



Quick Wins proposals

RightCare has issued a call for CCGs to submit proposals for Quick Wins.

The Primary Care Respiratory Society UK has put together 4 outline proposals for improving respiratory disease outcomes, for CCGs wanting to improve aspects of respiratory care. Since respiratory disease is an area of high spend, morbidity and mortality, we expect many CCGs will be keen to make improvements in outcomes and reduce expenditure in this area.

All of the four ideas for respiratory improvement put forward here meet the criteria that RightCare has set.

A quick win has been defined by NHS RightCare as a project which:

- Improves or maintains health outcomes
- Can be Implemented within an annual cycle (Implementation means the delivery plans are now live/in action)
- Delivers in-year saving
- Provide a quick rate of return, i.e. start to see results within first cycle, or early in the second cycle

NHS RightCare has written to CCGs explaining the detail of the scheme – sharing the templates and outlining the steps from submission to implementation. If you need more information, please contact the RightCare leads within your CCG or identify your RightCare delivery partner via the website.

<https://www.england.nhs.uk/rightcare/imp/delivery-partners/>.

The Primary Care Respiratory Society UK (PCRS-UK) is a UK-wide professional society supporting primary and community care to deliver high-value patient-centred respiratory care. Our members are passionate about improving the nation's respiratory health care. Working together we:

- Campaign to influence policy, striving to ensure standards and guidance in respiratory medicine are relevant to primary care nationally and locally
- Provide open-access best practice, evidence-based clinical guidance and resources to support colleagues in the diagnosis and management of respiratory diseases
- Aim to create a friendly, multidisciplinary community supporting respiratory professional development through the PCRS-UK annual conference, affiliated groups, respiratory clinical leadership programme and our membership publication, *Primary Care Respiratory Update*

For more information please see the PCRS-UK website www.pcrs-uk.org .



RightCare Quick Wins: Respiratory

Title	COPD diagnosis: Raising accuracy of prospective diagnosis of COPD to avoid costly, hazardous and inappropriate care
Issue	<p>Diagnosing causes of chronic breathlessness and cough that may include Chronic Obstructive Pulmonary Disease (COPD) requires a systematic, rigorous and structured clinical approach. The diagnosis must involve a good clinical history and examination and be confirmed with lung function testing. CT scanning may be needed in a small proportion of cases where FEV1 isn't possible or reliable. As with any imaging, spirometry requires skilled and suitably trained healthcare professionals and operators to both perform and interpret.</p> <p>It has been shown from the recent RCP National COPD Primary and Secondary care audits that many people with a COPD diagnosis do not have any record of post-bronchodilator spirometry in their notes. This means that they may be being treated for COPD, but not have a confirmed diagnosis. This inaccurate label of diagnosis means;</p> <ul style="list-style-type: none"> • They may be receiving costly inappropriate medication that doesn't help and can cause increased harm • Life changing diagnosis will have a psychological impact and practical one in terms of work, insurance premiums and travel for example • Incorrect delayed diagnosis may have increased healthcare use both in terms of workforce and also costs • Incorrect diagnosis of breathlessness or cough may progress to more advanced stages of disease.
Objective	To reduce the number of people with respiratory symptoms being inappropriately labelled and treated with a COPD diagnosis
Rationale	By ensuring any patients presenting with respiratory symptoms and a risk factor for COPD have quality assured diagnostic spirometry, this will lead to more accurate diagnosis, and only those with a comprehensive and accurate diagnosis will receive treatment for COPD, thus avoiding costly and inappropriate treatment.
Intervention	Do not initiate inhaled pharmacotherapy for suspected COPD until the diagnosis has been confirmed by quality assured spirometry or CT chest scan in cases where this is not possible
Evidence	<p>Stone RA, Holzhauer-Barrie J, Lowe D, Searle L, Skipper E, Welham S, Roberts CM. <i>COPD: Who cares matters. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Clinical audit of COPD exacerbations admitted to acute units in England and Wales 2014. National clinical audit report. London: RCP, February 2015.</i></p> <p>Baxter N, Holzhauer-Barrie J, McMillan V, Saleem Khan M, Skipper E, Roberts CM. <i>Time to take a breath. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Clinical audit of COPD in primary care in Wales 2014–15. National clinical audit executive summary. London: RCP, 2016</i></p>



<p>Current spend and potential saving in next year</p>	<p>Calculate current potential wasteful inhaled pharmacotherapy spend where:</p> <p>a = Number of patients on COPD register (COPD prevalence) b = Number of patients added to COPD register in the last year (COPD incidence) c = Population (b) with Post bronchodilator FEV1/FVC >0.2 and <0.7 (339m) (Spirometry confirmed diagnosis) d = Current annual COPD inhaled pharmacotherapy spend</p> <p>Using the formula –</p> <p>$(b - c / a) \times d = \text{Inappropriate inhaler spend}$</p> <p>Assuming the same annual incidence of COPD, a proportion of inhaler costs will be saved for those that do not have COPD and who you have helped avoid initiate on pharmacotherapy</p> <p>Potential current indicative costs of selected inhalers per patient per year (maximal therapy includes both types of inhaled therapy)</p> <ul style="list-style-type: none"> • Fluticasone /Salmeterol 250 Aerosol Inhaler - £720.00 • Long acting muscarinic antagonist inhaler - £360.00
<p>How to/models</p>	<p>Professionals performing or interpreting spirometry need to be competent through having been trained or having many years of experience. Some areas are skilling up practice nurses and HCAs so that every practice can deliver quality diagnostic spirometry. Others are creating diagnostic hubs to which patients are referred.</p> <p>Top tips:</p> <ul style="list-style-type: none"> • We recommend setting up an alert when every new diagnosis of COPD is entered to ask user whether quality assured spirometry has confirmed the diagnosis. • We strongly recommend that this is led and coordinated by a champion across the CCG.
<p>Resources</p>	<p>Up to date respiratory data for your CCG is available in an updated 'Commissioning for Value Focus pack'. This can be accessed via your CCG RightCare leads – clinical, operational and analytic, or from your RightCare delivery partner who can be contacted via https://www.england.nhs.uk/rightcare/imp/delivery-partners/.</p>



Title	Inhaled corticosteroid use in COPD: reserving this treatment only for those people with COPD who have documented two or more exacerbations per year
Issue	Many COPD patients (both new and historically) are taking 'triple therapy' for COPD – an inhaled corticosteroid (ICS), a long acting bronchodilator (LABA) and a long acting muscarinic antagonist (LAMA). These are among the most costly medicines to the NHS and usually sit within the top 5 spend, yet there is evidence that ICS may be an inappropriate treatment with the risk of side effects, unless they are patients having frequent exacerbations.
Objective	To reduce unnecessary and inappropriate use of steroids (ICS) in COPD
Rationale	The GOLD strategy is increasingly being used to guide COPD management. This identifies different COPD phenotypes, and presents a 2x2 matrix, known as 'ABCD grading' to guide treatment approach depending on whether the patient is primarily experiencing breathlessness, or having exacerbations. A patient with predominant breathlessness will start in box A and move to box B if symptoms persist. A patient with predominant exacerbations will start in box C and move to box D if continuing to have exacerbations. ICS are unlikely to help those in groups A&B, so identifying the type of COPD they have and treating accordingly will enable many patients being treated inappropriately with ICS to be identified and have their ICS withdrawn or stepped down.
Intervention	Identify patients on COPD registers who primarily have breathlessness and fewer than 2 exacerbations/year who are on ICS – with or without LABA - and call them for review with expectation of being able to stop ICS. Ensure that recording of exacerbations annually is a priority task within the consultation.
Evidence	LSE work on high value interventions in COPD – this identifies triple therapy as a low value intervention. Ref: British Thoracic Society, IMPRESS Guide to the relative value of COPD interventions. in British Thoracic Society Reports (2012). GOLD – Global initiative for COPD. http://goldcopd.org/gold-2017-global-strategy-diagnosis-management-prevention-copd/ d'Ancona G, Patel I, Saleem A, <i>et al</i> P29 Impact Of Respiratory Virtual Clinics In Primary Care On Responsible Respiratory Prescribing And Inhaled Corticosteroid Withdrawal In Patients With Copd: A Feasibility Study <i>Thorax</i> 2014; 69 :A90
Current spend and potential savings	In the d'Ancona project to withdraw inappropriate ICS in people with COPD, they found from primary care data in Lambeth that 38% of COPD patients were over treated with high dose ICS, resulting in 12 additional cases of pneumonia, and costs of £500,000, annually. 45/48 (94%) of CCG practices took part. Overall, from one quarter - Q4 13/14 prescribing data, there was a 4% decrease in high dose ICS (as proportion of total ICS use) resulting in a saving of £50,000 .



How to/models	This work can be undertaken in surgeries by reviewing people on the COPD register and currently being prescribed an ICS. This work is feasible if carried out in conjunction with respiratory specialists from pharmacy, nursing and physician backgrounds according to the published work referred to.
Resources	Up to date respiratory data for your CCG is available in an updated Commissioning for Value Focus pack. This can be accessed via your CCG RightCare leads – clinical, operational and analytic, or from your RightCare delivery partner who can be contacted via https://www.england.nhs.uk/rightcare/imp/delivery-partners/ . NICE COPD guideline 101 is now very out of date and in the process of being updated



Title	Reducing high dose steroid use in asthma: identifying patients on high dose inhaled steroids and stepping down to standard dose
Issue	In the UK, over a third of asthma patients are treated at BTS step 4. This has resulted in the highest dose ICS (HDICS-licensed daily dose equivalent to 2000 micrograms beclomethasone dipropionate) with long-acting Beta2-agonist combination inhalers consistently appearing in the top five costliest drugs to the NHS. Patients should be maintained on the lowest level of medication at which they are controlled – which means, fewer symptoms and their daily lives not impacted by their asthma.
Objectives	To reduce the cost and clinical harm of asthma patients prescribing by reducing the use of high dose inhaled steroids in patients who do not need them and in whom the steroid dose can be reduced to lower safe clinical levels whilst maintaining good asthma control.
Rationale	Respiratory prescribing overall is responsible for a very high spend for the NHS and some products are among the top 10 most costly to the NHS. Heavy promotion by the pharmaceutical industry has led to higher levels of medication being encouraged than may be necessary. Also, the practice of stepping down treatment following a period when a patient has had optimal control is not as well established as it should be so patients may be on higher doses of ICS than necessary for months and years. Reviewing patients on high dose inhaled steroids will be good for the prescribing budget and for the pharmacological burden on patients. Overtreatment in younger patients reduces management options further down the line because too many steps have been taken without consideration of adherence and other factors and potentially causing long term side effects.
Intervention	Identify patients on the asthma register who are on high dose ICS (> 1000bdp equivalent) or using the new BTS/SIGN strength grading system, and review their control using a recognised tool for monitoring control with a view to reducing the dose of inhaled steroid to standard dose.
Evidence	<p>British Asthma guideline September 2016 https://www.brit-thoracic.org.uk/document-library/clinical-information/asthma/btssign-asthma-guideline-2016/</p> <p>Knowles V, Mackay R, Watts D Review of the use of high dose inhaled corticosteroids in people with asthma aged 12 or over in primary care. (Guildford and Waverley CCG) p10 of Dec 2016 Ed.33 KSS AHSN newsletter http://www.kssahsn.net/what-we-do/better-quality-and-safer-care/KSS-respiratory-programme/Documents/BM/Breathing%20Matters%2033%20161221.pdf (Also abstract and poster Primary Care Respiratory Society UK conference 2016 – p53 of handbook (no url) (Corresponding author: vikkiknowles@nhs.net)</p>



	<p>Mak V, D'Ancona G P62 Avoiding inappropriate prescribing of high dose inhaled corticosteroid combination inhalers – is the message getting through? <i>Thorax</i> 2016;71:A118-A119.</p>
Current spend	<p>In 2015–16, the monthly spend on all HDICS combination inhalers fell from around £20million/month to £18million/month, and number of items fell from around 400,000/month to 365,000/month. By the last quarter, the switch from high cost HDICS combinations to lower cost ones accounted for 15% of all HDICS combinations, saving around £0.75million/month.</p>
Potential saving	<p>The reduction by the end of 2015-16 in high dose prescribing was less than 10% of the total number prescribed. Given the extent of overuse, further harm and waste reduction can be made at a rate of 750,000 per month nationally.</p>
How to/models	<p>This work can be undertaken in surgeries by identifying patients with an asthma diagnosis and using high dose ICS. This work can be carried out by anyone trained in stable asthma management such as GP, Practice Nurse and Pharmacist. Identified patients should be recalled for review.</p>
Resources	<p>Up to date respiratory data for your CCG is available in an updated Commissioning for Value Focus pack. This can be accessed via your CCG RightCare leads – clinical, operational and analytic, or from your RightCare delivery partner who can be contacted via https://www.england.nhs.uk/rightcare/imp/delivery-partners/. (A management guideline for asthma is in development by NICE, but will not be published until October 2017)</p>



RightCare Quick Wins: Respiratory

Title	Reduce inappropriate prescribing of home oxygen: by ensuring that patients already on oxygen and all new patients are assessed by accredited healthcare professionals trained to both to assess oxygen need and appropriately prescribe oxygen
Issue	<p>Home oxygen has not always been prescribed appropriately – sometimes for inappropriate patients, and sometimes by professionals who lack the required expertise. There has also been poor follow-up and reassessment of patients on oxygen to ensure they are deriving the expected benefit from home oxygen.</p> <p>The issue is also one of safety. A risk assessment must be considered on everyone who has home oxygen as often people who use home oxygen live in dense or multiple residency blocks and the consequences of explosion and fire can be devastating to the individual and those around them. Anyone prescribing oxygen for use in the home must consider their responsibility in this regard. In the draft BTS Home Oxygen QS it states; ‘Any decision to proceed with installation of home oxygen in the presence of significant risks should be made after careful MDT discussion and with the full understanding of the potential implications of this decision by the patient.’</p>
Objectives	Long term home oxygen therapy (LTOT) is only prescribed by someone who has had specific training and is registered to complete a home oxygen ordering form (HOOF B)
Rationale	<p>In areas where there is a full Home oxygen assessment and review service (HOS-AR), oxygen is more likely to be provided to patients who will really benefit. Some areas have saved significant money by ensuring a proper process of prescribing oxygen. PCTs that introduced a review of their oxygen registers coupled with the introduction of a formal assessment service have reduced their annual spend by up to 20% (DH data quoted in Service specification for HOS-AR - 2012). Patients who are breathless but not hypoxic will not benefit from oxygen and should not receive it.</p> <p>There are two forms on which oxygen can be ordered. Home oxygen order form A (HOOF A) is designed for use by non-specialists and should be used only while waiting for an assessment by a HOOF B certified specialist, such as when palliative oxygen is required. Home oxygen order form B (HOOF B) is for use by specialists who can specify the exact requirement of the patient. LTOT in COPD is never an urgent prescription. It is a therapy that has a long term impact; if acute oxygenation is required urgently then home oxygen is not the right prescription and specialist review is required.</p>
Intervention	Ensure systems within your commissioned acute trusts, community trusts and in general practice exists such that all home oxygen prescriptions that are renewed or are initiated are completed by HOOF B certified prescribers.



	<p>In the case of HOOF A prescriptions (often issued by GPs for palliative care scenarios) ensure that these are followed up within a month of issue by a HOOF B prescriber.</p> <p>An important first step is to work with GPs locally to ensure they know the responsibilities of prescribing oxygen if they choose to and ensure that they have an easily accessible service that can respond in a timely manner. This service is usually delivered by respiratory teams.</p>
Evidence	<p>British Thoracic Society guide to home oxygen use in adults 2015 https://www.networks.nhs.uk/nhs-networks/respiratory-leads/news/new-good-practice-guide-home-oxygen-assessment-review</p> <p>Service specification – home oxygen assessment and review service , Dept Health 2012 http://www.respiratoryfutures.org.uk/knowledge-portal/department-of-health-documents/service-specification-home-oxygen-assessment-and-review-service/</p>
Current spend and potential savings	<p>Calculate current potential wasteful and harmful oxygen spend where :</p> <p>a = Number of people in receipt of home oxygen on latest CCG invoice from oxygen company (these are issued monthly)</p> <p>b = Number of new and renew patients using oxygen added to the invoice since the previous month (incidence of new oxygen prescription)</p> <p>c = Population (b) with HOOF B initiation</p> <p>d = Current monthly oxygen therapy spend</p> <p>Using the formula – $(b-c / a) \times d = \text{Potential inappropriate oxygen spend}$</p>
How to/models	<p>Identify all HOOF A oxygen initiation each month and ask respiratory team or other responsible oxygen lead clinician to review.</p>
Resources	<p>Up to date respiratory data for your CCG is available in an updated Commissioning for Value Focus pack. This can be accessed via your CCG RightCare leads – clinical, operational and analytic, or from your RightCare delivery partner who can be contacted via https://www.england.nhs.uk/rightcare/imp/delivery-partners/.</p> <p>Service specification – home oxygen assessment and review service , Dept Health 2012 http://www.respiratoryfutures.org.uk/knowledge-portal/department-of-health-documents/service-specification-home-oxygen-assessment-and-review-service/</p> <p>British Thoracic Society guide to home oxygen use in adults 2015 https://www.networks.nhs.uk/nhs-networks/respiratory-leads/news/new-good-practice-guide-home-oxygen-assessment-review</p> <p>NICE COPD guideline 101 https://www.nice.org.uk/guidance/cg101</p>