Welcome & Housekeeping

Dr Jo Congleton, Clinical Lead, Respiratory Programme, KSS AHSN
Consultant Respiratory Physician, Brighton & Sussex University Hospitals
NHS Trust
Outline of the day

- Respiratory Network Overview
- GIRFT and the National Perspective
- NACAP National Leads: Audit update + a proposition!
- LUNCH
- QI projects around the region
KSS Respiratory Programme update

Data update: Jo Congleton
Oxygen & PR update: Julia Bott, Clinical Leads, KSS Respiratory Programme
• COPD Discharge Bundle
• KSS AHSN Respiratory Dashboard: Developments
• Medicines Optimisation
• CAP
• PR Network
• Oxygen Network - Oxygen wristband project
COPD Discharge Bundle

• Submissions from all 10 acute trusts
• 14/16 acute sites submitting data
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Inhaler technique</td>
<td>24%</td>
<td>97%</td>
<td>54%</td>
<td>65%</td>
<td>80%</td>
</tr>
<tr>
<td>Written Information</td>
<td>8%</td>
<td>44%</td>
<td>50%</td>
<td>67%</td>
<td>85%</td>
</tr>
<tr>
<td>Rescue Pack</td>
<td>25%</td>
<td>42%</td>
<td>34%</td>
<td>46%</td>
<td>61%</td>
</tr>
<tr>
<td>Referred for smoking cessation</td>
<td>59%</td>
<td>73%</td>
<td>65%</td>
<td>81%</td>
<td>91%</td>
</tr>
<tr>
<td>Assessed for PR</td>
<td>22%</td>
<td>44%</td>
<td>34%</td>
<td>63%</td>
<td>83%</td>
</tr>
<tr>
<td>Follow up arranged</td>
<td>54%</td>
<td>70%</td>
<td>64%</td>
<td>69%</td>
<td>89%</td>
</tr>
<tr>
<td>All elements</td>
<td>4%</td>
<td>29%</td>
<td>30%</td>
<td>40%</td>
<td>65%</td>
</tr>
</tbody>
</table>
Appropriate Care Score (ACS)
Composite Quality Score (CQS)

In 2017 3,626 patients had at least 1 element of the COPD Discharge Bundle delivered.
COPD Discharge Bundle: Case ascertainment

• Case ascertainment was ~ 50% of HES recorded AECOPD admissions (higher May to September)

• March 2018: 33.3%
Is a case a case? Availability of spirometry
Admissions, LOS, inpatient mortality

KSS AHSN Respiratory Dashboard: Outcome Trends

**12 month rolling average**

**Organisation Level**
- Trust
- Organisation (AHSN)

**Legend**
- Green: Current attainment
- Red: Baseline

**COPD Admissions**

**Length of Stay**

**In-hospital Crude Mortality %**
Compared to National Data

<table>
<thead>
<tr>
<th>Phase</th>
<th>AHSN</th>
<th>Change per year</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-intervention</td>
<td>Rest-of-England</td>
<td>-0.19%</td>
<td>0.17</td>
</tr>
<tr>
<td></td>
<td>KSS</td>
<td>-0.27%</td>
<td>0.17</td>
</tr>
<tr>
<td>Interventions</td>
<td>Rest-of-England</td>
<td>-0.26%</td>
<td>0.07</td>
</tr>
<tr>
<td></td>
<td>KSS</td>
<td><strong>-0.44%</strong></td>
<td><strong>0.04</strong>*</td>
</tr>
</tbody>
</table>

Legend
- KSS
- Rest-of-England

COPD in-hospital mortality rate

Shaded area indicates 95% confidence intervals.
Data obtained from HES, at yearly quarters.
30 day re-admission rate
Bundle compliance and Respiratory Review by week
HRG Value Breakdown (2016/17)

<table>
<thead>
<tr>
<th>HRG</th>
<th>Description</th>
<th>Number of Spells</th>
<th>Additional Money</th>
</tr>
</thead>
<tbody>
<tr>
<td>DZ21A</td>
<td>Chronic Obstructive Pulmonary Disease or Bronchitis with length of stay 1 day or less discharged home</td>
<td>393</td>
<td>£215,111</td>
</tr>
<tr>
<td>DZ21H</td>
<td>Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with Major CC</td>
<td>231</td>
<td>£76,570</td>
</tr>
</tbody>
</table>

Sum of money the trust was reimbursed: £1,283,892
The sum of money the trust would have been reimbursed had BPT been met: £1,419,985
A difference of: £136,093

Equivalent number of Band 6 HCP (£30,681 p/a): 4
Equivalent number of Band 7 HCP (£38,613 p/a): 4
The Dashboard of Dashboards
Dashboard of Dashboards

New Dashboards Produced

Pointless Indicators

Annoyance Achieved

Understanding of WTF it Means

Error: No
Dashboard Lite: Data at your finger tips!
Houston, we have a problem.......
10. Discharge

10.1 Was the patient alive at discharge from your hospital?
   - Alive
   - Died as inpatient

10.2 Date of discharge / death: dd/mm/yyyy

10.3 Was a discharge bundle completed for this admission?
   - Yes
   - No
   - Self-discharge

10.4 Which of the following specific elements of good practice care were undertaken as part of the patient’s discharge?
   - Inhaler technique checked
   - Medication issued/classes reviewed
   - Self-management plan provided or referred to community team for plan
   - Emergency drug pack provided or referred to community team for pack
   - Oxygen alert card provided
   - Smoking cessation drugs/referred for behavioral change intervention
   - Assessed for suitability for pulmonary rehabilitation
   - Follow-up requests at home within 72 hours by person or by phone
   - Patient discussed at an MDT with a community- and/or primary-care team
   - BLF passport offered to the patient
   - None
NACAP COPD

V2 Patient record: (unsaved record) - DRAFT record - 22 questions remaining (0% complete)

This dataset is only for patients discharged from 1 October. If the patient was discharged on or after 1 October, complete this record. If the patient was discharged earlier, enter the patient using 'Dataset 1'.

11. Custom Fields

Was Inhaler Technique Assessed with Patient Prior to Discharge?

Does the patient or carer have information & understands their self management plan or self care?

Was a Rescue Pack provided to the patient on discharge?

Is there documentation of referral to a stop smoking service?

Is there evidence of an assessment for suitability for enrolment into a pulmonary rehabilitation programme being made?

Has appropriate follow-up been arranged?
CAP Outcomes
CAP mortality

No suggestion of drifting post end of EQ project
Oxygen Network 2018

• **Oxygen saturation wristband project** commenced in East Kent, who have kindly shared their strategy

• Rollout planned in other acutes and community teams; SECAmb involved
  
  • Support from Dolby Vivisol for community HOS-ARs
  
  • Interest from South Central in collaborating: East Berks (FPH area) and IOW

• HOS teams need your support by getting involved in the training and dissemination of information/awareness

• Introduce wristbands as a means of using NEWS2 effectively
PR Network

In preparation for National Accreditation (started) and the NACAP PR Audit go-live March 2019:

• Network meeting June with National Clinical & Programme Leads, Neena Garnavos and Sally Singh
• Another meeting with Neena planned to try the audit tool
• Medical & managerial support is needed to help PR clinicians in
  • Increasing appropriate referrals
  • Making a case for increased resources to cope with demand
• Commissioning/managerial support for accreditation & QI to reach achievable target patient numbers and outcomes
Preliminary analysis of NACAP PR 2017 audit demonstrates KSS performing better than national average in some metrics:

- A significantly higher number completing a practice walk for tests of exercise tolerance (83% vs 43%, Fisher’s exact test p<0.0001)
- A significantly higher PR completion rate (72% vs 61%, Fisher’s exact test p<0.0001)
- A greater number of patients with a written programme of exercise at discharge (93% vs 84%).

Work is underway on re-analysis to check as 1st RCP dataset withdrawn.
KSS Respiratory Programme

Improving the quality, availability and accessibility of respiratory services, and reducing unwarranted variation in the management of pathways, such as CAP (community acquired pneumonia) and COPD. Focused on addressing the interdependency between polypharmacy prescribing issues and respiratory prescribing, reducing unnecessary prescriptions, increasing value based prescribing, reducing medicines linked complications and reducing the high respiratory drug spend.

COPD Discharge Bundle
- In 2017, 3626 patients received at least one measure of the discharge bundle.
- So far in 2018, 1773 patients received at least one measure of the COPD discharge bundle.
- All 10 acute trusts in KSS deliver the COPD discharge bundle and report to the system, data is submitted from 13 of 16 acute sites.

Pulmonary Rehabilitation
- PR Clinical Network: 136 network members.
- 3 meetings per year.

Respiratory Dashboard: Medicines Optimisation
- Low/moderate ICS/LABA inhalers as a % of all ICS/LABA inhalers.
- No. of reliever inhalers (including refills) per 1000 respiratory patients (asthma & COPD QOF).
- No. of spacers per respiratory patient (asthma & COPD QOF).

Respiratory Collaborative
- 2 Collaborative events per year.
- Positively received by KSS Respiratory Network:
  - 98% said the event met their expectations – May 2018.
  - 100% of attendees said the event met their expectations – Nov 2017.
  - 95% of attendees agreed we made good progress towards developing better care for respiratory patients across KSS – May 2017.

Oxygen
- Oxygen wristbands.
- 3 regional protocols designed in 2017.
- 3 meetings per year.

Breathing Matters
- 4 editions per year.
- 918 subscribers.
- 40 issues published to date.
Thank you!
Agenda item 3

Get ready for GIRFT

Dr Martin Allen, Respiratory Clinical Lead – GIRFT
Consultant Physician for Respiratory Services & Lead in Sleep Services, University Hospitals of North Midlands NHS Trust

Please note: Slides unavailable for circulation
NACAP (National Asthma & COPD Audit Programme) Update

Professor Mike Roberts, Clinical Director, NACAP
Consultant Physician, Barts Health NHS Trust, Programme Director, UCLPartners
Viktoria McMillan, Programme Manager, NACAP
Spirometry – how to improve across KSS AHSN?

Mike Roberts and Viki McMillan
13 November 2018
Overview of NACAP

The National Asthma and COPD Audit Programme (NACAP) for England, Scotland and Wales aims to improve the quality of care, services and clinical outcomes for patients with asthma (adult and paediatric) and chronic obstructive pulmonary disease (COPD).

NACAP comprises 6 key workstreams...

1. PRIMARY CARE
   - Collection of audit data from GP records in Wales for patients with asthma and COPD.
   - NACAP will explore how the primary care audit can run in England and Scotland from 2018 to 2019.

2. COPD
   - Continuous clinical audits of admissions to hospital
   - Continuous since February 2017

3. ADULT ASTHMA
   - Starts November 2018
   - Snapshot organisational audits

4. PAEDIATRIC ASTHMA
   - Starts June 2019
   - Snapshot organisational audits

5. PULMONARY REHABILITATION
   - Starts March 2019
   - Continuous clinical audit of service provision and delivery
   - Snapshot organisational audits

6. QUALITY IMPROVEMENT (QI)
   - NACAP will provide teams with the QI tools and support for service development and improvement
Update on NACAP progress

➢ COPD dataset refreshed:
  ➢ NEWS2 replaced DECAF
  ➢ Co-morbidities added
  ➢ Elements of discharge bundle added

➢ Adult asthma launched 1 November 2018

➢ PR dataset and web-tool pilot – November 2018
  ➢ Will launch in March 2019

➢ CYP asthma will pilot in February 2019 ahead of a launch in June 2019
Spirometry - background

➢ NICE COPD QS 10
➢ People should have post-bronchodilator spirometry if they:
  ➢ are aged over 35 years and present with,
  ➢ a risk factor and
  ➢ one or more symptoms of COPD.

➢ For a diagnosis of COPD the FEV1/FVC ratio must be less than 0.7.
➢ Clinical judgement alone is not sufficient to confirm a diagnosis.
On average, **only 40%** of patients admitted to hospital with AECOPD have a spirometry result available.
National picture

➢ Of patients included in the 2018 report:
  ➢ Only 39.7% had spirometry available
  ➢ Of these who did have a spirometry result, 12.4% had no record of airflow obstruction (i.e. they had an FEV1/FVC ratio greater than 0.7)
# KSS picture

<table>
<thead>
<tr>
<th>Hospital</th>
<th>March 2017*</th>
<th>September 2018*</th>
</tr>
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<tbody>
<tr>
<td>Darent Valley</td>
<td>40%</td>
<td>20%</td>
</tr>
<tr>
<td>Medway Maritime</td>
<td>10%</td>
<td>0%</td>
</tr>
<tr>
<td>QE</td>
<td>10%</td>
<td>25%</td>
</tr>
<tr>
<td>Royal Sussex</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>St Peter’s</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>St Richard’s</td>
<td>30%</td>
<td>35%</td>
</tr>
<tr>
<td>Maidstone</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Tunbridge Wells</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>William Harvey</td>
<td>5%</td>
<td>20%</td>
</tr>
<tr>
<td>Worthing</td>
<td>30%</td>
<td>45%</td>
</tr>
</tbody>
</table>

* Approximate, snapshot figures
Why do we need to get better?

Readmissions

To see the data analysis in full, please access the ‘Readmissions’ section at www.rcplondon.ac.uk/copd-outcomesreport2014

- One-quarter (24%) of the patients were readmitted at least once (for any reason) within 30 days of discharge.
- Nearly half (43%) of the patients were readmitted at least once (for any reason) within 90 days of discharge.
- Twelve percent of the patients were readmitted at least once owing to COPD within 30 days of discharge.
- Twenty three percent of the patients were readmitted at least once owing to COPD within 90 days of discharge.
- Although COPD was the commonest reason for readmission, it accounted for fewer than half of all the readmissions within 30 (44%) and 90 (43%) days of discharge.
Isn’t spirometry done in primary care?

54.3% of patients diagnosed within the last 2 years had a record of any spirometry ratio with a result consistent with COPD.

Only 11.1% of patients diagnosed within the last 2 years had a record of the gold standard diagnostic test for COPD (post-bronchodilator FEV1/FVC; 339m).

8.5% of patients had a result for this test (339m) that was consistent with COPD.

2.7% of patients had a result recorded for 339m that was inconsistent with COPD or was invalid.
Why not?

- Examples from West Essex CCG:
  - Diagnosis of COPD made in secondary care, so recorded on primary care record (but no spirometry requested)
  - Diagnosis of COPD made by radiologist on CXR and patient record updated based on this
Getting spirometry right

All patients have a thorough review of notes

Previous spirometry sought from GP/outpatient records

Inpatient spirometry if no result found/it is inconclusive

Royal Bournemouth Hospital (The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust)

- The local team realised from initial scoping that availability of spirometry was a key area they would need to improve upon.
- The medical teams have now been made aware they need to ensure that diagnosis of COPD has been made with spirometry, otherwise the patients cannot be classified as COPD.
- There have been focused teaching activities conducted locally to enhance this.
- Previous spirometry is now routinely and actively sought from either previous outpatients or GP records.
- Every patient identified has their notes reviewed, including checking for recent spirometry.
- If there is no spirometry available or the spirometry is inconclusive, the team are able to access inpatient spirometry via the lung function test department or the integrated respiratory service.
- When a patient has inpatient spirometry showing an obstructive ratio, and the team are able to diagnose the COPD but not the severity, it is ensured that patients have a follow up in a respiratory hospital clinic.
Getting spirometry right

All outpatients have spirometry

Monthly list of audit cases given to spirometry team who complete the data
Getting spirometry right

- Insights from Maidstone and others...
What’s the root cause of the problem?

➢ Determine the root cause – using the 5 Whys

➢ **Problem statement**: Only X% of patients admitted with AECOPD have an available spirometry result

➢ **Why 1**: Why do only X% of patients admitted with AECOPD have an available spirometry result?
  ➢ *Because squirrels steal the results*

➢ **Why 2**: Why do squirrels come into the hospital and steal the results?
  ➢ *Continue until you get to Why 5 – then feedback.*
Tackling the root cause - PDSA

1. Plan
   - Objective
   - Who, what, where, when

2. Do
   - Carry out the plan
   - Document problems

3. Study
   - Look at your data
   - Summarise what was learned

4. Act
   - What changes are to be made?
   - Next cycle?
Repeated change cycles

Think small and realistic, not earth-shattering!
Next steps
Any questions?
Achieving BPT

Sam Halliwell, Lead Specialist Respiratory Nurse (Inpatient), QEQM - East Kent University Hospitals NHS FT
COPD Best Practice Tariff – East Kent’s story

Inpatient Respiratory Practitioner Team
Background

- BPT commenced April 2017.
- EKHUFT was one of the lowest performing Trusts within our region achieving only around 6% of BPT when it commenced.
- Development of an inpatient practitioner team to work to achieve the required 60% minimum to qualify for the enhanced tariff.
How?

- Employment of team of suitably skilled practitioners
- Roles designed creatively
- Employed for passion and personal qualities
- In house training and external training
- Networking with Community Respiratory Team as well
Results

• “Went live” October 2017
• How did we support “roll out”
• Achieved 63% for Oct – Dec 2017 quarter
• Sustaining achievement of BPT
• Ongoing issues and challenges and the future
• Advice for other teams!
Questions?
Achieving high case ascertainment

Lucy Flight, Senior Respiratory Nurse, Darent Valley Hospital – Dartford & Gravesham NHS Trust
Darent Valley Hospital

- 463 inpatient beds
- Growing population of around 340,000
- 31 bedded Respiratory Ward
- 10 bedded Hyperacute unit
- 31 bedded MAU

- 5 Respiratory consultants
- 2.5 Respiratory Nurses
- 0.75 Respiratory Support worker

Lucy Flight
Senior Respiratory Nurse
lucyflight@nhs.net
• **Majority of audit is done retrospectively**
  • Coding differs from those we identify on admission

• **Engage other departments in the project**

• **Coding Department**
  • Once a set of notes has been coded as COPD they are set aside by the coding department
  • Sent to Resp Nurse team to audit

• **Information department**
  • Run a twice monthly list of COPD discharges
  • Sent automatically via email
  • List checked to see which patients were missed at the coding department step
• **Scanning department**
  • Under normal circumstances 8 week turn around of notes
  • Patients identified by information list fast tracked for scanning

• **Audit Department**
  • Helps iron any problems and gives advice

Share you victories with the other teams and say thank you!
Improving Engagement with Primary Care

Dr Neil Banik, GP, East Kent CCG
Dr Rani Shenoy, GP, Guildford & Waverley CCG
Engaging with Primary Care

Nov 2018 REAG

by

Rani Shenoy & Neil Banik
Our vision for primary care

- Educating and upskilling primary care teams
- Rolling education programs
- Guideline based approaches
- Spirometry training and accreditation
- Cost effective strategies
- Prescribing inhalers that match the patient & the condition
- Antibiotic stewardship
- Accurate early diagnosis
- Referral when things are not clear/ not working
- Shared care – MDT approach
Challenges in primary care

- Depleting source of COPD practitioners
- Lack of unified criteria/targets of training needed to maintain practice
- Unlike other chronic long term conditions like DM
- Lack of incentives in primary care teams – locally commissioned services
- Difficulty accessing training
- How can AHSN help
- Promoting nurse/practitioner training in primary care
- Locally approved training programmes for practitioners
- Buddy system/mentorship for new practitioners
Primary care focuses on multi-morbidity:

- Mental Health
- Musculo-skeletal
- Cardiac
- Chronic Lung disease
- Renal
- Vascular
- Metabolic

- Chronic
- Lung
- Disease

- Renal

- Vascular

- Metabolic

- Musculo-skeletal

- Mental Health
Appropriate use of antibiotics

**Bad & Good Bacteria**

- Total Bacteria
- Diversity
- Idea Balance

It is important to have high total number of bacteria.

170 - 200 types. Health problems arise if diversity decreases.

Higher percentage good bacteria & lower percentage bad bacteria. Loss of balance will create toxins (smelly farts) etc.
Promoting Lung Health from childhood

- Early Life origin theory of COPD:
  - Smoking in pregnancy reduces foetal lung growth
  - 2\textsuperscript{nd} hand smoke from parents and smoking from early teenage years affect peak FEV1
  - Bronchiolitis /RSV infections and childhood pneumonia can retard lung growth
  - Uncontrolled & severe childhood asthma can lead to early COPD
  - Weak lung group is formed early and then can develop a COPD even without cigarette exposure
Air pollution and lung health

- Air pollution can trigger asthma and COPD attacks
- Smog and ozone can trigger asthma attacks as can thunderstorms which create ozone
- High levels of fine particles has been linked to asthma-copd overlap syndrome - 10 micron particle studies
- Toronto study showed in 6000 adult asthmatics - air pollution doubled the chances of developing COPD an effect as great as smoking cigarettes regularly [ AJRCCM Aug 2016]
- Breathing good quality air is now a key priority of UK joint Parliamentary committee and Defra
Guidelines clarity or confusion!

BTS V NICE 2017
Local COPD information pack

- 2017 COPD self-management book
- For East Kent patients with COPD
- Encouraging non-pharmacological Approach
- Recognising exacerbations
- Staying active
- Stopping smoking
- Encouraging Pulmonary rehab.
- Breathe-easy local group
- COPD and singing program
- The correct use of “rescue packs” and inhalers
Involving patient groups

12 MILLION PEOPLE diagnosed with a lung condition

COPD causes more deaths than any non-respiratory cancer

Do hills leave you breathless?
Do stairs leave you breathless?
Do hills leave you breathless?

Around three million people in the UK have COPD, but over two million are undiagnosed

Diagnosed: 1 million people
Undiagnosed: 2 million people

www.blf.org.uk/World-COPD-Day
Understanding our patients point of view: “An official diagnosis can be the catalyst we need to move us past denial. Social support, from friends and family & fellow members, helps you slowly climb the staircase of grief into a more predictable plateau.”

“Walking through life with COPD isn’t easy or what we asked for, but it makes all the difference to walk this new path with others who understand.”
COPD Value Pyramid

COPD FEV1 >50% predicted

High costs

Better value

1. Triple Therapy
   £78,000-£130,000/QALY

2. Two Long Acting Bronchodilators
   £80,000/QALY

3. LABA & ICS
   £52,000/QALY

4. One Long Acting Bronchodilator
   £5,000 (LABA)-£8,000 (LAMA)/QALY

5. Short Acting Bronchodilator
   (no QALY available)

6. Pulmonary Rehabilitation
   £2,000-£8,000/QALY

7. Stop Smoking Support
   £2,000/QALY

8. Flu Vaccination
   £?1,000/QALY in ‘at risk’ patients

COST EFFECTIVE APPROACHES

www.em-respiratorynetwork.co.uk
V3 updated October 2012 – MW

East Midlands Strategic Health Authority
Encouraging exercise for better Lung health - Tai Chi for COPD?

- In COPD, tai chi confers long-term benefit
- May be alternative to pulmonary rehabilitation
- Publish date: CHEST May 3, 2018
SMOKING CAN CAUSE AT LEAST 14 TYPES OF CANCER

Larger circles indicate cancers with more UK cancer cases linked to smoking.

WHAT'S THE MOST SUCCESSFUL WAY TO STOP SMOKING?
SUCCESS OF POPULAR METHODS COMPARED WITH GOING COLD TURKEY

The study used going cold turkey as the baseline.

No more successful than cold turkey – probably because people don't use enough.

60% More successful

COLD TURKEY
Quitting with no support

NRT
Using Nicotine Replacement Therapy without professional support

E-CIGARETTES
Using electronic cigarettes without professional support

SUPPORT AND MEDICATION
Combined specialist support and prescription medication*

*Available free from your local Stop Smoking Service nhs.uk/smokefree


WE WILL BEAT CANCER SOONER cru.i.org

LET'S BEAT CANCER SOONER cru.uk/smoking

CANCER RESEARCH UK
PCRS-UK National Respiratory Conference

BUILDING CONFIDENCE IN A CHANGING WORLD
28-29th September 2018
Telford International Centre

PCRS-UK Membership

- Helping you to deliver high value patient centred respiratory care
- Supportive, friendly respiratory community passionate about improving respiratory care
- Supporting you with professional development and learning

PCRS-UK Clinical Leadership Programme

Equipping you to make things happen in your respiratory community

Local Nurse Groups

Work together with like-minded nurses to inspire best practice
“Lung disease is scary but having a lung condition is not the end of the world, we can go forward with a little help and understanding.”
appendix
THE EVIDENCE SO FAR SHOWS THAT E-CIGARETTES ARE FAR SAFER THAN SMOKING

1. E-cigarettes contain nicotine but not cancer causing tobacco

2. Nicotine is addictive, but does not cause cancer

3. **Tobacco** is the biggest cause of preventable death in the UK

   Over 100,000 deaths per year

4. Passively breathing vapour from e-cigarettes is unlikely to be harmful

5. Growing evidence shows e-cigarettes are helping people to stop smoking

LET'S BEAT CANCER SOONER
cruk.org
Review of the use of ICS/LABA combinations in adult asthma patients in primary care

Caroline Nice, Prescribing Advisor, Surrey Downs CCG
Review of the use of ICS/LABA inhalers in adult asthma patients in primary care

Caroline Nice- Primary care pharmacist
Medicines Management Team. Surrey Downs CCG
Content

• Why?
• Aim
• How?
• Improvement?
Why?

• **Maximise safety**
• Risks of long term high dose ICS
• **Maximise Value**
• ICS 7.7% of total prescribing spend 2013/14
• Seretide Evohaler 250/25- item with highest spend
• **Prescribe according to guidelines**
• Study Covvey et al- initiation of combination ICS/LABA therapy (BTS Step 3) resulted in widespread increases in ICS dose (compared to highest dose of ICS before initiation).
Are we prescribing according to the guidelines – asthma?

- Studied 685 people who started combination inhaler therapy with ICS and LABA in 46 GP practices
  - 144 (21%) had no history of ICS use
  - 541 (79%) had been prescribed an ICS within the previous year

Low dose ICS  Moderate dose ICS  High dose ICS  No prior ICS

Figure 1  Changes in inhaled corticosteroid (ICS) dose at the index date. CMB, combination therapy; HD, high dose; LD, low dose; MD, medium dose.

Why?

- Audit
- Education
- Action plan
Aim

• Assess the appropriateness of prescribed doses of ICS/LABA therapy in adult asthma patients in line with BTS/SIGN asthma guidelines (2014) and ensure safer prescribing of high dose ICS.
How?-Audit

• 2015/16-CCG PCP reviewed prescribing of ICS/LABA initiated in adult asthma patients (naïve to LABA) in the previous 12 months to establish what happened to ICS doses upon initiation of combination therapy.

• 28 EMIS practices. 640 patients (sample size per practice 20-50 depending on practice size)
Results

(differentiated by prior dose of ICS (i.e. low (, ≤400mcg*) medium (>400mcg and ≤800mcg*) or high (>800mcg*)

Surrey Downs CCG
% asthma patients started on high dose ICS/LABA at BTS step 3

Low dose ICS to high dose ICS/LABA
Medium dose ICS to high dose ICS/LABA
High dose ICS to high dose ICS/LABA
No prior ICS to high dose ICS/LABA

Surrey Downs CCG (n=640)
Results-
(differentiated by prior dose of ICS (i.e. low, medium or high).

% asthma patients started on high dose
ICS/LABA at BTS step 3

- Low dose ICS to high dose ICS/LABA
- Medium dose ICS to high dose ICS/LABA
- High dose ICS to high dose ICS/LABA
- No prior ICS to high dose ICS/LABA

Surrey Downs CCG (n=640)  Covvey et al results (n=685)
How?-Education

• Learning objectives
  • To recognise the risks of harm to patients associated with use of high dose inhaled corticosteroids (ICS) in asthma.
  • To discuss the treatment pathway in asthma, particularly the place in therapy of high dose ICS
  • To be aware of equivalent doses and potency of inhaled corticosteroids.
How ? Action plans

Common themes

- Prescribers to familiarise themselves with BDP dose equivalences.
- To review asthma patients on high dose ICS with a view to stepping down.
- To provide high dose ICS safety cards.
Improvement

SURREY DOWNS CCG
Low and moderate dose ICS and ICS/LABA as a % of all ICS and ICS/LABAs
April 2013 - Jul 2018

April 2013 - Jul 2018
Improvement

Items for Low / moderate dose ICS/LABAs as a % of all ICS/LABAs

- % low mod dose - 2014-15
- % low mod dose - 2015-16
- % low mod dose - 2016-17

[Bar chart showing percentage improvement over three years for different practices and regions.]
Questions?
Quality Assured Spirometry

Vikki Knowles
Respiratory Nurse Consultant
G & W CCG
Wrap up & close

Jo Congleton
The KSS Respiratory Quality Improvement Awards are back!

Award categories:
• Medicines optimisation
• Acute QI project
• Community QI project
• Spirometry

Potential topics: COPD, Oxygen, Pulmonary Rehabilitation, general services, spirometry etc.

The awards will be presented at the May 2019 Respiratory Collaborative
Keep an eye out for further details!