

# Redesigning the COPD pathway in West Essex

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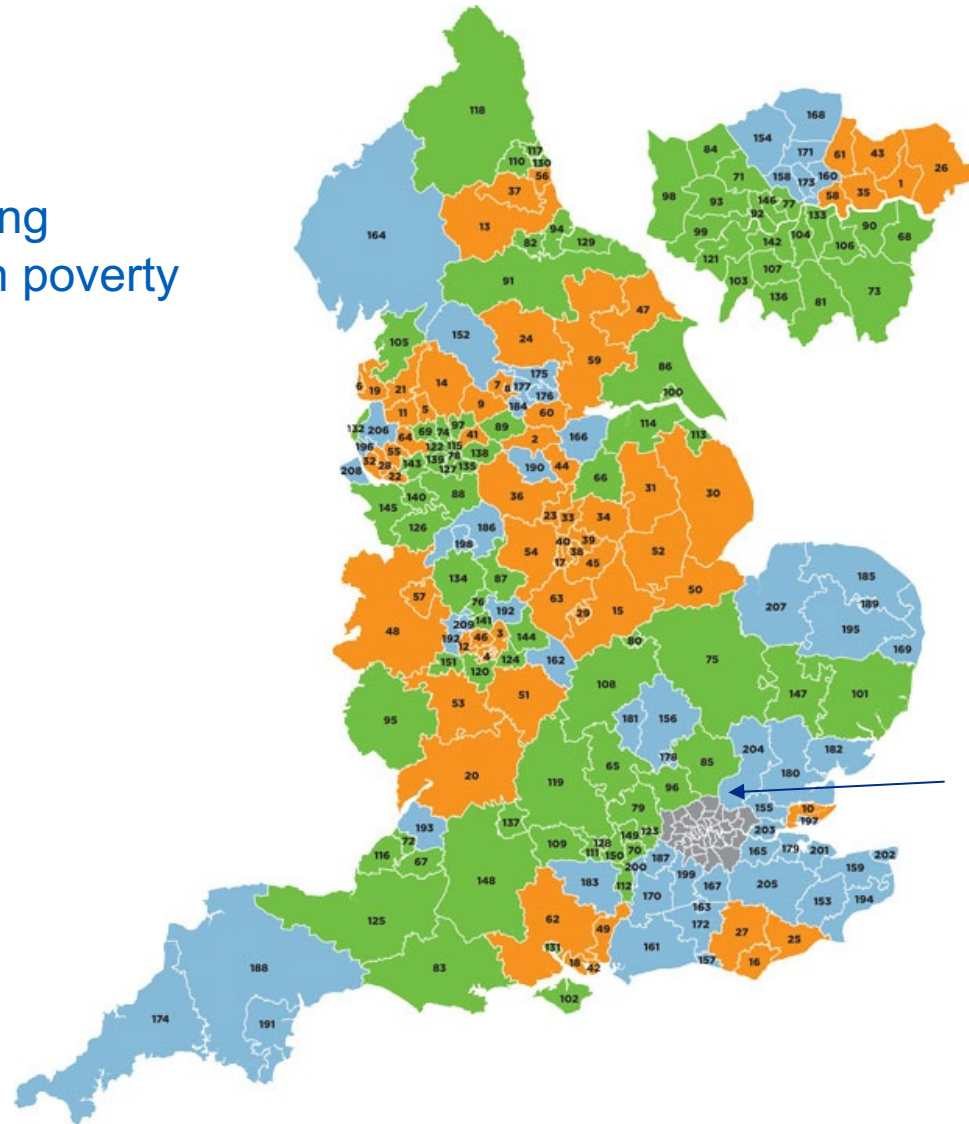
&

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GP and Deputy CMO, West Essex CCG

# West Essex

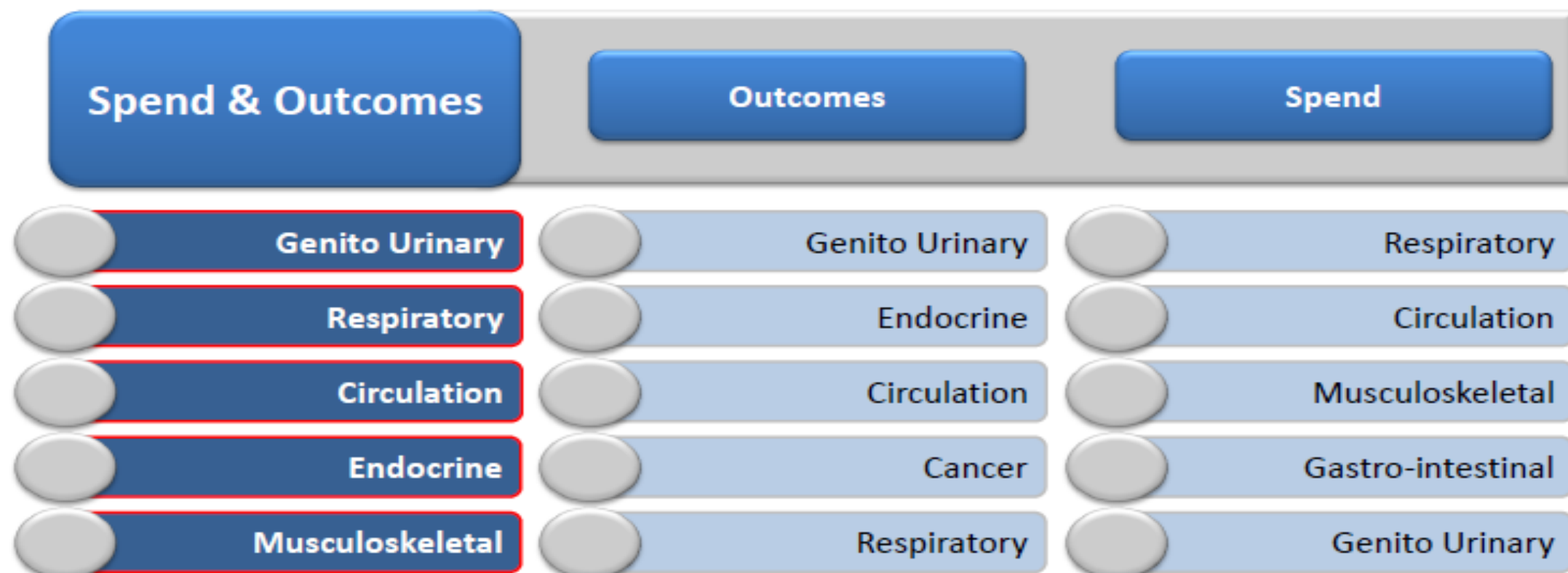
Population c. 240,000  
Main towns Harlow and Epping  
Mix rural affluence and urban poverty



# The opportunity

- 1 Data from RightCare NHSEngland highlighting respiratory care as a performance outlier
- 2 System organisational move to an Accountable Care Partnership

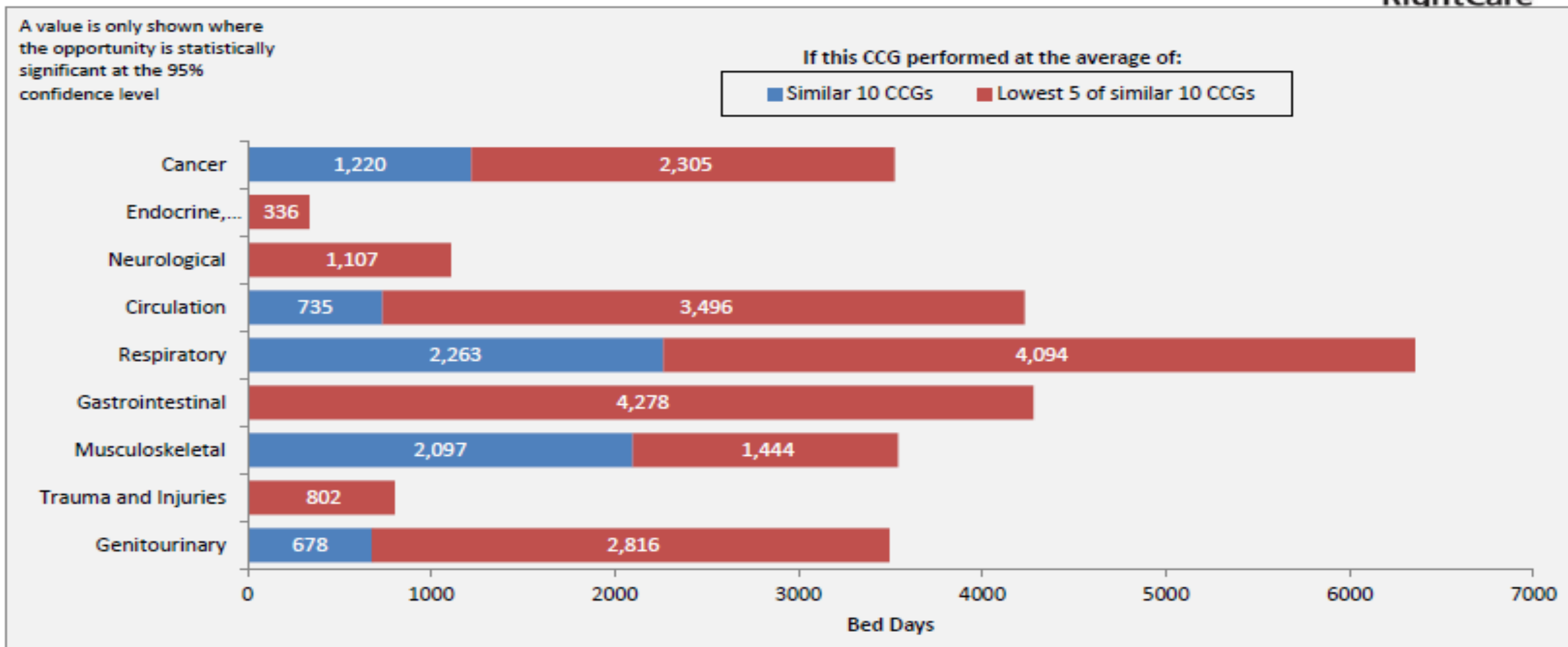
## Headline opportunity areas for your health economy



Where there has been a change to your improvement opportunities from the January 2016 pack this could have been caused by actual improvement or deterioration in your own CCG or peer CCG performance or the robustness and timing of local data. If your local opportunities have changed significantly and you would like to investigate the reasons for this further, please contact your Delivery Partner or [england.healthinvestmentnetwork@nhs.net](mailto:england.healthinvestmentnetwork@nhs.net).

You can also request the methodology used to calculate your headline opportunities from this e-mail address : [england.healthinvestmentnetwork@nhs.net](mailto:england.healthinvestmentnetwork@nhs.net).

# How different are we on bed days?

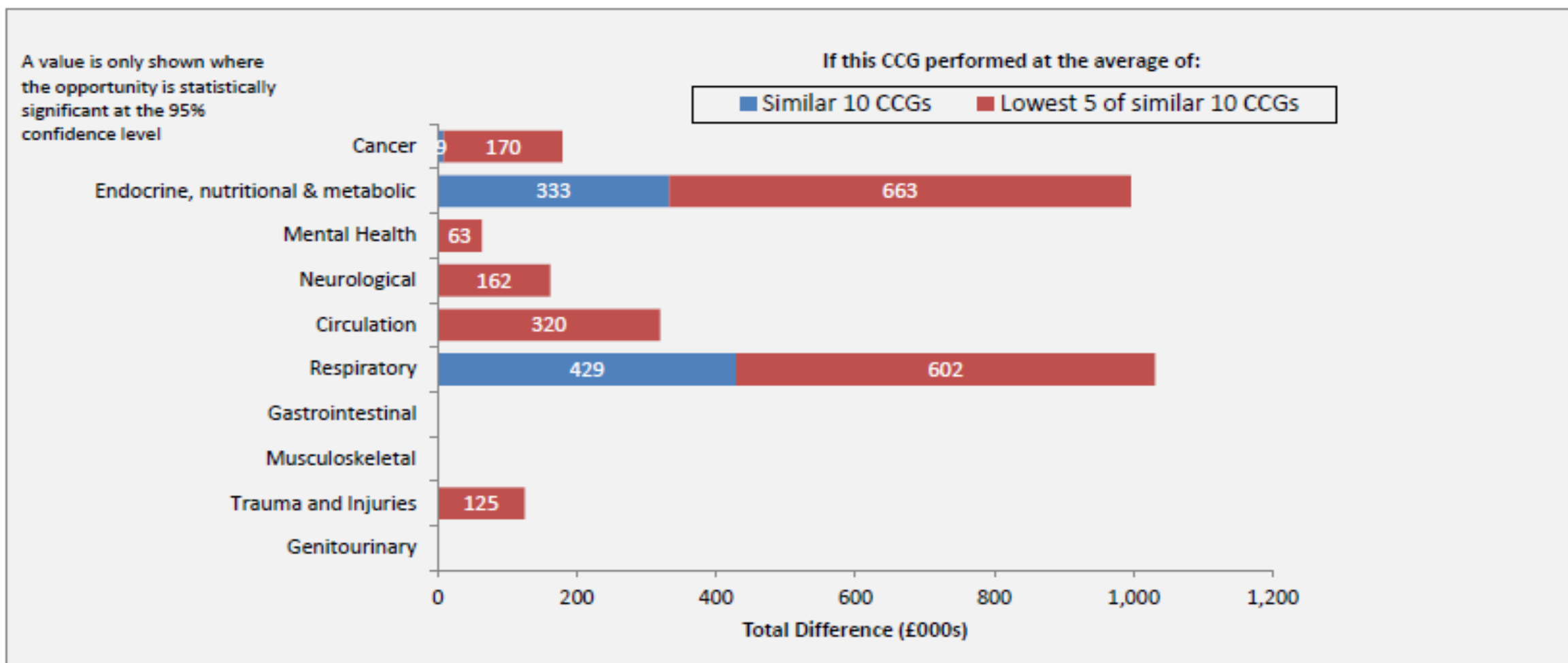


The bed days data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

The calculations in this slide are based on admissions for any primary diagnoses that fall under the listed conditions (based on Programme Budgeting classifications which are in turn based on the World Health Organisation's International Classification of Diseases). This only includes admissions covered by the mandatory payment by results tariff and includes NHS England Direct Commissioning activity. These figures are a combination of elective and non-elective admissions.

Length of stay is derived from admission and discharge date. Spells that have the same admission and discharge date (including planned day cases) have a length of stay in SUS as zero. These have been recoded as a length of stay of 1 day in order to capture the impact of these admissions on total bed days for a CCGs.

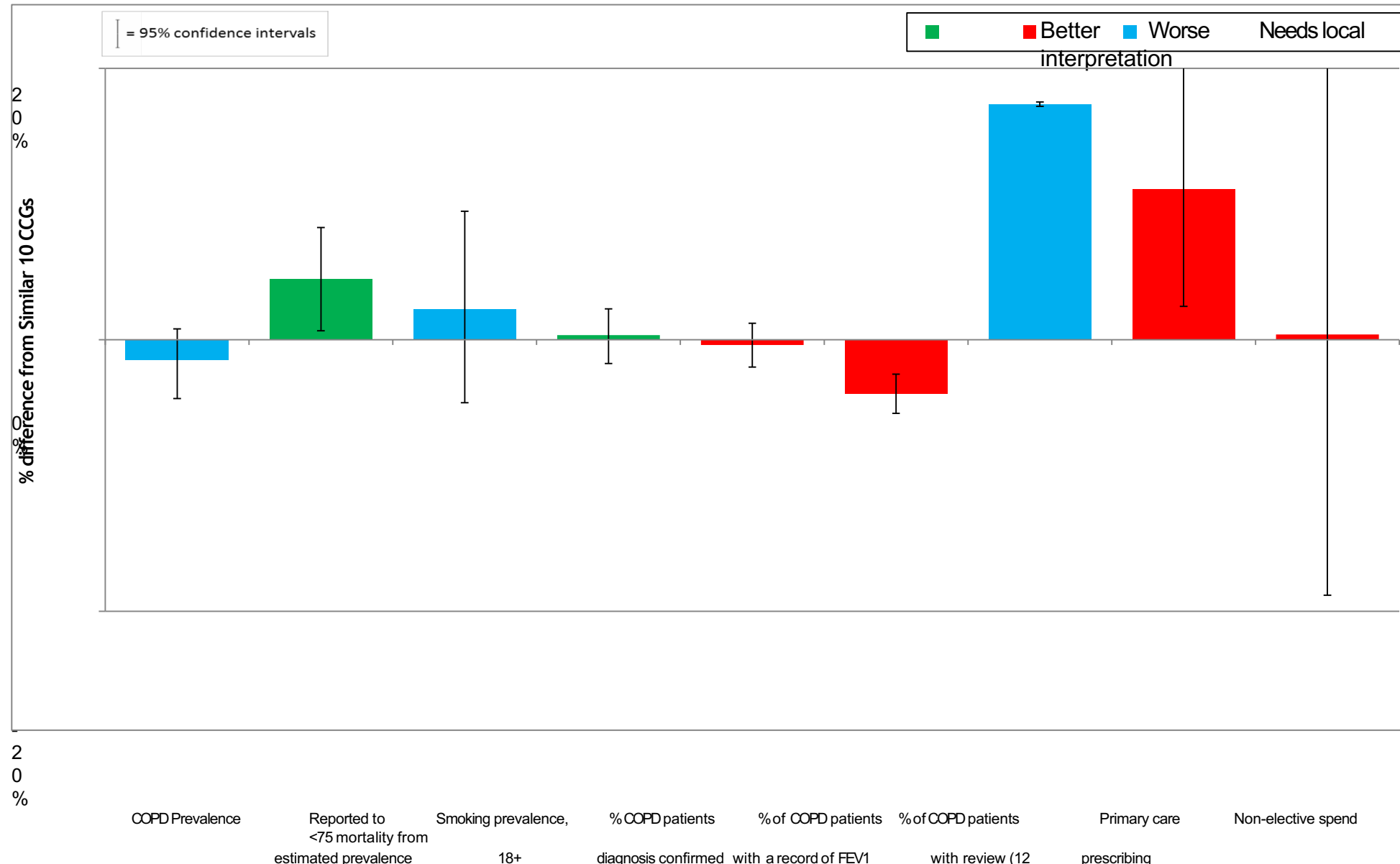
## How different are we on spend on primary care prescribing?



The prescribing data presented above uses Net Ingredient Cost (NIC) from ePact.com provided by the NHS Business Services Authority and is from financial year 2015/16. Each individual BNF chemical is mapped to a Programme Budget Category and aggregated to form a programme total. The indicators have been standardised using the ASTRO-PU weightings. Opportunities have been shown to the CCGs similar 10 and the lowest 5 CCGs. Prescribing opportunities are for local interpretation and should be viewed in conjunction with the individual disease pathways.

More detailed analyses of prescribing data, outlier practices, and time trends can be produced rapidly using the following resource: <http://www.OpenPrescribing.net>

# COPD pathway



# Understanding the issues.....finding solutions

- Running simple queries on electronic health care records using coded data field (Read or Snomed) then practice visits for deep dives
- Using national data to set a context
- Then formulating a targeted action plan to address the issues
- Data feedback at a personal level
- Providing financial incentives to do the right thing
- Providing tools to promote good care
- Integrating responsibility for good care to all providers



# NICE Quality Standard for COPD No.1

- 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
- exertional breathlessness
- chronic cough
- regular sputum production
- frequent winter 'bronchitis'
- Wheeze
- Risk factor usually smoking but could be biomass fuel or occupational fume exposure over years

# West Essex Eclipse Audit.....38 Practices

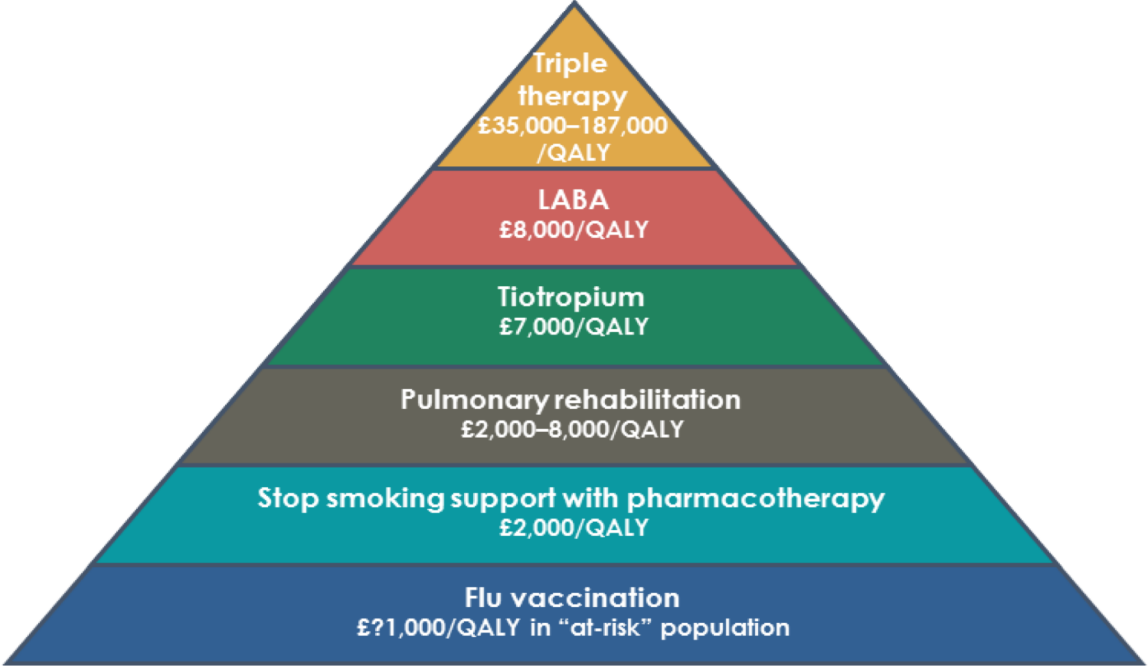
- 4179 COPD patients on registers
- 2003 (48%) with a recorded FEV1/FVC ratio <0.7
- **1074 (26%) no record of spirometry Read coded**
- **1102 (26%) with a normal or high ratio**
  
- Deep dive of 10 of these patients all on triple therapy (and additional meds) cost to the system c.£60pp/pcm or £360 pa
- *For the CCG medication cost c. £396,720 (A\$674,424) pa*
- Add visits to primary care (8 per year) admissions etc and patient cost
- Well over £1,000,000 (A\$1,700,000) p.a. direct costs

# West Essex Deep Dive 5 practices

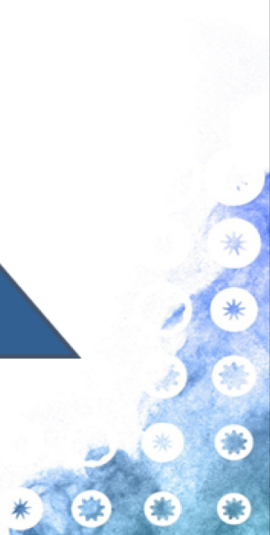
- Post BD spirometry never done pre 2011 diagnosis
- Spirometry done but not coded
- Spirometry was obstructive subsequently normal
- Spirometry technically unsatisfactory
- Spirometry incorrectly interpreted
- Patient registered from another practice
- Diagnosis made in secondary care without spirometry
- Symptomatic difficult diagnosis

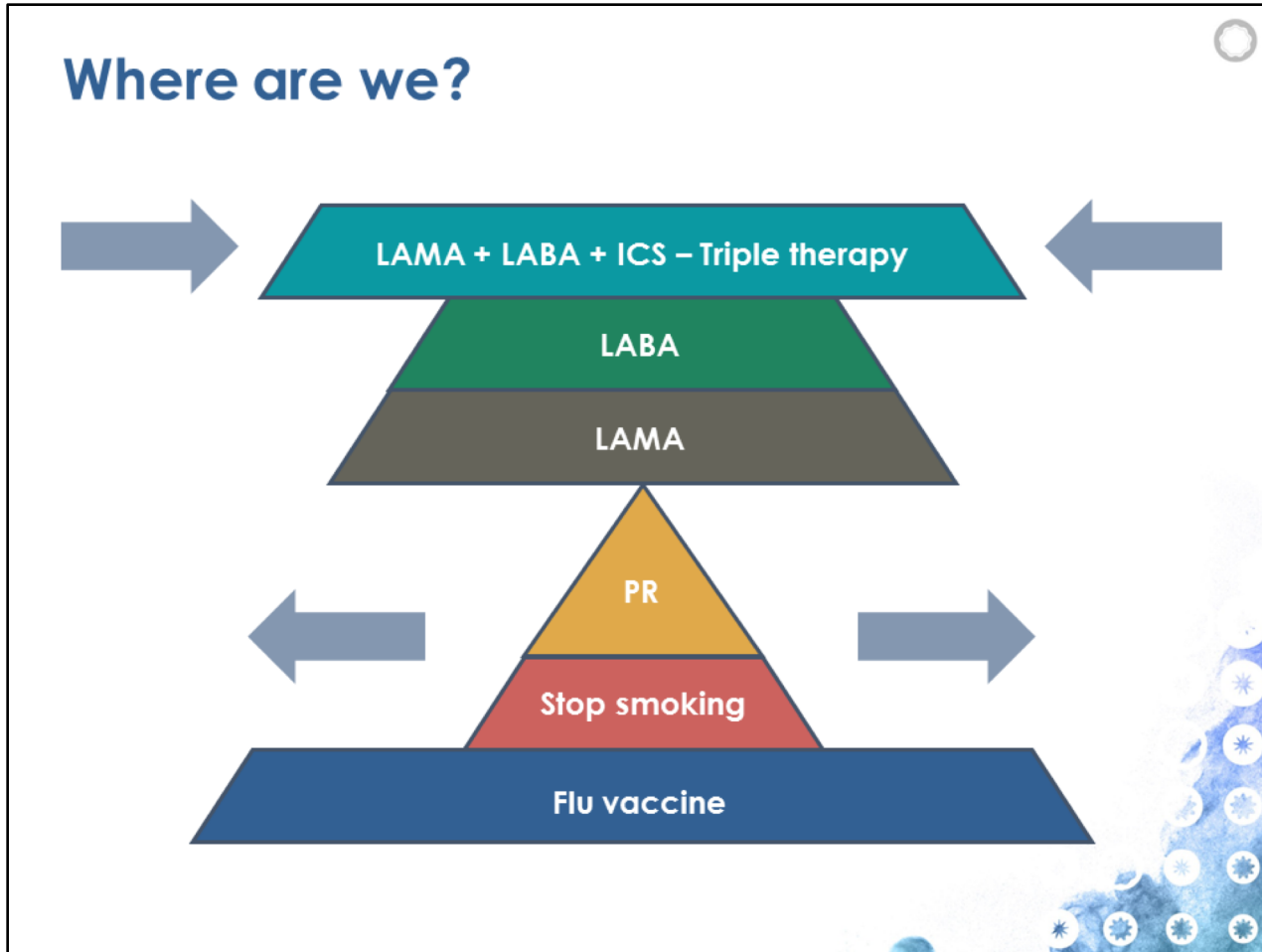


# COPD 'value' pyramid



Adapted from Zoumot Z et al. Thorax 2014; 69: 973–5

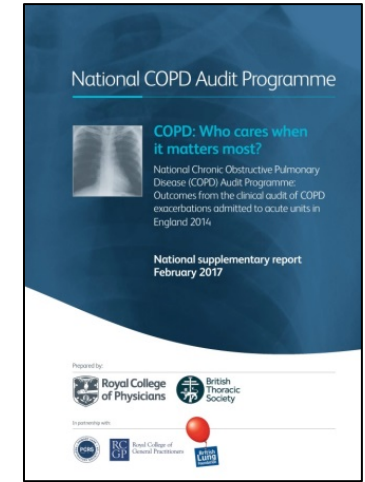




# It's the system stupid!

## Secondary care outcomes

- Spirometry results available in only 44% of admitted cases of which 11% have a ratio incompatible with the diagnosis of COPD



### Readmission 30/90 days after index discharge

Patients who were readmitted for any reason within 30 days (24%), and within 90 days (43%).



12% were readmitted at least once within 30 days owing to COPD.



23% were readmitted at least once within 90 days owing to COPD.



### Mortality within 30/90 days of index admission

Within 90 days:

16.3%

14.2%

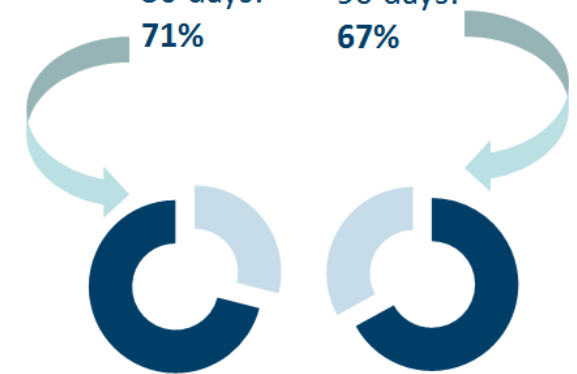
12.0%

2003 audit 2008 audit 2014 audit

COPD was the main cause of death.

30 days:  
71%

90 days:  
67%



# How we responded....

- **Established an oversight group:** clinicians/managers, primary/community/secondary care, commissioners/providers
- **Using data to understand the problems**
  - Electronic searches and deep dive visits
- **Developing a strategy**
  - Establishing what good looks like,
  - Education sessions
  - New financial incentive contract to support good
  - Regular data feeds on performance
  - A new clinical system template to prompt good care
  - Integrated hospital and community team to support early discharge and post discharge care
  - Discharge MDTs
  - Community MDTs
  - Telephone and E mail consults

The screenshot shows a clinical system interface for a patient named Chris (Miss) TEST, GP2GP - 136 (136). The patient is active and has a usual GP of ANDREI, Elena (Dr). The interface displays various clinical data points and checkboxes for COPD management tasks.

**3. Confirm the patient has been advised, had or declined a flu vaccine**

Influenza immunisation advised No previous entry

**4. Record CAT score & record of exacerbations with patient (and MRC scale)**

**COPD Assessment Test**

|                                                      |             |                   |
|------------------------------------------------------|-------------|-------------------|
| CAT score                                            | 29-Jan-2018 | 25 / 40           |
| MRC Breathlessness Scale                             | 25-Oct-2016 | MRC Breathle...   |
| Number of COPD exacerbations in past year            | 29-Jan-2018 | 1 / year          |
| If they have had - any hospital admissions for COPD? |             | No previous entry |

**5. Confirm the patient has been advised, had or declined smoking cessation/service**

N/A - not current smoker No previous entry

If smoker - consider advice/intervention or referral for behavioural/pharmacological intervention

Smoking cessation? 29-Jan-2018 Referral to s...

**6. Confirm the patient has been advised, had or declined referral to pulmonary rehabilitation**

Consider referring patients MRC 3-5 who are functionally limited by breathlessness and MRC 2 who are functionally limited by breathlessness for pulmonary rehabilitation.

Pulmonary rehabilitation 29-Jan-2018 Pulmonary re...

**7. Optimise medication and devices including patient education on inhaler technique**

Latest Contacts

Clinical Practitioner | HENDERSON, Angus (Dr) | Location: The Stansted Surgery | In Consultation



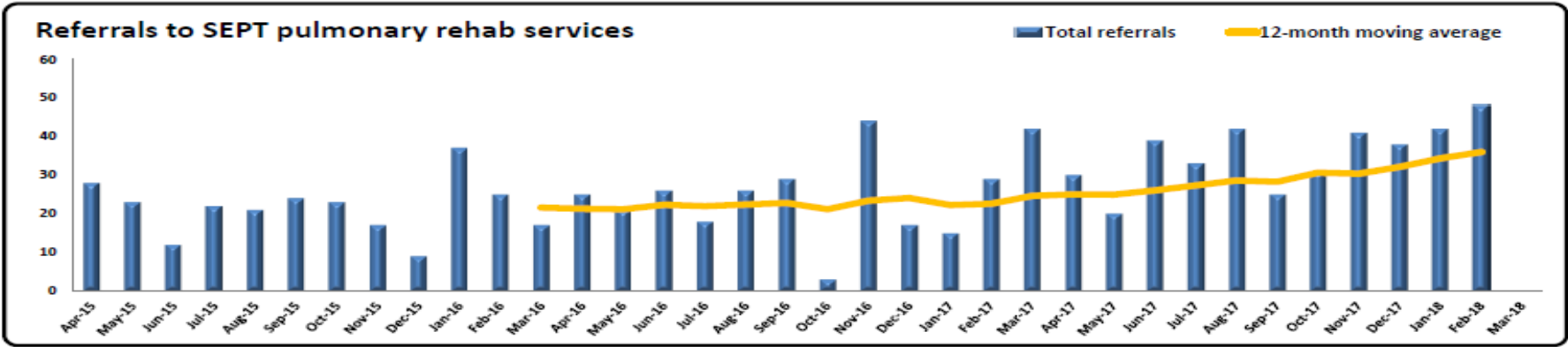
## COPD plan based on evidence of cost effectiveness Nine High Value Interventions

- 1. Post-bronchodilator spirometry (FEV1/FVC<0.7)**
- 2. Co-morbidity**
- 3. Flu vaccine**
- 4. CAT score & exacerbations and MRC scale**
- 5. Smoking cessation**
- 6. Pulmonary rehabilitation**
- 7. Optimise medication and devices**
- 8. Self management**
- 9. Patient empowerment and care navigation**

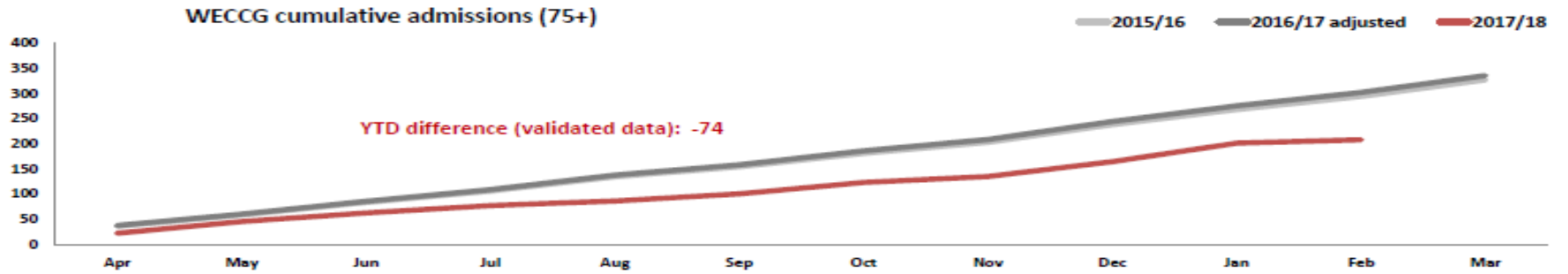


## 9 high value interventions for patients with COPD

1. Confirm an accurate diagnosis of COPD
2. Consider co-morbidity, frailty index and end of life in patients with COPD
3. Confirm the patient been advised a 'flu vaccine
4. Record CAT score, exacerbations and MRC scale
5. Confirm the patient has been advised about smoking cessation
6. Confirm the patient has been advised about pulmonary rehabilitation
7. Optimise drug and devices - including patient education on inhaler technique
8. Go through self-management options
9. Patient empowerment and care navigation

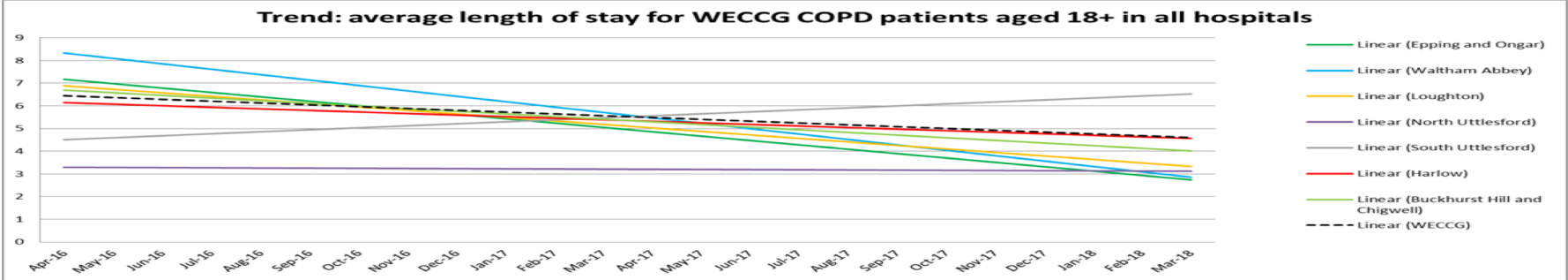


Pulmonary rehabilitation referrals



Reduction in NELs

LOS reduction



# Next steps

- This service redesign driving the Accountable Care Partnership agenda
- Contracting
- Financial model
- Governance
- IT system connectivity
- Local authority and social care interface with health