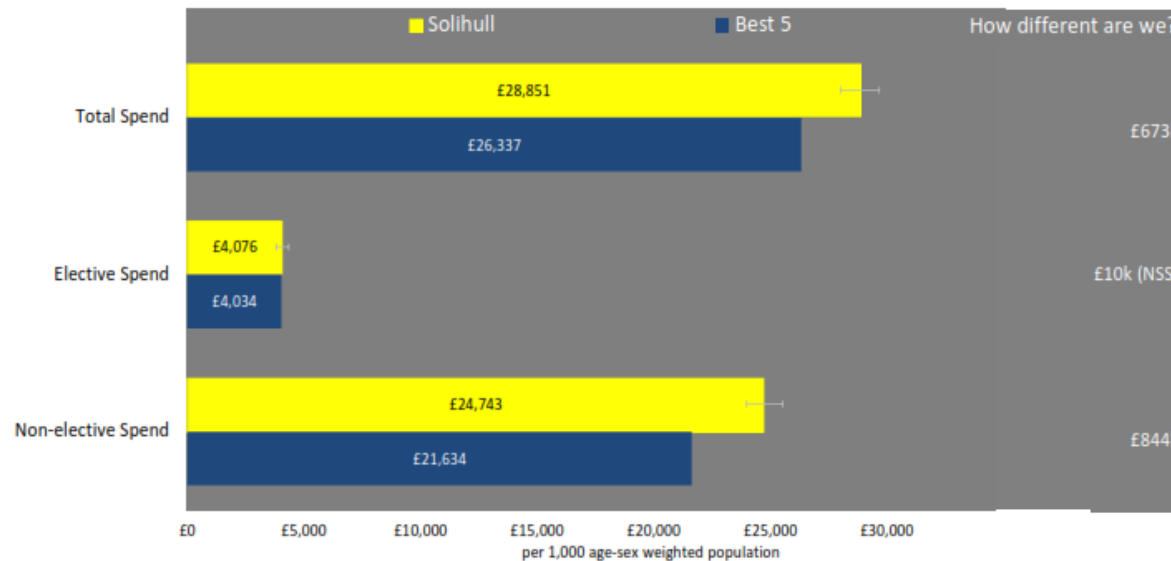
RightCare

NHS Solihull CCG

OFFICIAL
Gateway ref: 04938

Total respiratory spend – Solihull

Respiratory - Spend 13



NHS RightCare CFV Respiratory focus pack

95% confidence intervals
 NSS Not statistically significant*
 *Where an opportunity is 'NSS' CCGs can investigate further whether this reflects a true opportunity e.g. by looking at more than 1 year's data or triangulating with other indicators

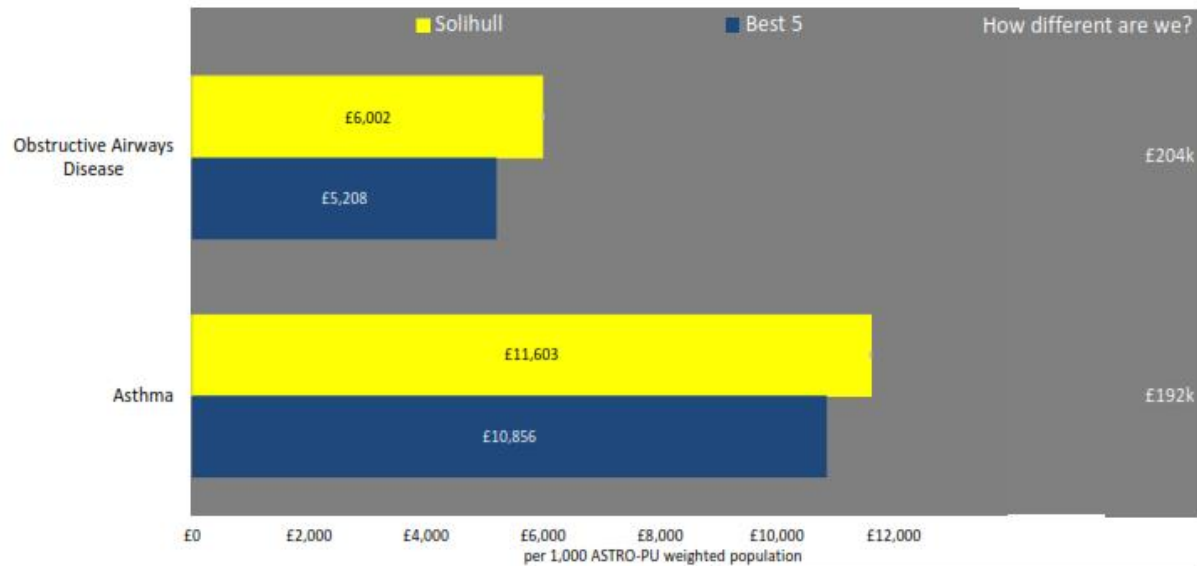
NHS Solihull CCG

Primary care prescribing spend – Solihull



Respiratory - Primary Care Prescribing Spend

32



Medicines Optimisation Dashboard: <https://www.england.nhs.uk/ourwork/optimise-dash/>

Innovation Scorecard: <https://www.england.nhs.uk/ourwork/innovation/innovation-scores/>

NHS RightCare CFV Respiratory focus pack

95% confidence intervals
N/S Not statistically significant*
*Where an opportunity is 'N/S' CCGs can investigate further whether this reflects a true opportunity e.g. by looking at more than 1 year's data or triangulating with other indicators.

NHS Solihull COG

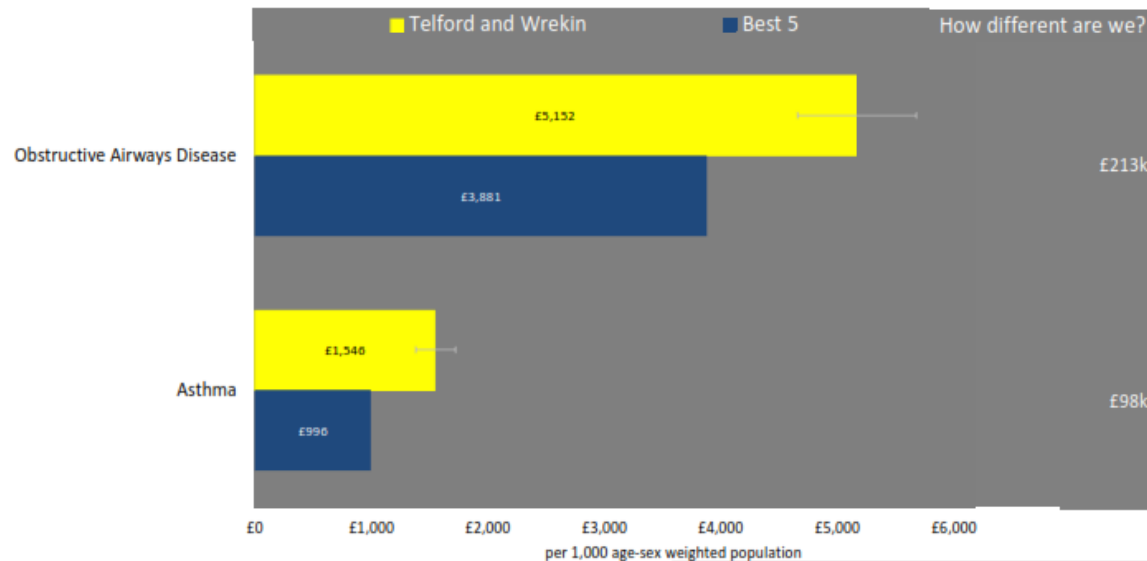
Inspiring best practice in respiratory care

Respiratory spend – non-elective admissions – Telford



Respiratory - Spend on non-elective conditions

17



NHS RightCare CFV Respiratory focus pack

95% confidence intervals
NSS Not statistically significant*
*Where an opportunity is 'NSS' CCGs can investigate further whether this reflects a true opportunity e.g. by looking at more than 1 year's data or triangulating with other indicators

NHS Telford and Wrekin CCG

Inspiring best practice in respiratory care

Potential savings – non elective admissions - Bham sth/ctrl



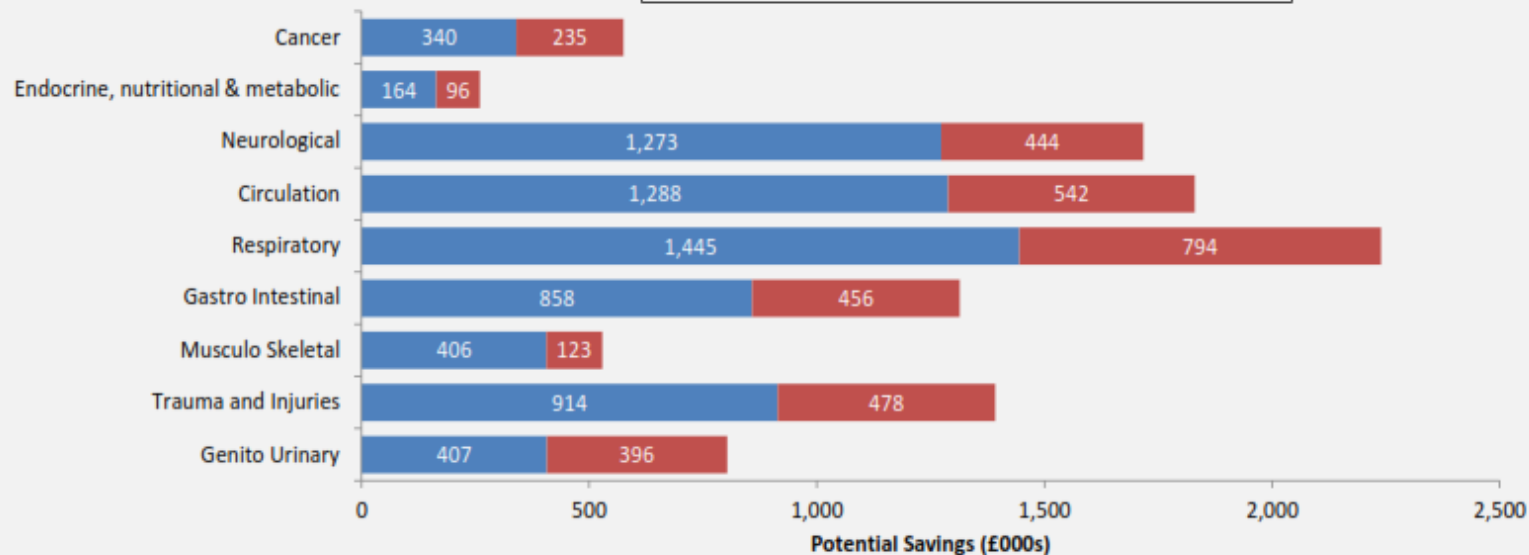
What are the potential savings on non-elective admissions?

NHS Birmingham South and Central CCG

A value is only shown where the opportunity is statistically significant

Potential Non-Elective Savings If this CCG performed at the average of:

■ Similar 10 CCGs ■ Best 5 of similar 10 CCGs



Savings on prescribing Bham sth/ctrl

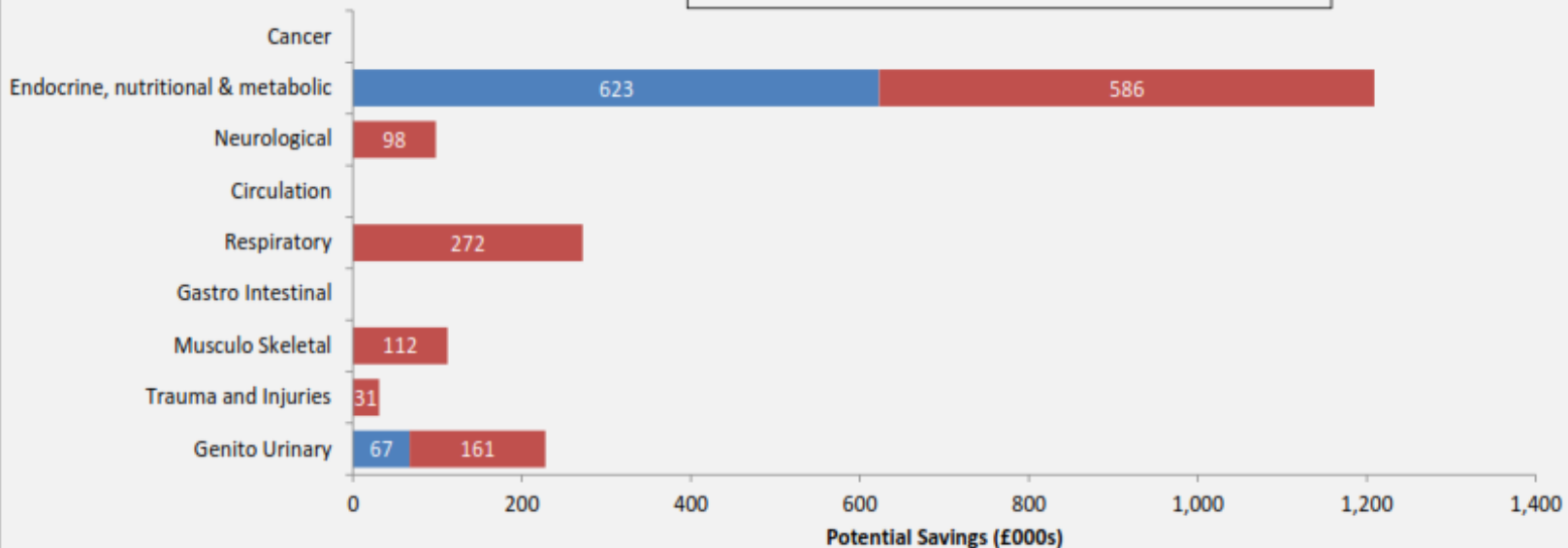
What are the potential savings on prescribing?

NHS Birmingham South and Central CCG

A value is only shown where the opportunity is statistically significant

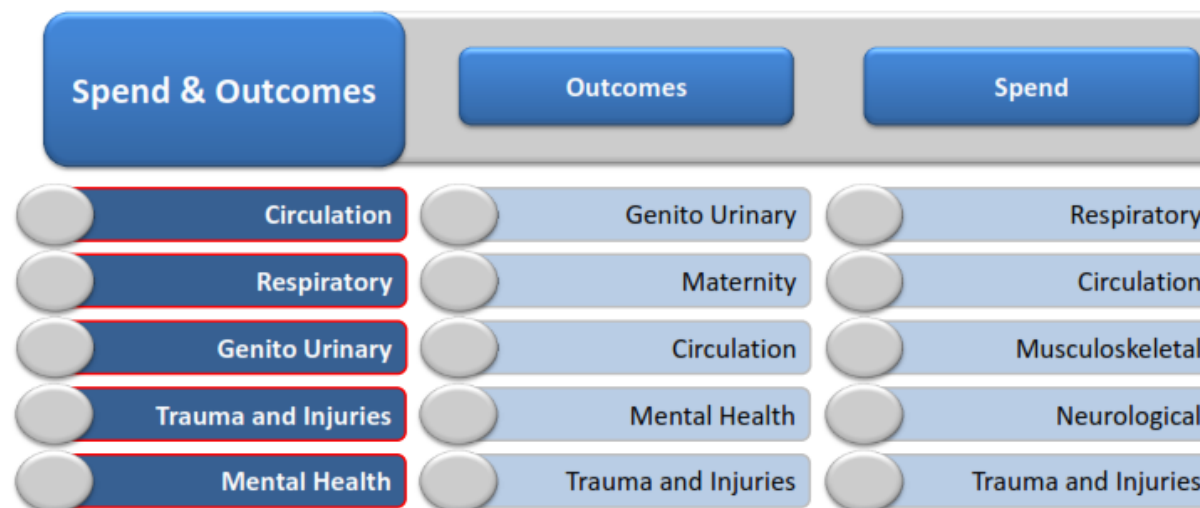
Potential Prescribing Savings If this CCG performed at the average of:

■ Similar 10 CCGs ■ Best 5 of similar 10 CCGs



Highlighting areas for focus

Headline opportunity areas for your health economy



A note on the methodology used to calculate your headline opportunities is available on our website:

<https://www.england.nhs.uk/comm-for-value/>

NHS Birmingham South and Central CCG

Public Health
England

RightCare

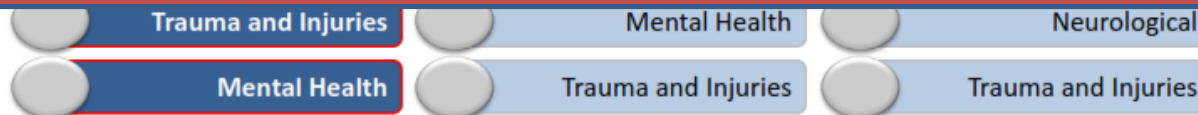
NHS
England

Inspiring best practice in respiratory care

Highlighting areas for focus

Headline opportunity areas for your health economy

<http://www.rightcare.nhs.uk/index.php/commissioning-for-value/#Focus>



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NHS Birmingham South and Central CCG


Public Health
England

RightCare

NHS
England



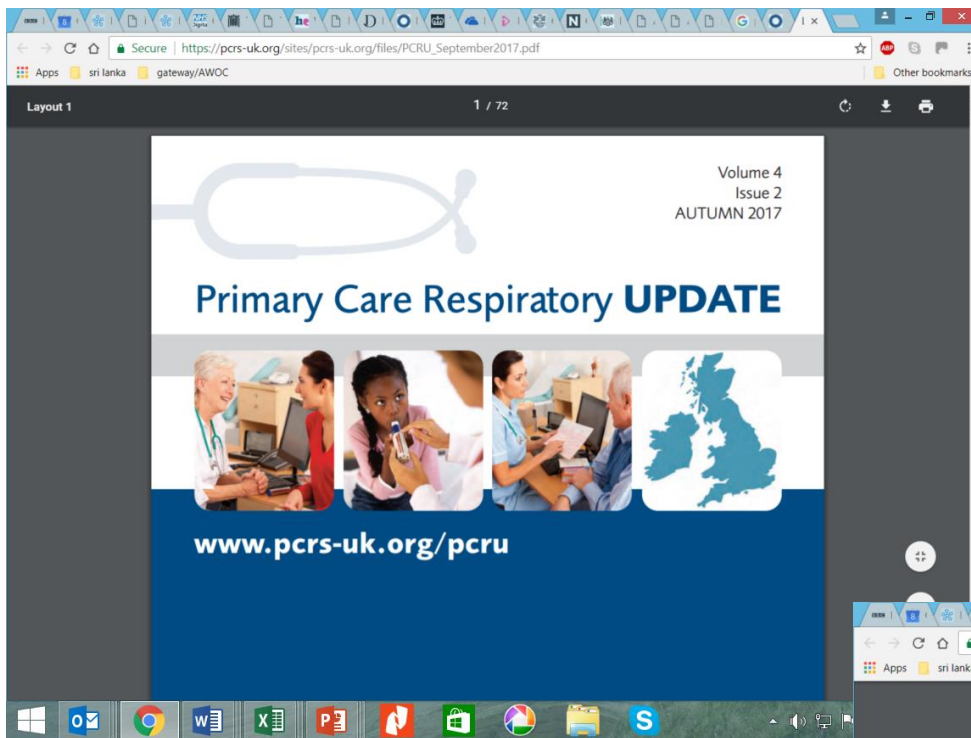
Inspiring best practice in respiratory care

Snapshot of respiratory guidance expected in coming months

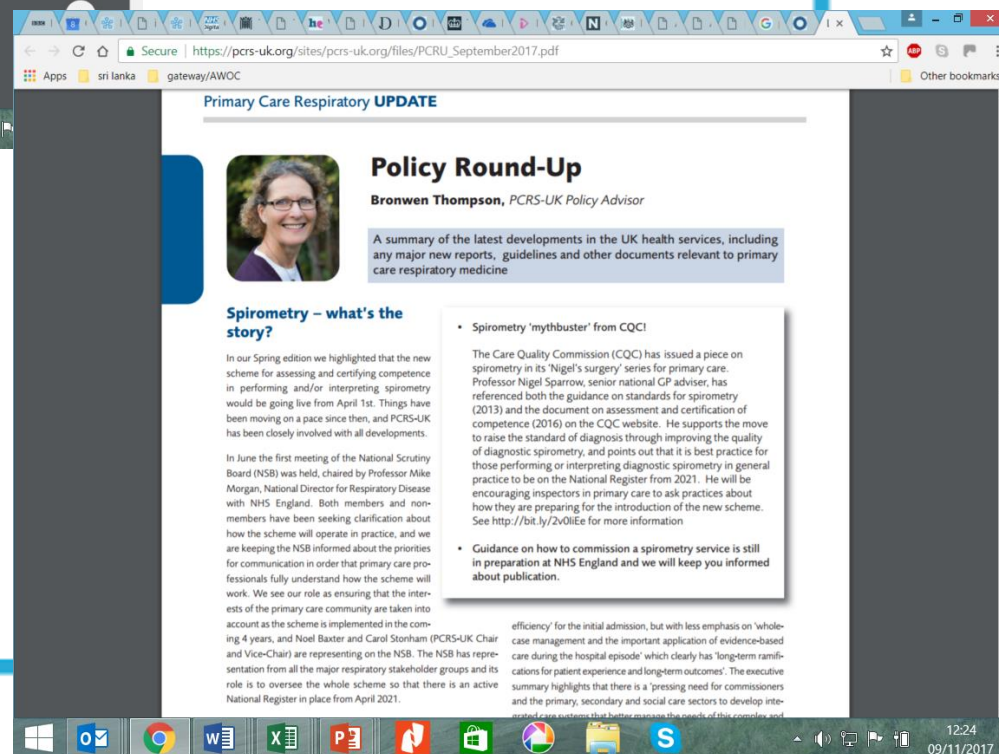


3	Asthma guideline – diagnosis and monitoring	October 31 2017 – delayed	NICE
4	Asthma management guideline	October 31 2017 – delayed	NICE
5	Spirometry commissioning guidance	Oct 2017?	NHSE
6	Right Care – Optimal Value Solutions project for COPD	Dec 2017?	Right Care
7	COPD audit - Wales primary care report No. 2	Dec 14 2017	RCP
8	Mesothelioma guideline	late 2017	BTS
9	COPD audit - Pulmonary rehab rept	Dec 14	RCP
10	Diagnosis innovations mtg report	Late 2017	Asthma UK
11	Asthma Care report	Early 2018	Asthma UK





Plus ...
E alerts



6 mins to understand the NHS



Secure | <https://www.kingsfund.org.uk/audio-video/how-does-nhs-in-england-work>

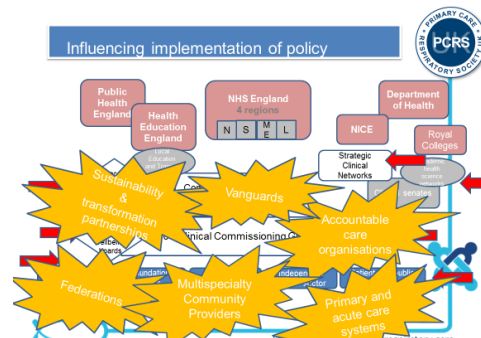
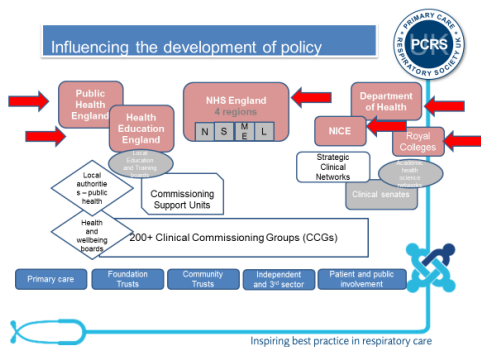
<https://www.kingsfund.org.uk/audio-video/how-does-nhs-in-england-work>



Primary care



In summary



National enablers: Spirometry



Highlighting areas for focus

