NHS
Yorkshire and the Humber

Yorkshire and the Humber SHA Respiratory Clinical Leads Annual Report 2010/11

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Summary

Introduction

The Yorkshire and Humber Respiratory Programme commenced in September 2010 to support the implementation of the National Respiratory Programme. The RHSG set key objectives which are to:

- develop advice on the work needed to implement the national COPD strategy
- co-ordinate SHA work on respiratory health with that of the national programme
- support the development and delivery of the national respiratory programme across Yorkshire and the Humber
- develop a virtual network of PCT, commissioner and provider colleagues with an interest in lung health and support the establishment and strengthen existing communities of Practice
- advise the SHA on the key deliverables and expectations for PCTs as commissioners of respiratory services
- ensure that national developments relevant to the QIPP agenda are brought to the attention of the SHA and PCTs
- support the Clinical Leads, Respiratory Health in their work to achieve the key objectives issued to Respiratory Leads

Priority areas for implementation identified by the group include:

- Early Facilitated Discharge
- Pulmonary Rehabilitation
- Home Oxygen Services
- Unwarranted variation in primary care

Key Facts 2010/11: In the 14 NHS Yorkshire and the Humber PCT's:

- COPD diagnosed prevalence varies from 1.5% to 2.5% of the population (102,972 people)
- Predicted prevalence varies from 2.5% to 4.5% of total population for 2010 (3% to 6% of population over 16 years old, 179,123 people)
- Provision of evidence based services such as early supported discharge for those admitted with COPD and Pulmonary Rehabilitation is inconsistent
- Years of life lost to COPD (directly age standardised rate per 1000 population) varies from 6 to 22 years
- Total Admissions for COPD per 1,000 people on the COPD QOF register varies from 100 to 250
- Reducing COPD admission rates in Y&H trusts with above the average admissions per 1,000 to the national average would produce a saving of around £8 million in a year

- NHS Yorkshire and Humber Health Economists estimate that close to £50m can be saved in Y&H from reducing emergency COPD care through programmes to manage the condition in primary and community settings.
- Provision of oxygen assessment and monitoring services, shown to improve clinical effectiveness and cost efficiency, are inconsistent
- The DH report that between 24% and 43% of home oxygen is not used or derives no clinical benefit.
- Implementation of oxygen assessment and monitoring DH recommendations has potential to save £300,000 per PCT a year
- Asthma diagnosed prevalence varies from 5.7 to 6.8% of the population (330,000 people)

Key Facts 2010/11: In the 14 NHS Yorkshire and the Humber PCT's:

- QOF data is considered to underestimate the true prevalence of asthma, almost 40% of those with asthma are not recognised on QOF registers
- Proportion of patients receiving a review in primary care within 15 months varies from 75% to 82%, with exception rates from 1.5% to almost 9%
- 90% of asthma deaths are preventable
- 75% of Asthma admissions are avoidable
- Standardised admission rates per 100,000 population varies from 60 to 139
- Readmission rates vary from 60 to 125
- Reducing admission rates in Y&H trusts with above the average admissions per 1,000 to the national average would produce a saving of around £1million in a year

Key Initiatives:

Virtual Network

The aim of the network is to facilitate effective two way communication with key stakeholders and 'champions' across our region to support the achievement of the overall aims of the COPD strategy. It can be found on line at NHS Networks.

Respiratory Dashboard

The Yorkshire Public Health Observatory has produced a 'Respiratory Dashboard' to demonstrate performance and variation across the PCT's. The Dashboard includes primary and secondary care information regarding Asthma and COPD.

Home Oxygen

The RHSG members will be supporting the Home Oxygen Service Reprocurement Group throughout in the reprocurement of the home oxygen service provider contracts, renegotiation of these contracts nationally and regionally will deliver significant cost savings. The RHSG will support the implementation of DH commissioning and clinical process recommendations to deliver on further cost savings.

Unwarranted Variation

Information from the Respiratory Dashboard will be used to engage local COP, confirm and challenge service provision in PCT's and emerging GP commissioning consortia and offer peer review of primary and secondary care pathways.

Pulmonary Rehabilitation

All PCT's are currently providing or plan to provide pulmonary rehabilitation services for their patients. However, in some areas places appear to be underutilised. A service review/ audit is planned with expertise provided by industry. The work will assess barriers and challenges to referral and attendance at Pulmonary Rehabilitation and suggest strategies to address those challenges.

Sustainability and contribution to the transition

With the abolition of the SHA in June 2012, and the likely withdrawal of DH funding for the programme at the same time, the RHSG is working with the new respiratory network and its linked communities of practice to identify a plan for maintaining this work from 2012/13 onward.

Introduction

COPD is a major cause of morbidity and mortality nationally and internationally. There are approximately 900,000 people living with diagnosed COPD in England and Wales with a further estimated 2 million people undiagnosed. Across the whole population there is an estimated prevalence of between 2 to 4% with those living in urban deprived areas at greatest risk. Although prevalence in men has plateaued in recent years, diagnosis in women continues to rise, giving an overall rise in prevalence.

In the 14 PCT's that made up NHS Yorkshire and the Humber in 2010/11, diagnosed prevalence of moderate to very severe COPD varies from 1.5% of the population to 2.5% of the population (a total of 102972 people) (QOF 2010). The predicted prevalence of moderate to very severe COPD, based on modelling by the Association of Public Health Observatories, varies from 2.5% to 4.5% of total population for 2010 (total 179,123 people), expressed by APHO as 3% to 6% of population over 16 years old, leaving an estimated 76,151 people with undiagnosed moderate to very severe COPD in NHS Yorkshire and the Humber (APHO 2008). Following changes to diagnostic criteria included in the NICE COPD update in 2010, there will be further people with mild disease not presently identified or recorded on disease registers.

Many die with COPD rather than because of COPD making accurate measure of mortality from COPD difficult to ascertain. Many more will die of causes or complications related to COPD which may or may not currently be recorded in the death certificate. Identification of trends is further complicated by changes in diagnostic labels. The publication of the National Strategy for COPD and the NICE 2010 COPD Management update, both of which raise the profile of COPD is likely to further compound these complications. NICE, 2010, reports the annual mortality from COPD as 30,000 deaths a year, with 90% of these deaths in the over 65's and 85% attributable to smoking. Standardised mortality rates have fallen progressively in men since the mid 1970's, however the increasing rate in women, an ageing population and increasing prevalence are expected to see a future increase in mortality. In men 5 year survival from diagnosis is 78% and in women 72%, this reduces to 30% of men and 24% of women with severe/ very severe disease.

Inpatient mortality for acute exacerbation, according to the National COPD audit, is 7.7% with increased mortality in hospitals with fewer respiratory consultants and those serving deprived areas (NCROP 2008). Mortality 90 days post admission is 14% and 25% at 12 months nationally. People in urban deprived areas are again most at risk.

The greatest cost to both the individual and the health care economy are associated with exacerbation of the condition and admission. COPD exacerbations also result in worsening quality of life, faster disease progression and increased mortality. There is growing evidence that self care activities, including exercise, early identification of exacerbation symptoms and lifestyle adaptation, can reduce the number and severity of exacerbation.

People with COPD look after themselves most of the time, only spending a few hours per year with Health Care Professionals. Therefore, high quality education is necessary to enable people with COPD to reach their full potential in self management and self care for their condition. People with COPD report that they want access to high quality information that will help them to manage and understand their condition better (DH 2010).

Background

In 2010 the Department of Health Published the Consultation on a Strategy for Chronic Obstructive Pulmonary Disease (COPD) in England.

The Strategy states that its intention is to:

- reduce the risk of developing COPD by improving prevention and Health promotion initiatives;
- identify those people with COPD or at risk of developing COPD as early as possible;
- ensure accurate diagnosis, evidence-based treatment, proactive management and regular review through an integrated care pathway that provides the right care in the right place for the right person and that includes comprehensive community-based services, where most people are cared for;
- ensure better support for people with COPD and their carers, so that they become active partners in their care;
- provide the best support and treatment in periods when the condition worsens, through the integration of services and care across the primary, secondary and tertiary sectors, in the NHS and social care;
- provide access to the best available support for those who are at the end of life and for those who are bereaved.

The Strategy contains 24 key recommendations to support these intentions.

Regional implementation has been supported by the appointment of regional clinical respiratory leads, who are tasked to work with PCTs and key personnel to drive local implementation. The Department of Health (DoH) has requested the development of regional respiratory boards. In Yorkshire and the Humber SHA a Respiratory Health Steering Group has been established.

Objectives

The objectives of the regional leads are to:

- develop advice for the SHA and the Long Term Conditions Pathway Leadership Board on the work needed to implement the national COPD strategy
- co-ordinate the work of the SHA on respiratory health with that of the national respiratory programme
- support the development and delivery of the national respiratory programme across Yorkshire and the Humber
- assist in the development of a virtual network of PCT and provider colleagues with an interest in lung health
- advise the SHA on the key deliverables and expectations for PCTs as commissioners of respiratory services
- ensure that national developments relevant to the QIPP agenda are brought to the attention of the SHA and PCTs
- support the Clinical Leads, Respiratory Health in their work to achieve the key objectives issued to Respiratory Leads

Priorities

The Respiratory Health Steering Group identified the following evidence based interventions and key challenges as priorities for its work:

- Early Facilitated Discharge
- Pulmonary Rehabilitation
- Home Oxygen Services
- Unwarranted variation in primary care

Achievements to date

- Appointment Clinical Leads
    - Dr John White (Respiratory Consultant York Hospitals NHS Trust) and Dr Maria Read (GP Sheffield) were appointed joint clinical leads for the regional programme.
- Regional events
    - Three Regional events have been organised by the Department of Health and all were well attended.
- Respiratory Health Steering Group (RHSG) established
    - The RHSG has membership from Patients (British Lung Foundation), Physiologists, Respiratory Nurse Specialists, Public Health Professionals, NHS Commissioners and Professions Allied to Medicine.
- Support LIP pilot sites
    - In 2010 7 projects on four sites were accepted by the Lung Improvement Programme. These were
        - Sheffield: Diagnosis, Chronic/Self Management and Oxygen
        - Leeds: Diagnosis
        - Hull: Oxygen
        - Rotherham: Pulmonary Rehabilitation and End of Life
    - At the end of the first year 3 of the pilots were discontinued by mutual consent. The ongoing pilots are:
        - Sheffield: Oxygen
        - Hull: Oxygen
        - Rotherham: Pulmonary Rehabilitation and End of Life

- Initial results from the three remaining sites are positive and will be published shortly. Learning from the oxygen pilots is already being shared across the SHA. The programme continues to provide support for the pilot sites as required.

- An additional site, Mid Yorkshire NHS Hospitals Trust, has been chosen in Yorkshire and the Humber as an Asthma pilot site.

- Virtual Network established

  - In order to deliver the 10 year COPD Clinical Strategy, it is important to harness the skills and capacity of a wide range of stakeholders. The aim of the network is to facilitate effective two way communication with key stakeholders and 'champions' across our region to support the achievement of the overall aims of the COPD strategy.

  - The key Network objectives are to:

    - Engage with colleagues leading and stimulating debate
    - Disseminate useful resources, tools, training and opportunities
    - Motivate, inspire, empower and invigorate others
    - Engage with, support, inform and update colleagues on progress within our region

  - The Yorkshire and Humber Respiratory Network is the largest of the respiratory Networks with 357 members from a variety of clinical backgrounds. It has been established on the NHS Networks site and is maintained by the National Programme Communications lead.

- SHA Web pages

  - The RHSG has established respiratory information pages on the SHA website. These are regularly updated and contain information about the programme and its activities.

- Regional services review

  - A service Respiratory Organisational Stock take was carried out through the PCT Respiratory Commissioning Leads. Results were received from all 14 PCTs and results have been included in the Respiratory Dash Board (Appendix 1).

- Care Quality Indicators (CQUINs) (Appendix 2)

  - Two CQUIN Bundles (Asthma in accident and emergency and inpatients COPD) were accepted as part of the SHA 'pick list' and shared with PCT's. Information regarding selection of these CQUINS is still awaited, however, positive feedback was received from clinicians and at least 3 PCT's have selected to use locally adapted versions of the CQUINS.

- Respiratory Dashboard (Screen Shot Appendix 3)

    - The Yorkshire Public Health Observatory has produced a ‘Respiratory Dashboard’ to demonstrate performance and variation across the PCT’s. The Dashboard includes primary and secondary care information regarding Asthma and COPD, for example prevalence, admission rates, Length of stay and readmission rates. It also contains information about the use of home oxygen across the PCT’s. The launch date for the Dashboard is June 2011.

- Long Term Conditions Care Planning Template

    - Work is ongoing at the SHA to implement a care planning template to support the implementation of care planning across the health care community. The RHSG are working closely with the team responsible for the role out of the template to ensure a comprehensive template is included for managing COPD and Asthma effectively.

- Better for less briefings

    - The Respiratory Health Steering Group has contributed to three SHA ‘Better for less’ briefing packs as part of the SHA’s work to support QIPP activity within NHS commissioners and providers on the subjects of:

        - COPD
        - Children’s Asthma
        - Adult Asthma

    All provide useful information regarding the respiratory condition and the challenges faced in Yorkshire and the Humber. The packs also give practical advice on addressing local challenges and examples of good local practice. Feedback has generally been very positive.

Future Activities

In April 2011 NHS Bassetlaw became responsible to NHS Yorkshire and Humber for performance management purposes and also became part of the new South Yorkshire and Bassetlaw PCT Cluster. In 2011/12 the RHSG will develop links with clinicians and commissioners in NHS Bassetlaw and offer them the opportunity to become involved with work planned with the existing 14 PCT organisations as appropriate. NHS Bassetlaw data will be added to the Respiratory dashboard where available.

The RHSG has planned a programme of work for 2011-12. This work will include:

- Prioritise and engage with PCT/GP Commissioning Consortia areas

    - Local meetings to discuss respiratory dashboard findings will be booked through individual PCT or PCT Cluster Communities of Practice to discuss local challenges faced from respiratory disease and offer practical support and provide information about evidence based commissioning of respiratory services

- Confirm and Challenge PCT/primary and secondary care meetings
    - Confirm and challenge service provision in PCT's and emerging GP commissioning consortia
    - Support PCT/GPCC colleagues to develop an action plan and implement actions necessary to implement national strategy evidence based recommendations and how these can feed into strategic and operational plans and QIPP programmes.
    - Support Practices to work towards Primary Care Respiratory Society respiratory best practice awards for Primary Care
- Newsletter
    - A quarterly newsletter is planned for 2011/12 to keep all key stakeholders informed of developments in the programme. The first will be published in June 2011.
- QIPP oxygen work stream
    - The RHSG will support implementation of national guidance on commissioning and providing oxygen services to realise non reprocurement QIPP benefits (NHS, 2011). Reprocurement of the Home Oxygen Services is a national workstream which will recognise significant cost savings through negotiation of a new oxygen contract in all regions. The RHSG intend to compliment this workstream by the implementation of process and data management recommendation through working with the Regional HOS leads group and provision of education across the region. Training will include information to support data cleansings and evidence based cost effective provision of oxygen. Learning from the two pilot sites and areas achieving cost savings through service redesign will be shared across the region.
- Work with the Pharmaceutical Industry
    - Meetings are planned with key industry representatives to discuss the possibility of working together within DH recommendations. This will take the form of joint funding and sharing of resources. This work will also seek to bring together initiatives ongoing across the region with the work of the RHSG to ensure that work is complimentary, attains sufficient standards and outcomes may be objectively assessed.
- Marketing campaign for Pulmonary Rehabilitation
    - All PCT's are currently providing or plan to provide (2 PCT's) pulmonary rehabilitation for their patients. However, in some areas places appear to be underutilised. A service review/ audit piece of work is planned with expertise provided by industry. The work will assess barriers and challenges to referral and attendance at Pulmonary Rehabilitation. The work will explore challenges to health professionals and patients and implement strategies to address those challenges.

- Support for Yorkshire and Humber Improvement Programme (YHIP) Paediatric Asthma Programme
    - Over the next 12 months the YHIP Paediatric asthma programme will be supported through the RHSG.
- Link with relevant national, regional and local work streams, for example:
    - Training provision
    - QIPP
    - Long Term Conditions

The following actions were identified as part of the National Leads review of the Yorkshire and Humber Programme:

- Key Priorities
    - Oxygen
    - Prescribing
    - Transforming acute care encompassing
        - service integration
        - care closer to home
        - self management
        - early supported discharge
        - pulmonary rehabilitation

- Key Actions
    - Extend RHSG membership to include Social Care representation
    - Develop strategies for incorporating wider respiratory themes of Obstructive sleep apnoea and pneumonia in 2012/13
    - Engage with Primary and Acute sectors
    - Engage with Medical Directors and Chief Nurses of local clusters to promote models of integrated care

The re organisation and uncertainty experienced through out the NHS has added an extra dimension to the challenges faced by the NHS Yorkshire and Humber Respiratory Programme in its first six months. However, during this time the Respiratory Health Steering Group has established links and raised the profile of Respiratory Disease across Yorkshire and the Humber. It has created a tool in the Respiratory Dashboard that will enable it to engage with Communities of Practice across the region and has resources in place to offer support to improve the quality of services experienced by those with respiratory disease and reduce unwarranted variation across the health care community.

Sustainability and contribution to the transition

With the abolition of the SHA in June 2012, and the likely withdrawal of DH funding for the programme at the same time, the RHSG is working with the new respiratory network and its linked communities of practice to identify a plan for maintaining this work from 2012/13 onward.

An aim of the network is to bring together primary and secondary care colleagues and so NHS provider organisations will be central to the work on developing the local communities of practice.

An aim of the PCT/GPCC meetings planned for 2011/12 is to identify issues for emerging consortia to consider as they prepare for authorisation in 2012 and then become operational from April 2013.

The maintenance of broadly based network that brings together NHS commissioners and providers from 2013 will be an important element of work within individual localities and health communities to promote health, improve outcomes for people with respiratory illness and deliver more effective and efficient services.

References

Association of Public Health Observatories (APHO) (2008) accessed April 2011

http://www.erpho.org.uk/ViewResource.aspx?id=18025

Department of Health 2010 Consultation on a strategy for services for COPD in England

National COPD Resources and Outcomes Project (NCROP) http://old.rcplondon.ac.uk/clinical-standards/ceeu/Current-work/ncrop/Pages/Resources.aspx

Audit National Institute of Clinical Excellence (2004) 'Chronic Obstructive Pulmonary Disease: National clinical guideline on management of chronic obstructive pulmonary disease in adults in primary and secondary care' *Thorax* vol 59 (Suppl) 1-232

National Institute of Clinical Excellence (2010) 'Chronic Obstructive Pulmonary Disease: National clinical guideline on management of chronic obstructive pulmonary disease in adults in primary and secondary care (update) http://guidance.nice.org.uk/CG101

NHS Primary Care Commissioning, (2011), Home Oxygen Service. Assessment and Review. Good Practice Guide.
http://www.pcc.nhs.uk/uploads/HOS/2011/04/home_oxygen_service_assessment_and_review.pdf

HCC 2006 HCC Health Care Commission (2006) Clearing the air: a national study of chronic obstructive pulmonary disease. Health care commission http://www.healthcarecommission.org.uk

Appendix I: Respiratory Organisational Stock take of Yorkshire and Humber SHA Region PCT's Initial findings 5th November 2010

Introduction

An organisational audit of the 14 Y&H SHA PCTs was undertaken over October/September 2010 using an amended NCROP PCT organisational audit tool. The audit tool was sent to the respiratory commissioner for each of the PCT's.

The aim of the stock take was to establish key links with respiratory leads in all 14 PCTs and to establish a baseline for service provision and training in each of the PCTs.

Results

All 14 PCT organisations returned the questionnaire. The quality of completion of the questionnaire varied greatly and the detailed information was not always available. The results below are for initial information only and a full report will follow.

1) Is there a group that is responsible for developing COPD Services across your Primary Care Organisation?

All but East Riding report that there is a group in place. NHS Barnsley does not have a specific group for COPD or Respiratory disease. Respiratory disease is included in older peoples QIPP Planned Care and Unplanned Care groups.

Lead contact details have been supplied for all groups.

2) Is there a written, agreed plan to develop COPD services across your Primary Care Organisation?

All reportedly have a plan in place or in development.

3) Is there an agreed care pathway for managing COPD across your Primary Care Organisation?

All report having a care pathway in place or in development.

4) Is a Community Pulmonary Rehabilitation Programme currently provided within your PCO?

All except Doncaster and North Lincolnshire report having access to Pulmonary Rehabilitation

5) Do COPD patients within your Primary Care Organisation currently have access to an Early Discharge Scheme?

Wakefield and Sheffield have a service available 7 days a week. Barnsley, Bradford and Airedale, Hull, Leeds, Kirklees and East Riding PCTs have a 5 day service.

Calderdale, Doncaster, North East Lincolnshire, North Lincolnshire and Rotherham have no service. North Yorkshire and York have a service in Harrogate but not in other areas.

8) Do COPD patients within your Primary Care Organisation currently have access to an Admissions Avoidance Scheme?

Rotherham has a 24 hours a day 7 day a week service. Sheffield, Wakefield, Barnsley and North Lincolnshire have a 7 day a week service.

East Riding, Leeds and North Lincolnshire have 5 day a week services.

Bradford and Airedale, Calderdale, Kirklees and North Yorkshire and York have no service.

North East Lincolnshire and Hull have admission avoidance through a generic long term conditions service model.

9) Do you have access to an Oxygen assessment service for: Long term oxygen therapy (LTOT), Ambulatory Oxygen, Short burst oxygen therapy/ Intermittent Oxygen Therapy

Oxygen Assessment Services are in place in all but NYY PCT, 2 of which are newly commissioned. Services in 4 PCT's are in place for LTOT only.

- LTOT 13/14
- Ambulatory 9/14

There are 2 LIP Oxygen Pilot Projects in NHS Yorkshire and the Humber in Hull and Sheffield.

10) Are there formal arrangements for patients with COPD to receive palliative care in your area?

Barnsley, Bradford and Airedale, Kirklees, North Lincolnshire, Hull and Wakefield all report formal arrangements are in place.

East Riding, North Yorkshire and York and Sheffield report arrangements are in development.

Calderdale, Leeds, Doncaster, Rotherham and North East Lincolnshire have no formal arrangements.

11) Education/ Training in Primary Care

7 PCTs had no available information on training.

The majority of those that did have information reported with a caveat that information may not be a complete or accurate reflection of local training need. Most PCTs reported that work was being undertaken to identify training in primary care.

Barnsley reports 36 Practices with a COPD qualification to diploma level and 36 Practices attending spirometry training out of a total of 46 Practices.

Leeds reports 63 Practices with an Asthma qualification and 62 with a COPD qualification to diploma level out of a total of 116 Practices

Hull reports 21 Practices with an Asthma qualification and 17 with a COPD qualification to diploma level and 37 Practices attending spirometry training out of a total of 60 Practices. A further 17 Practices have a member of staff who has completed the spirometry diploma.

Rotherham reports 13 Practices with an Asthma qualification and 17 with a COPD qualification to diploma level and 5 Practices attending spirometry training out of a total of 40 Practices

Wakefield reported 40 of 41 Practices with a member of staff qualified to COPD and Asthma diploma level and 41 of 41 Practices with a member of staff who has attended the two day spirometry foundation course.

Discussion

This is a brief overview of the reported information from the 14 PCT's. Further work will be required to analyse the finer detail from the audit tool including information re capacity and performance of some services.

It has been surprising that some data is not readily available to commissioning colleagues, for example completion rates for pulmonary rehabilitation, admissions prevented by admission avoidance schemes and bed days saved by EFD services.

It is hoped that the information provided in the full stock take be used in the interpretation of information across the region regarding admissions and other reflections of variation in outcomes which will then inform priority setting for this work programme.

Appendix II Regional Care Quality Indicators (CQINS). Yorkshire and the Humber SHA

Description of indicator	**Chronic Obstructive Pulmonary Disease (COPD) discharge care bundle**
Numerator	Number of patients admitted with OPCS code J40-44 as primary diagnosis who are discharged with a completed care bundle **The Care Bundle reflects British Thoracic Society standards and includes all of the following 6 measures**: i. Referral to smoking cessation service if a current smoker ii. Assessment of suitability and/or enrolment into a pulmonary rehabilitation programme iii. Appropriate education, written information, self-management plans and rescue packs for future exacerbations iv. Ensure that patient understands their medications and have demonstrated good inhaler technique whilst on the ward v. Ensure that those patients in respiratory failure are issued with an oxygen alert card vi. Appropriate follow-up arrangements once discharged from hospital
Denominator	Number of patients admitted with OPCS code J40-44 as primary diagnosis
Rationale for inclusion	COPD accounts for a significant number of admissions, readmissions and bed days. Patients admitted with acute exacerbation of COPD require a structured hospital admission to ensure that length of stay and subsequent readmission are minimised; and patient outcomes are improved (National Strategy).
Data source	PAS to identify 50 consecutive admissions with COPD as primary diagnosis (J40-44) during the previous quarter
Frequency of data collection	Twice yearly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Twice yearly (Quarter 1 and Quarter 3)
Baseline period/date	Not applicable
Baseline value	Not available
Final indicator period/date (on which payment is based)	Quarter 1 Quarter 3
Final indicator value (payment threshold)	At least 75% for every measure in the care bundle
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Completed audit report required for Quarter 1 and Quarter 4 to be submitted to the commissioner by the end of the month following the quarter end.
Final indicator reporting date	Quarter 1 - 31 July 2011; Quarter 3 - 31 January 2012

Description of indicator	Asthma in Emergency Department (ED)
Numerator	Number of patients attending ED with asthma discharged home/not admitted with completed care bundle. **The care Bundle will include all of the following 7 measures:** **• Vital signs measurement and recording on arrival in Emergency Department** Peak Flow, O2 saturation, pulse and respiratory rate measured and recorded on arrival **• Beta 2 agonist administration in Emergency Department within 20 minutes of arrival** **• Steroid administration in Emergency Department within 30 minutes of arrival** **• Repeat vital sign measurement and recording in Emergency Department** Peak Flow, O2 saturation, pulse and respiratory rate measured and recorded prior to discharge **• Inhaler technique should be checked and explanation of action** **• Discharge prescription of oral steroids** Discharged adult patients should have oral prednisolone 30-50mg for 5 days Discharged paediatric patients should have oral prednisolone 20mg (2-5 years) or 30-40mg (over 5 years) for 3 days **• Appropriate follow up arrangements** Written symptom based and Peak Flow based self management plan given which allows patients to adjust therapy within recommendations Information re what to do if they have another asthma attack/ How to recognise deterioration for example given a copy of 'After your Asthma Attack' or 'After your Child's Asthma Attack leaflet' from 'Asthma UK'. Advised to see GP/PN within 2 working days of emergency department attendance Practice informed by Fax of attendance in A/E within 24hrs
Denominator	Completed audit report required for Quarter 2 and Quarter 4 to be submitted to the commissioner by the end of the month following the quarter end
Rationale for inclusion	1 in 4 people who have attended ED because of an asthma attack receive no information about follow up treatment and only 35% of those with asthma know what they need to do after an attack (Asthma UK). 1 in 6 people who have received emergency treatment for an asthma attack need treatment again within 2 weeks. Those attending ED will not receive the same level of information and follow-up as those admitted to a ward, even though this is a crucial time to deliver that education to patients and their carers. By providing the correct assessment, education and support reattendance rates will be reduced; admissions prevented; and patient outcomes improved.
Data source	Identify 50 consecutive attendances with a diagnosis as asthma during the previous quarter for audit - at least 20 to be aged 18 or over. Patients presenting with acute severe or life threatening symptoms and those admitted to hospital are excluded from the audit.
Frequency of data collection	Twice yearly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Twice yearly report (Quarter 2 and Quarter 4)
Baseline period/date	Audit dated November 2010
Baseline value	75-98%
Description of indicator	**Asthma in Emergency Department (ED) continued**

Final indicator period/date (on which payment is based)	Quarter 2 Quarter 4
Final indicator value (payment threshold)	At least 90% for every measure in the care bundle
Rules for calculation of payment due at final indicator period/date	Completed audit report required for Quarter 2 and Quarter 4 to be submitted to the commissioner by the end of the month following the quarter end
Final indicator reporting date	Quarter 2 - 31 October 2011; Quarter 4 - 30 April 2012.

Appendix III Screen Shot Respiratory Dashboard COPD

YHPHO
Yorkshire & Humber
Public Health Observatory

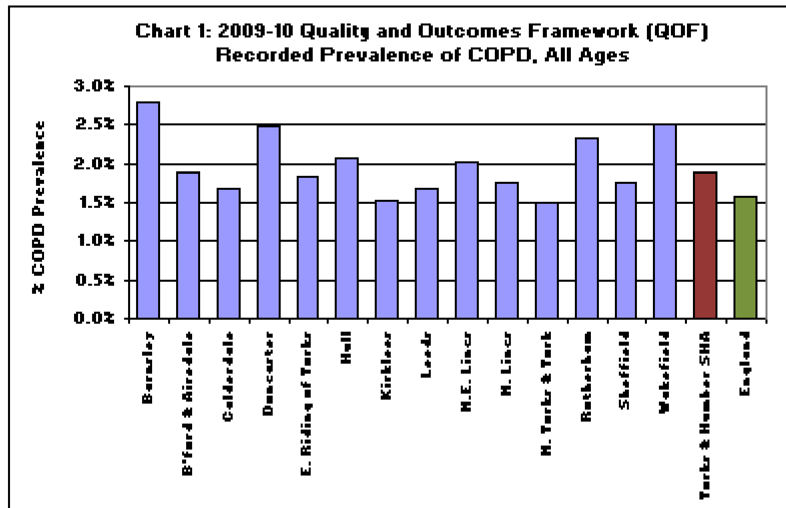
Chronic Obstructive Pulmonary Disease

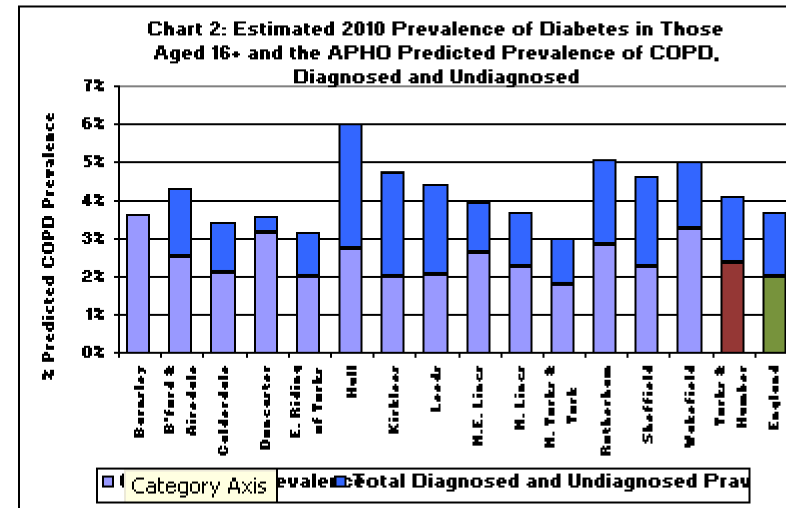
Primary Care Trust Summary

The information below summarises the provision of services against services usage, patient outcomes and expenditure information across the region.
This information is designed to allow the identification of differences in service provision and the potentially related variation seen at Primary Care Trust level in outcomes for those with COPD

More detailed information is available in the accompanying profiles available for each Primary Care Trust.

Prevalence:





BARNSLEY	BRADFORD & AIREDALE	CALDERDALE	DONCASTER	EAST RIDING OF YORKSHIRE	HULL TEACHING	KIRKLEES	LEEDS	NORTH LINCOLNSHIRE	NORTH EAST LINCOLNSHIRE	NORTH YORKSHIRE AND YORK	ROTHERHAM	SHEFFIELD	WAKEFIELD DISTRICT

SUMMARY - PCT | DETAIL - PCT