Kent Surrey Sussex
Academic Health Science
Network

Next Level

Respiratory programme:
showcasing the success of the programme, looking to the future and the use of innovation

Date /
8 June 2022

Next Level

Setting the scene

Ellie Mason, Programme Manager, KSS AHSN

Setting the scene: respiratory disease

- Respiratory disease **affects one in five people** and is the **third biggest cause of death** in England. Lung cancer, pneumonia and chronic obstructive pulmonary disease (COPD) are the biggest causes of death.
- **Hospital admissions** for lung disease have risen over the past seven years at three times the rate of all admissions generally.
- Respiratory diseases are a **major factor in winter pressures**; most respiratory admissions are non-elective, doubling during winter.
- The annual **economic burden** of asthma and COPD in the UK is estimated as £3 billion and £1.9 billion respectively. In total, all lung conditions (including lung cancer) directly cost the NHS £11billion annually.
- Incidence and mortality rates from respiratory disease are higher in **disadvantaged groups** and areas of social deprivation, with the gap widening. The most deprived communities have a higher incidence of smoking rates, exposure to higher levels of air pollution, poor housing conditions and exposure to occupational hazards.

Source: NHS England » Respiratory disease

Long Term Plan: Respiratory aims

- **Enable early and accurate diagnosis of respiratory diseases**, by supporting the training of staff to deliver and interpretate tests such as spirometry.
- **Expand pulmonary rehabilitation services** across the country so that patients who would benefit complete treatment in a good quality service.
- **Improve appropriate prescribing of medicines and the way they are reviewed**, and support patients to use their **inhalers** properly
- Design and develop tools and programmes that will **support patients to manage their condition themselves and receive personalised care**
- Improve the treatment and care of people who present with **community-acquired pneumonia**

Source: NHS England » Respiratory disease

Working collaboratively to improve the quality of respiratory services

Clinical leadership and support

Facilitating peer support and collaborative working

Programme management and analytics

Improving the quality of respiratory care

Sharing best practice
- KSS Respiratory Collaborative events
- Breathing Matters e-newsletter

Clinical Networks
- Pulmonary Rehabilitation
- Oxygen/ Respiratory Failure
- NIV e-learning modules

Supporting spread of innovation (RUP)
- FeNO
- Asthma biologics

Discharge Bundles:
Adopt & Spread
- COPD / Asthma

At the heart of our programme is the multidisciplinary KSS Respiratory Network (900+ members)

Next Level

Pulmonary Rehabilitation Network

Julia Bott, Respiratory Clinical Lead / Consultant Physiotherapist, KSS AHSN

KSS AHSN Pulmonary Rehabilitation Clinical Network

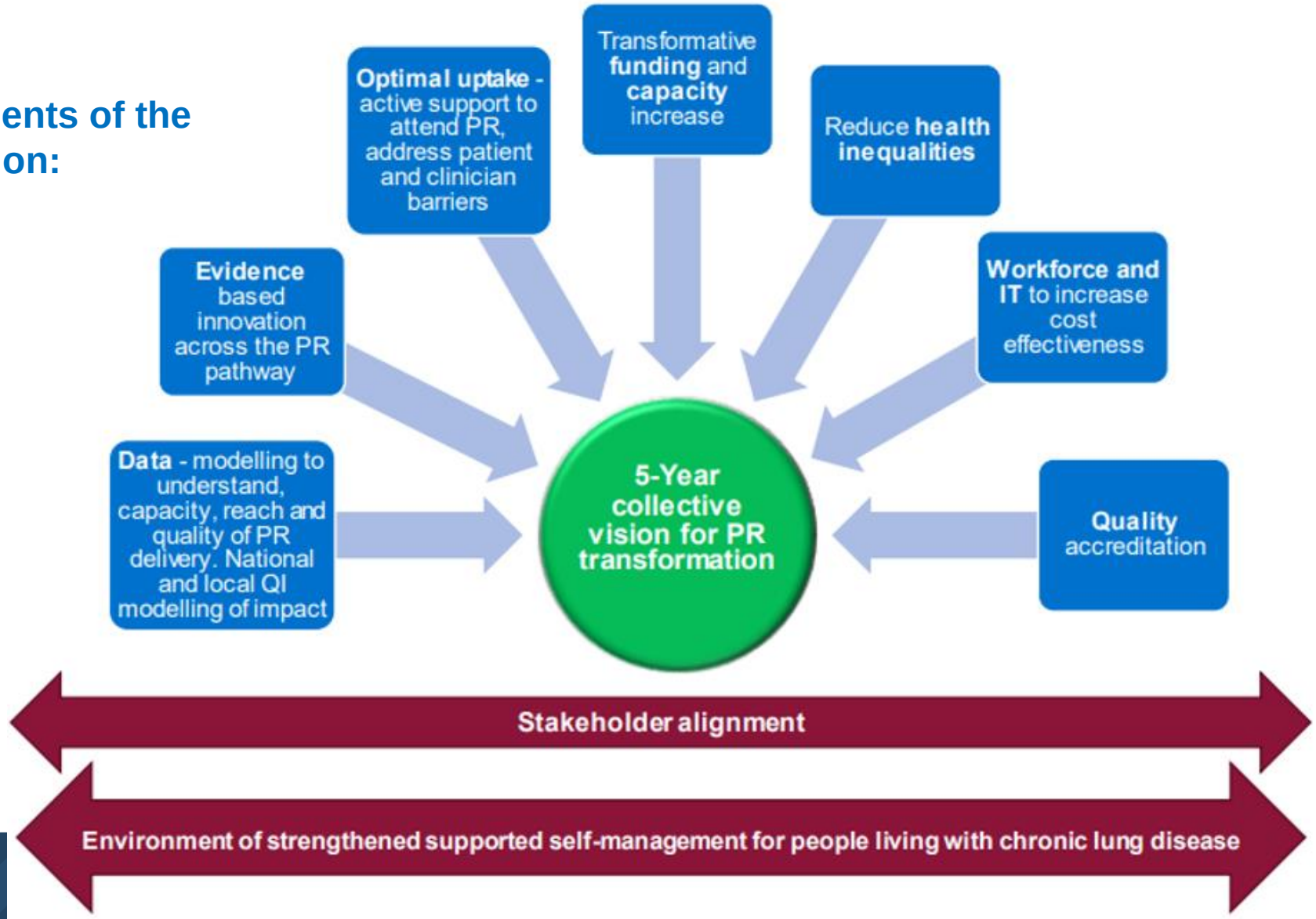
Supporting delivery of the National Respiratory Programme Pulmonary Rehabilitation Five-Year Vision

5. Summary of responsibilities at each level:

National level	regional and system level	Provider level
•Allocate national level investment. •Set the national direction on PR aligning to NHS Long Term Plan priorities. •Commissioning standards for local systems. •Provide data / modelling on projections of demand for PR over the next five years. •Support regions with planning.	•Work with providers to develop local level five year plans for PR, addressing barriers, plans to increase referrals and capacity. •Map population health needs and health inequalities for the region. •Support providers with local intelligence. •Allocate funding to providers / ICS as indicated in plans.	•Deliver quality assured PR services. •Workforce redesign based on PR pathway. •Service delivery options that are inclusive and support patient needs.

National Respiratory Programme
Pulmonary Rehabilitation Five-Year Vision

Key components of the five-year vision:



KSS AHSN Pulmonary Rehabilitation Clinical Network

Supporting delivery of the National Respiratory Programme Pulmonary Rehabilitation Five-Year Vision

Focus supporting providers attain RCP PR Accreditation (PRSAS) and provide menu of PR options

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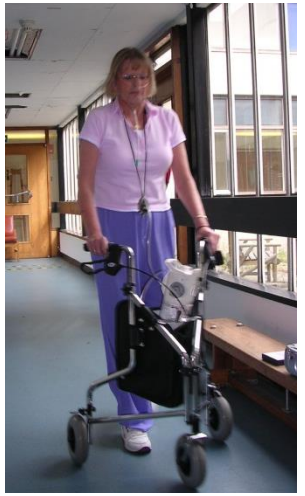
Submitted a grant application with NIHR CRN KSS on identifying under-served populations

Next Level

Oxygen and Respiratory Failure Network

KSS AHSN Oxygen and Respiratory Failure Clinical Network

12 years providing:

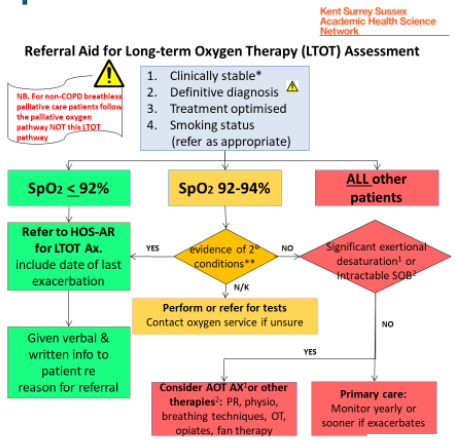


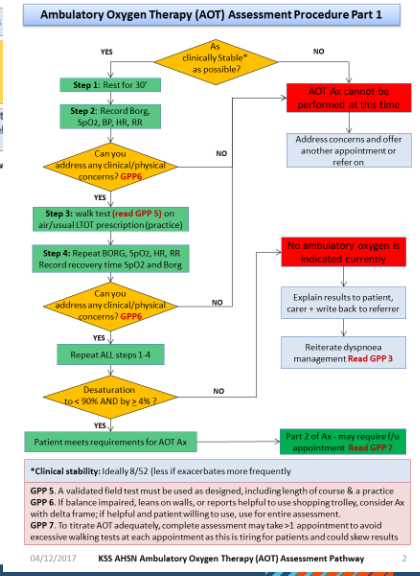
- **Clinical lead and peer support**, advice, shared learning and problem-solving in a safe environment
- Updates and facilitated discussion and agreed actions around relevant **National guidance and standards**
- A successful tripartite relationship between clinicians, the regional home oxygen supplier, and the Home Oxygen contract managers

KSS AHSN Oxygen and Respiratory Failure Clinical Network

Produced agreed documents to aid clinical decision-making and improve practice

1. Referral and clinical assessment pathways for various clinical requirements:
   - Long Term Oxygen Therapy (LTOT)
   - Ambulatory Oxygen Therapy (AOT)
   - Palliative Oxygen Therapy (POT)
   - Interstitial Lung Disease (ILD)
   - Heart Failure
2. Capillary blood gas (CBG) sampling protocol for O_2 and NIV assessments
3. Detailed Risk Assessment Tool (DRAT!)





Next Level

Programme response to COVID-19

Programme response to COVID-19

- **Rapidly adapted**
- **Researching, synthesising and disseminating information** via Bite Size *Breathing Matters* e-newsletters and networks
- **Problem solving** around key clinical themes throughout the pandemic
- **Clinical leadership support and programme management structure**
- Supported teams to set up **Virtual Wards for Oxygen to wean pathways**
- Advice to support the **continuation of best practice for non-COVID patients**, including virtual options for PR
- **Restoration and recovery** – sharing best practice and dealing with challenges

KSS AHSN Oxygen and Respiratory Failure Clinical Network

Peri-pandemic: emphasis on managing rapidly changing situation and unforeseen issues around:

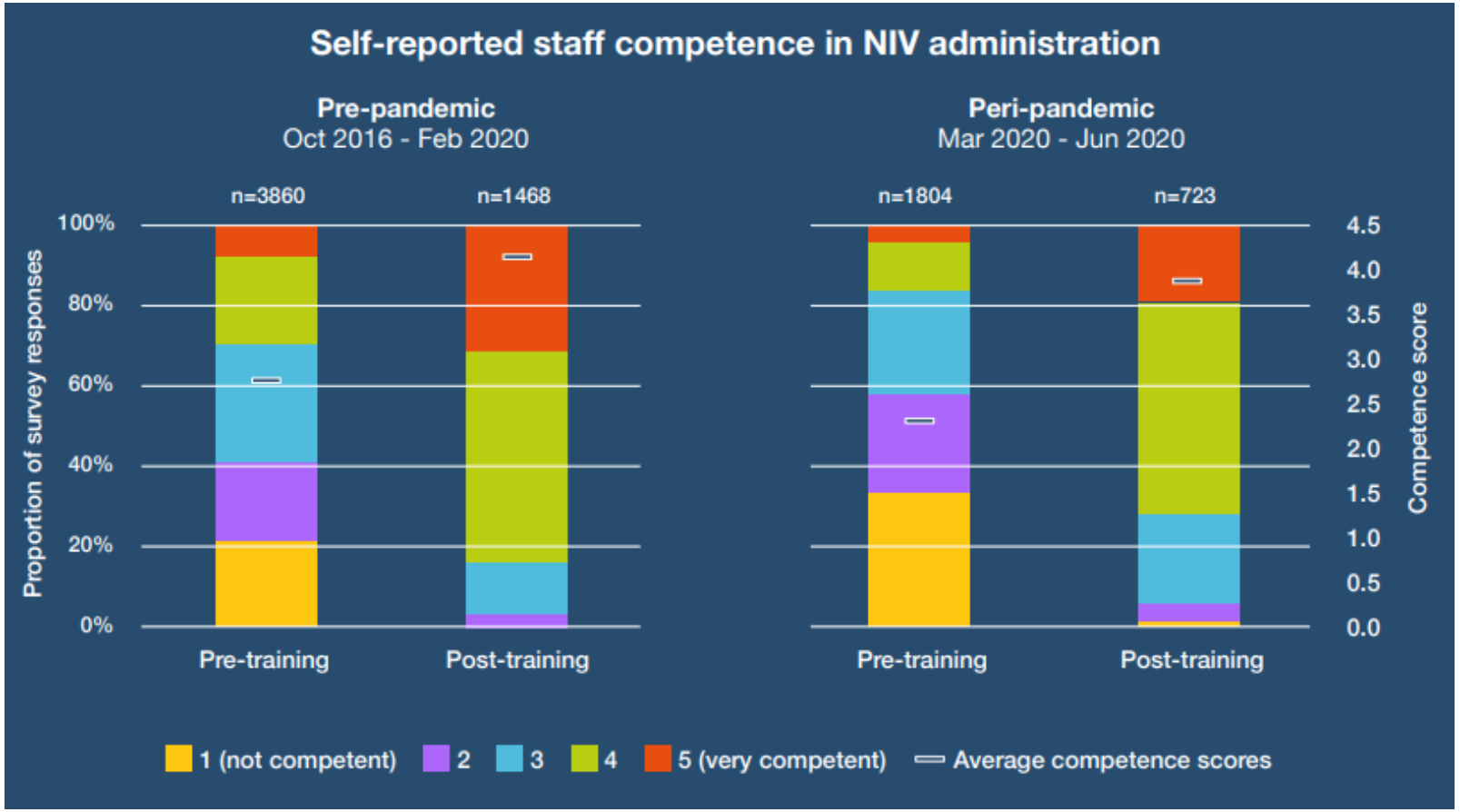
- Patients' clinical requirements, including proning, oxygen and equipment availability, including Non-invasive Ventilation **(NIV),** Continuous Positive Airway Pressure **(CPAP)**
- Staff safety/PPE and Aerosol Generating Procedures **(AGPs)**

Non-Invasive Ventilation (NIV) e-learning modules

During the SARS-CoV2 pandemic the demand for NIV training increased rapidly.

We assessed uptake and impact on learning outcomes of our Kent Surrey Sussex Academic Health Science Network designed e-learning module, pre- and peri-pandemic.

Non-invasive ventilation (NIV) e-learning is effective during the SARS-CoV2 pandemic, despite lower pre-training competence and higher uptake



Conclusion: Our NIV e-learning tool effectively increases self-reported staff competence for NIV administration, even with highly increased and urgent demand for learning.

KSS AHSN Pulmonary Rehabilitation Clinical Network

Peri-pandemic focus on virtual PR:
2 abstracts on KSS provider's data comparing uptake and outcomes of virtual options

Uptake of virtual platforms

Introduction: Our region has run a pulmonary rehabilitation (PR) clinical network since 2010. During the first Covid19 pandemic lockdown when PR services were suspended, PR clinicians from the region's 15 services were encouraged in fortnightly support video calls to move to virtual PR assessment and programme delivery, using virtual platforms of their service's choosing.

Methods: An e-survey of the region's 15 service providers was undertaken, to explore the uptake and active use of the different virtual PR platforms (both digital and paper-based) offered to patients between 1/3/20-7/8/20. Analysis included aggregation of individual services' data. The total number of patients offered, accepting, and actively using the separate platforms was then summed. Percentage of patients, both accepting and actively using, relative to total offered each platform, was calculated, as was percentage of patients actively using, relative to accepting each platform.

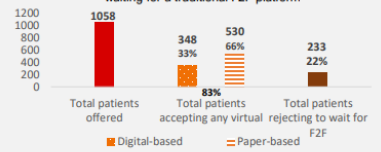
Results: Data are available on 13 of 15 providers; one service was restructuring and another unable to extract data at the time of submission. Platforms used were 3 digital options: SPACE for COPD[1], MyCOPD[2] and British Lung Foundation (BLF) Stay Active, Stay Well videos[3], and 2 paper-based options: BLF Exercise Handbook (BLFEH)[4] and providers' own Home Exercise Programmes (HEP). Most providers offered both digital & paper-based options.

1058 patients were offered at least one virtual platform, with paper-based platforms having a higher take-up rate than digital (66% vs 33%) and 228 patients (22%) preferring to wait for a traditional programme (Fig1).

All digital options had lower take-up than either paper-based platform (Fig 2).

1.SPACE FOR COPD®, 2. myCOPD (mymhealth.com)
3. BLF Stay active and stay well videos (blf.org.uk)
4. BLF Exercise handbook (blf.org.uk)

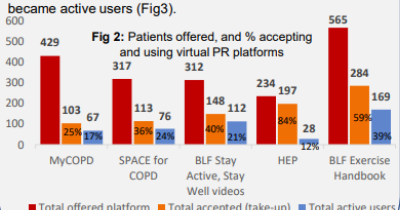
Fig 1: Total patients offered any virtual platform, accepting, and rejecting in favour of waiting for a traditional F2F platform



Although HEP had the highest take-up to offered rate, it had the lowest percentage of active users, relative to both total patients offered (12%) (Fig 2) and take-up* (14%) (Fig3). By contrast, the other paper-based platform, BLFEH, had greatest active users relative to total patients offered (39%) (Fig 2) and among the highest users relative to take-up (65%) (Fig 3).

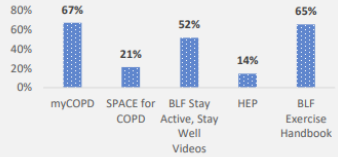
Of digital platforms, although myCOPD had the lowest take-up (25%) (Fig 2), 67% of accepting patients became active users (Fig3); 52% accepting BLF Stay Active, Stay Well videos became active users, whilst 24% accepting SPACE for COPD became active users (Fig3).

Fig 2: Patients offered, and % accepting and using virtual PR platforms



Few patients had completed PR by the end survey date so completion and outcome data were not available.

Fig 3: Percentage of patients actively using platform relative to total patients accepting



Conclusion: The majority of patients opted to try a virtual platform, with paper-based platforms having a higher take-up than digital. Active use relative to platform offered was low across most platforms, with the BLFEH paper-based platform having the highest. Active use relative to take-up varied across platforms. Completion rates and clinical outcomes are awaited. Qualitative data are required to understand attitudes towards virtual platforms and their place alongside traditional PR.

Discussion: Although currently digital interventions are burgeoning across the healthcare sector and use encouraged, we found paper-based platforms had a considerably higher take-up rate than digital. Although active use relative to take-up rate also was one of the highest for the paper-based platform, BLFEH, it was lowest in locally produced HEPs. *Subsequent data collection revealed some patients had accepted a HEP, but staffing issues had prevented them starting, and therefore actively using it, prior to data collection cut off.

Active use relative to take-up was variable across platforms and reasons for this need to be explored. We hypothesise that provider familiarity may influence platform performance.

Acknowledgement: Alex Round KSS AHSN for help with analysis and figures

Completion and outcomes

Introduction: Our region has run a pulmonary rehabilitation (PR) clinical network since 2010. During the first Covid19 pandemic lockdown when PR services were suspended, PR clinicians from the region's 15 services were encouraged in fortnightly support video calls to move to virtual PR (VPR) assessment and programme delivery, using virtual platforms of their service's choosing.

Methods: An e-survey was undertaken of VPR platforms between 1/3/20-7/8/20. Analysis included aggregation of individual PR services' data. Number of patients per platform accepting and completing were summed, and acceptance to completion rates calculated. Providers provided proportions of patients reaching the MCID for any exercise test and health status questionnaire, a total weighted average was then calculated. Qualitative data was gathered by providers on reasons for non-completers.

Results: Data are available on 13 of 15 providers; one service was restructuring and another unable to extract data at the time of submission. Platforms used were 4 digital options: SPACE for COPD[1], MyCOPD[2], providers' own Virtual Live Classes (VLC) and British Lung Foundation (BLF) Stay Active, Stay Well videos[3], and 2 paper-based options: BLF Exercise Handbook (BLFEH)[4] and providers' own Home Exercise Programmes (HEP). Most providers offered both digital & paper-based options.

Of the 869 patients accepting at least one virtual platform, 443 completed (51%), with VLC and BLF 'Stay Active, Stay Well' videos having the highest completion rates (71%, 70%) (see Fig.), reaching the national QI priority 70% target, exceeding the 2020 NACAP report for average completion (69.3%).

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2. myCOPD (mymhealth.com)
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All providers used the 1-minute sit-to-stand test (1-MSTST) of exercise tolerance; two providers used an additional test. 53% of completing patients met the MCID for any exercise test; however, no provider used a practice 1-MSTST.

68% of completed patients met the MCID for at least one health status measure, exceeding the national average (58%) in the 2020 NACAP report of standard PR.

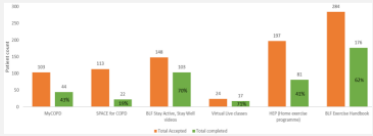

Fig: Patients accepting and completing (with %) VPR per platform

Responses to a suggested set of reasons patients gave for non-completion of VPR were documented by providers (Table). This shows number of providers identifying each specific reason; count of each category is totalled across providers and platform type, not weighted per platform or patient and therefore can only be used as an indicator without comparison.

Type of platform	Technology (digital) or text (Paper-based) too difficult	Exercise component too difficult	Educational component too difficult	Lost motivation /interest	Became too unwell	Domestic issues
Digital	9	1	2	12	9	6
Paper-based	1	2	1	8	7	2
Totals	10	3	3	20	16	8

Table: Count per provider of reasons given to each provider for non- completion of VPR

Conclusion: On average, digital and paper-based platforms had similar completion rates (48% and 53%), though rates varied greatly between individual platforms. Of the digital platforms, VLC and BLF 'Stay Active, Stay Well' videos have the highest completion rates; however, VLC has a smaller sample size (n=24) than other platforms and therefore caution needs to be used before drawing firm conclusions of their performance.

Average MCID attainment for completers was high for health status. Further data collection and analysis are required to understand virtual 1-MSTST performance, and the different VPR platform performances in clinical outcomes. Additional exploration behind the reasons patients may be finding the technology too difficult to use, losing motivation and/or interest should be undertaken.

Discussion: Not all providers tracked patients using and completing the programme, therefore their data has been excluded. Data collection continued for 2 months post the survey period end date, on the working agreed assumption with all providers, that this would allow any patient who had commenced during the survey period to have completed their VPR.

The results suggest lost motivation and becoming too unwell are the main drivers causing patients to not complete. However, specifically for digital platforms, an additional significant factor could be finding the technology too difficult. Identifying and addressing obstacles for patients in VPR completion should become a matter of priority. We furthermore hypothesise, from discussion, both intra- and extra KSS PR network, that provider familiarity may influence platform performance

Acknowledgement: KSS PR providers who kindly submitted data

KSS AHSN Pulmonary Rehabilitation Clinical Network

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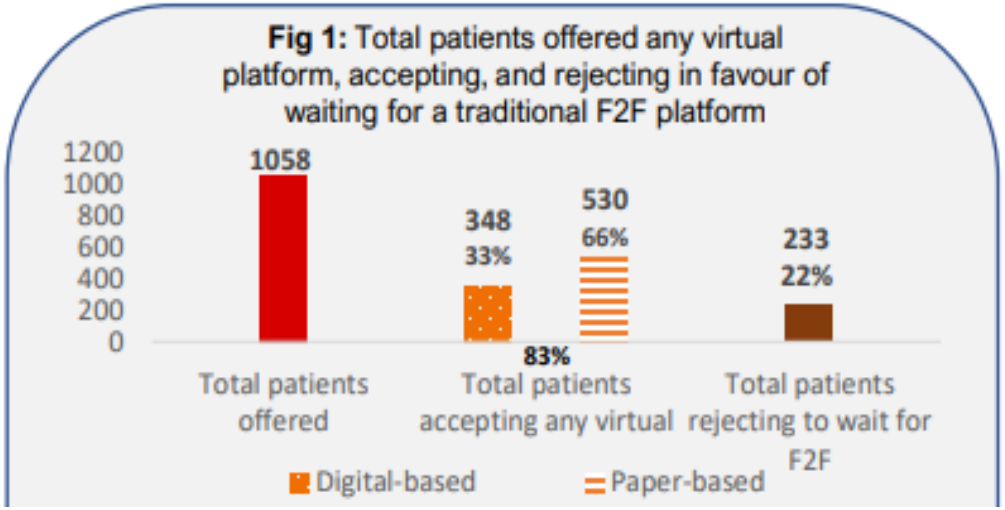

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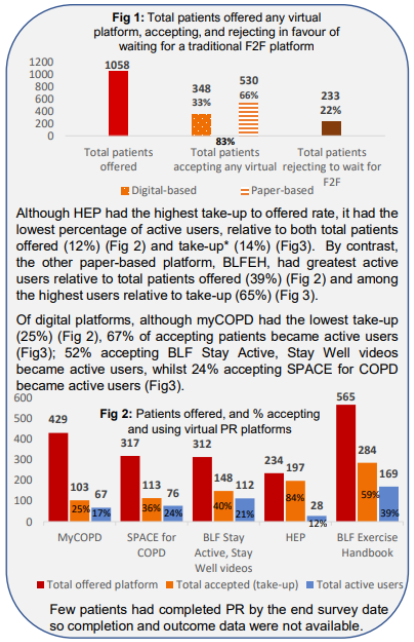

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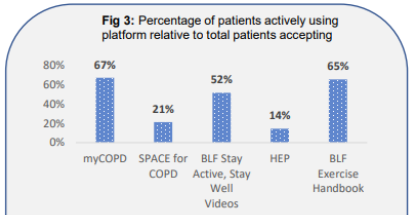

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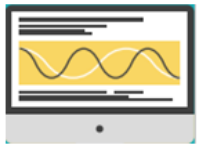
Next Level

COPD Discharge Bundle

Dr Jo Congleton, Respiratory Clinical Lead, KSS AHSN / Consultant in Respiratory Medicine, UHSFT / Clinical Lead, NHS Sussex Respiratory Network
Tom Myers, Senior Analyst, Unity Insights

Methodology



Building the collaborative
Gain commitment from regional spread partners and key stakeholders (including adopters)

Establishing measures
Agree metrics, outcomes, data sharing and start collecting data to establish baseline

Providing tailored support
On-site visits and web conferences to support change in-between events

Cross-AHSN and Local Collaborative events (IHI Breakthrough Series Model for Improvement)
Feedback progress, share learning, and celebrate successes. Includes QI training and leadership development

Demonstrating impact
Repeated data collection and review of outcomes, using measurement for improvement

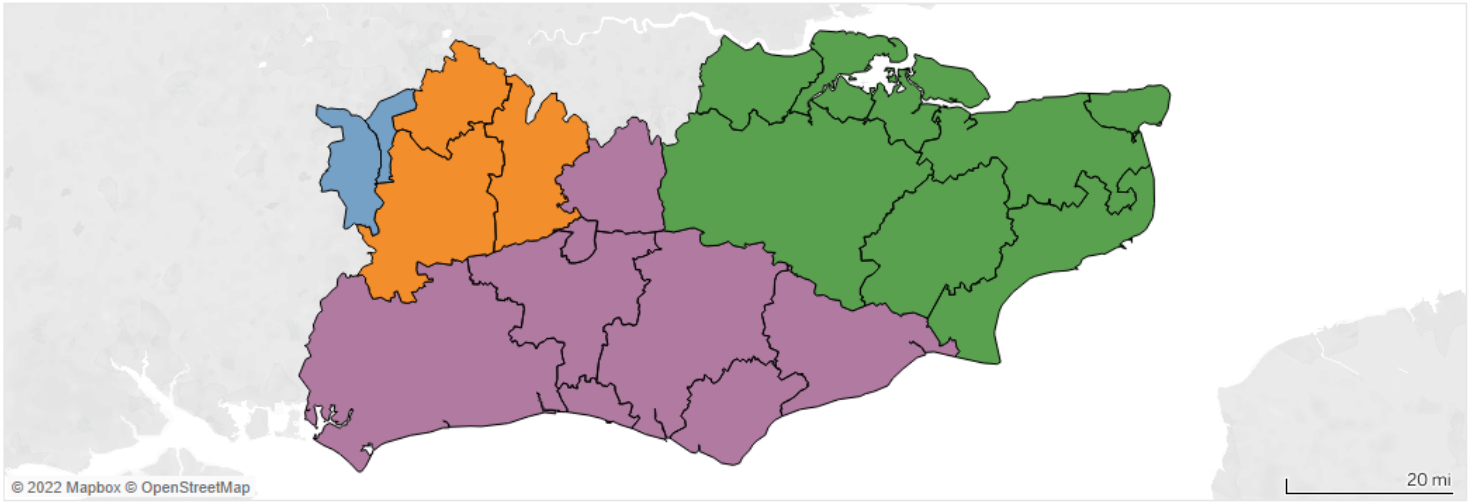
Continuous improvement & peer support network
Sustain changes & continue to embed the care bundle for better care

Adapted from: Leack, 2017, KSS AHSN

KSS Discharge Bundle dashboard

Kent Surrey Sussex Academic Health Science Network

KSS AHSN Respiratory Dashboard



COPD DISCHARGE BUNDLE MEASURES

- Overview
- Measure Trends
- Trust Data Submission Details

TRUST LEVEL OUTCOME MEASURES

- Overview
- Outcome Comparison

CCG LEVEL MEASURES

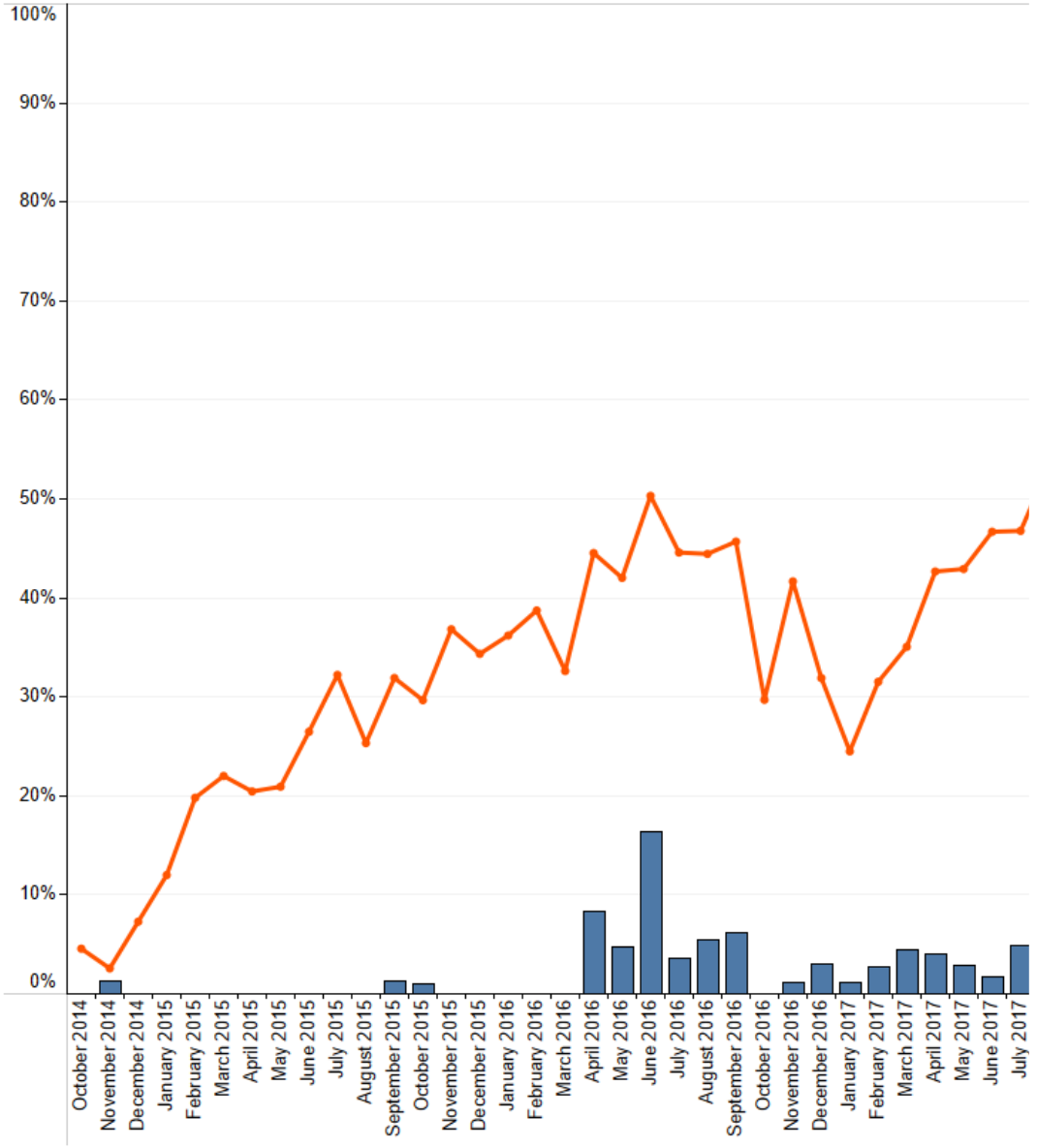
- Overview

BEST PRACTICE TARIFF

- Overview
- Economics

Trust example

- Met this trust in July/August 2017 at an RCP QI day
- Trust suggested that ‘none’ of their patients received a full discharge bundle
- Began providing data insights to support delivery of the discharge bundle



BPT Economic Breakdown

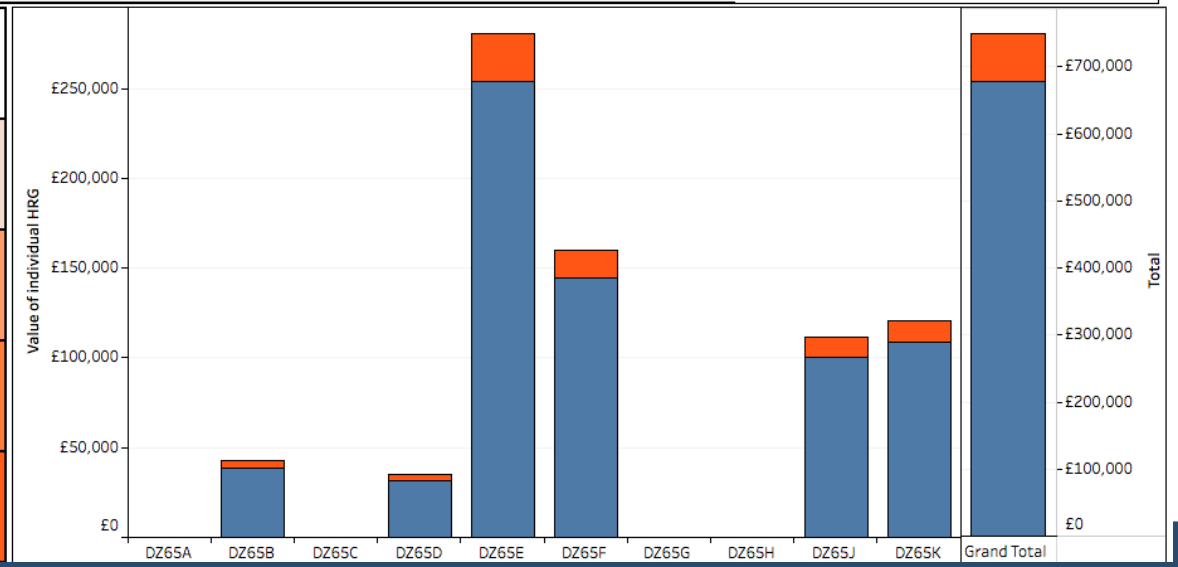
KSS AHSN Respiratory Dashboard:
Best Practice Tariff Economic Breakdown

Kent Surrey Sussex Academic Health Science Network

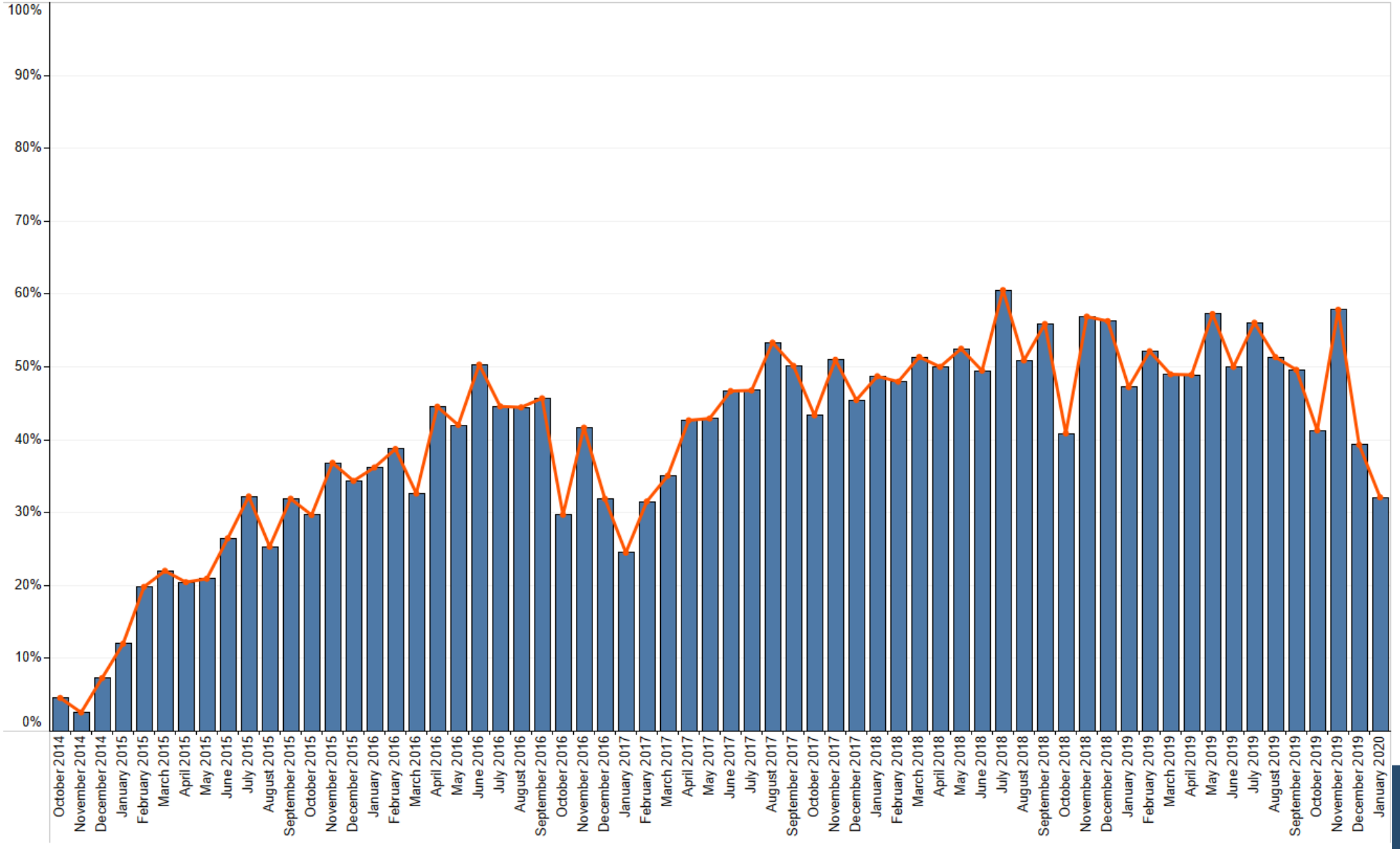
Instructions: Input the number of patients admitted for each HRG to calculate potential additional funding received from BTP if achieved.

DZ65A	Chronic Obstructive Pulmonary Disease or Bronchitis, with Multiple Interventions, with CC Score 9+	Standard HRG Value Additional reimbursement if BPT met	£6,617 £704	0
DZ65B	Chronic Obstructive Pulmonary Disease or Bronchitis, with Multiple Interventions, with CC Score 0-8	Standard HRG Value Additional reimbursement if BPT met	£3,849 £409	10
DZ65C	Chronic Obstructive Pulmonary Disease or Bronchitis, with Single Intervention, with CC Score 9+	Standard HRG Value Additional reimbursement if BPT met	£4,667 £496	0
DZ65D	Chronic Obstructive Pulmonary Disease or Bronchitis, with Single Intervention, with CC Score 5-8	Standard HRG Value Additional reimbursement if BPT met	£3,153 £335	10
DZ65E	Chronic Obstructive Pulmonary Disease or Bronchitis, with Single Intervention, with CC Score 0-4	Standard HRG Value Additional reimbursement if BPT met	£2,537 £270	100
DZ65F	Chronic Obstructive Pulmonary Disease or Bronchitis, without Interventions, with CC Score 13+	Standard HRG Value Additional reimbursement if BPT met	£4,818 £512	30
DZ65G	Chronic Obstructive Pulmonary Disease or Bronchitis, without Interventions, with CC Score 9-12	Standard HRG Value Additional reimbursement if BPT met	£3,346 £356	0
DZ65H	Chronic Obstructive Pulmonary Disease or Bronchitis, without Interventions, with CC Score 5-8	Standard HRG Value Additional reimbursement if BPT met	£2,587 £275	0
DZ65J	Chronic Obstructive Pulmonary Disease or Bronchitis, without Interventions, with CC Score 0-4	Standard HRG Value Additional reimbursement if BPT met	£2,013 £214	50
DZ65K	Chronic Obstructive Pulmonary Disease or Bronchitis, with length of stay 1 day or less, Discharged Home	Standard HRG Value Additional reimbursement if BPT met	£544 £58	200

Sum of money the trust would be reimbursed:	£677,710
The sum of money the trust would be reimbursed if BPT is met:	749,810
A difference of:	£72,100
Equivalent number of Band 6 HCP (£30,661 p/a):	2.352
Equivalent number of Band 7 HCP (36,613 p/a):	1.969



Increase in % of patients receiving all elements of COPD Discharge Bundle 2013/14 to 2019/20



Headline change in outcomes in KSS

2019/20

- There were **9,396** unscheduled hospital admissions with AECOPD
- COPD admissions accounted for **47,276 bed days**
- **3.5%** of patients admitted to hospital **with AECOPD died in that admission**
- **Reduced variation in 30 day readmission rate** (same cause)
  - Down from a difference of 8.3% to 4.9%

2014/15

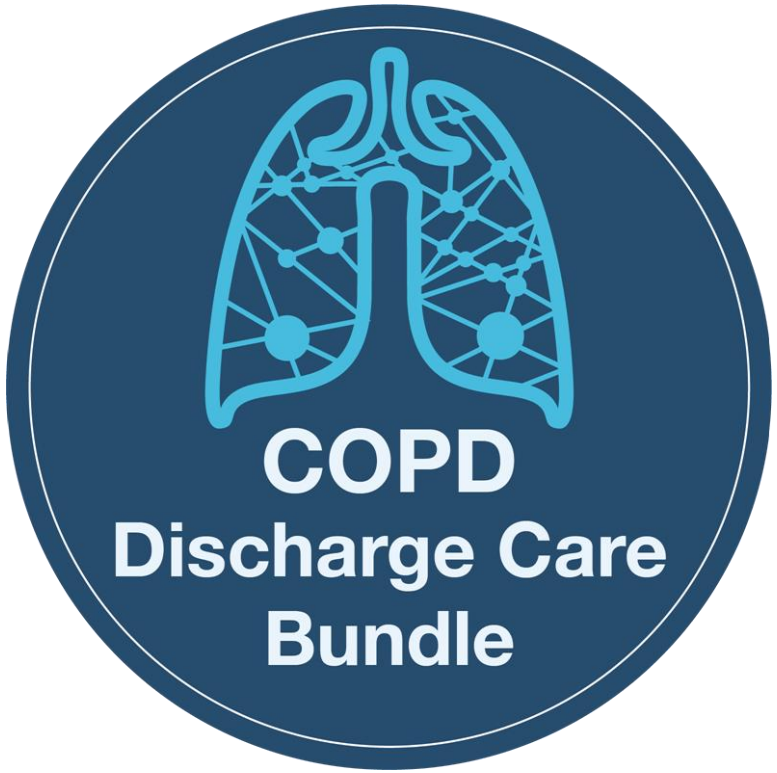
- There were **8,648** unscheduled hospital admissions with AECOPD
- COPD admissions accounted for **49,475 bed days**
- **4.9%** of patients admitted to hospital **with AECOPD died in that admission**
- **30 day readmission rate** (same cause): **8.3%**

Source: HES data

Adopt & Spread

- Commissioned as part of National Patient Safety Improvement Programme's Adopt & Spread workstream with KSS AHSN/PSC supporting nationally based on KSS Respiratory programme experience and learning.

- The aim of the Adopt and Spread Safety Improvement Programme (A&S-SIP) was to identify and support the adoption and spread of effective and safe evidence-based interventions and practice across England by March 2022.



Adoption and Spread: COPD Discharge Bundle

Welcome to the COPD Discharge Care Bundle Dashboard

As part of the National Patient Safety Improvement Programme's COPD Discharge Bundle adoption and spread work, this dashboard aims to support effective delivery of the COPD Discharge Care Bundle. Supporting improvement in the care of hospitalised COPD patients, reducing variation and ultimately improving patient safety and care on discharge. The dashboard provides insight into discharge bundle delivery and outcomes.

Overview

Respiratory disease has been identified as a clinical priority in the NHS Long Term Plan, with improving outcomes for respiratory disease and reducing variation featuring as distinct themes in the plan.

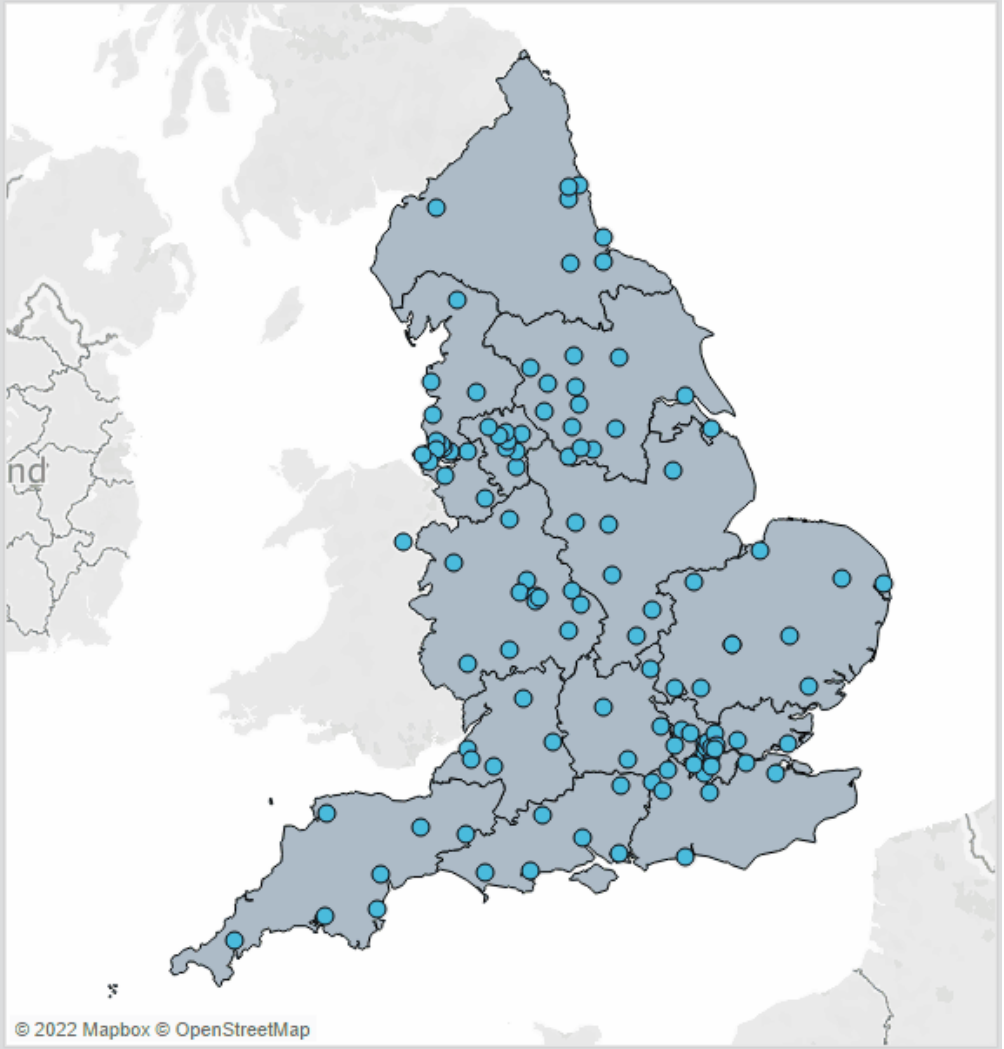
The British Thoracic Society (BTS) COPD Discharge Care Bundle describes high impact measures to ensure the best clinical outcomes for patients admitted with an acute exacerbation of COPD (AECOPD). The aim is to reduce the number of patients who are readmitted following discharge after an AECOPD and to ensure that all aspects of the patients COPD care is considered. Data on the COPD Discharge Bundle is collected as part of NACAP's continuous audit of admissions to hospital (spanning the entire patient care pathway for patients with asthma and COPD).

Get Started

You can begin navigating the dashboard using the ribbon and dropdown menu at the top of this window.

Contact Details

For all programme and data enquires, please contact KSSAHSN.Respiratory@nhs.net



Developed by

Kent Surrey Sussex Academic Health Science Network

In collaboration with

Patient Safety Collaborative

NHS Improvement

Royal College of Physicians | NACAP

Next Level

FeNO (Rapid Uptake Products)

Hinal Patel, Programme Manager, KSS AHSN

FeNO in Kent, Surrey and Sussex

- Improve patient care and outcomes by effectively diagnosing patients with suspected asthma
- Increase widespread access for patient & clinician access to FeNO testing in primary care

Mapping & Context

- 3 Respiratory Networks in KSS (1 per ICS)
- 105 PCNs across Kent, Surrey & Sussex
- Primary care contract team on Locally Commissioning Services
- Pathway Transformational Funding (PTF) applications 2021/22
- Successful & Unsuccessful PTF bids
- Identifying KSS sites with FeNO device but not testing
- Established KSS AHSN Respiratory Network
- 5-8% of prevalence rate of Asthma across KSS

FeNO in Kent, Surrey and Sussex

Engagement

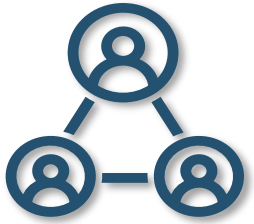
- Engaging and periodical update to Long term conditions leads in each ICS
- Working with Respiratory delivery network across KSS
- 1-2-1 presentations and engagement with PCN clinical directors
- Contacting clinical teams with unused devices

Support

- Guided & Project managed successful PTF sites **(2 sites)**
- Re-engaging with unsuccessful PTF sites **(all 3 sites now live)**
- Recent FeNO sites , with implementation and signposting to toolkit

Collaboration

- Collaboration with Wessex AHSN , and sharing learning with others via joint working group
- Device supplier relationships



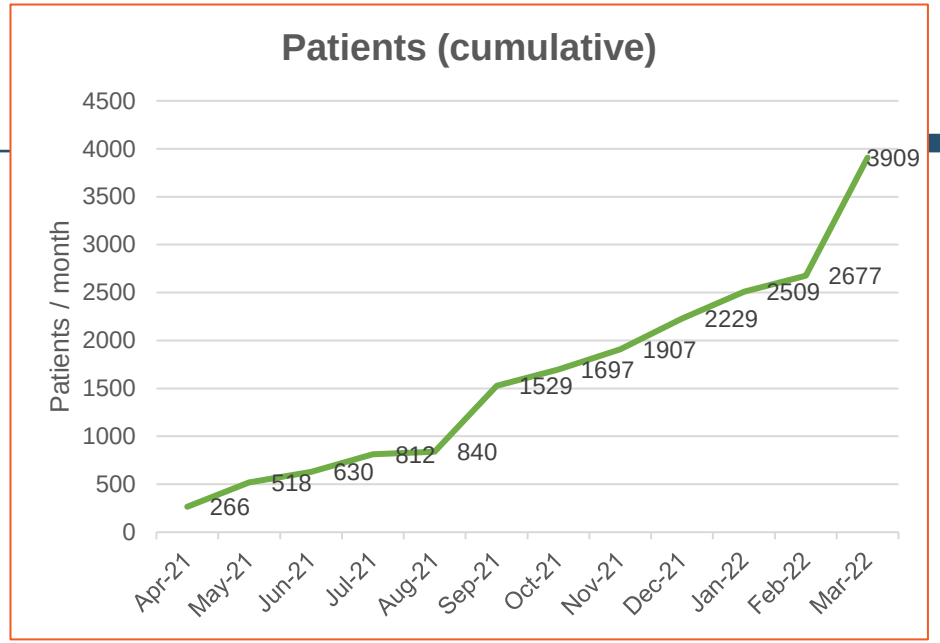
Showcase & On going Support

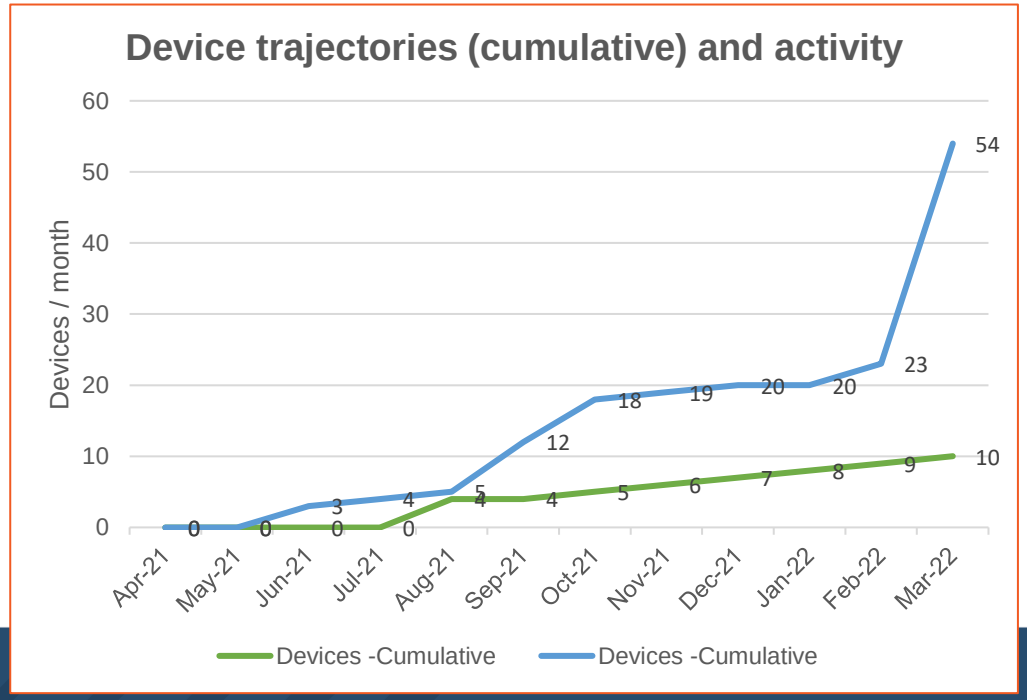
- Ongoing contact and update to primary care teams
- Showcasing the FeNO toolkit and resources;
- Workforce training provide by promoting eLearning modules on FeNO
- FeNO focussed KSS AHSN Respiratory Collaborative
- Actively contributing to national programme of learning via Wessex AHSN

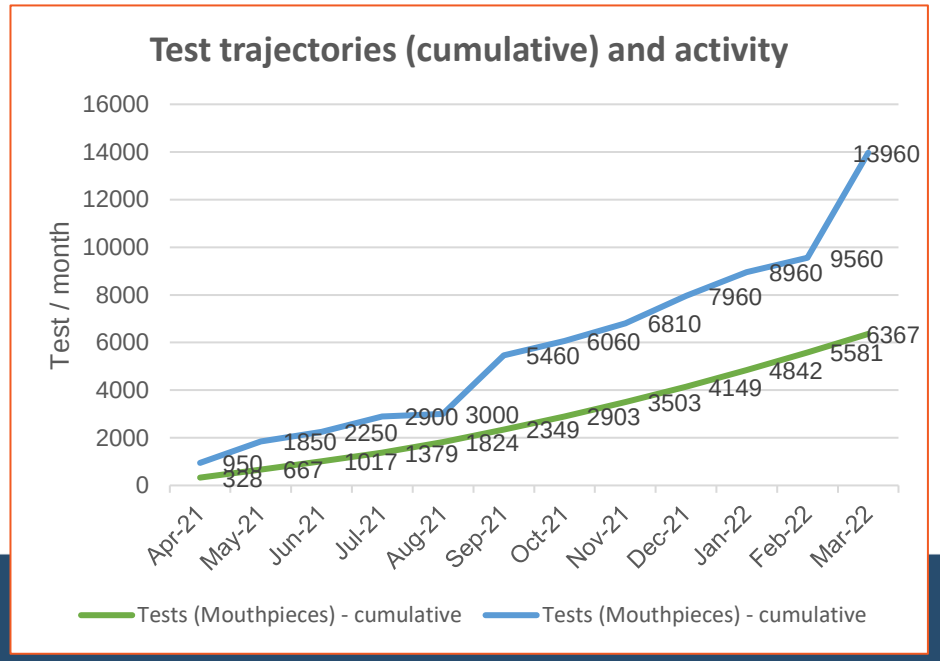
Delivery of FeNO in Year 1 (2021-22)

A practice nurse within our pilot sites emailed to say how much she loves the FeNO machine, saying that it is **extremely useful and helps back up treatment plans**. They have found so many patients already with high readings and then **appropriate ICS can be advised**. It has become a **very important part of patient reviews**

Su Ryan, AD for Scheduled Care FCHC

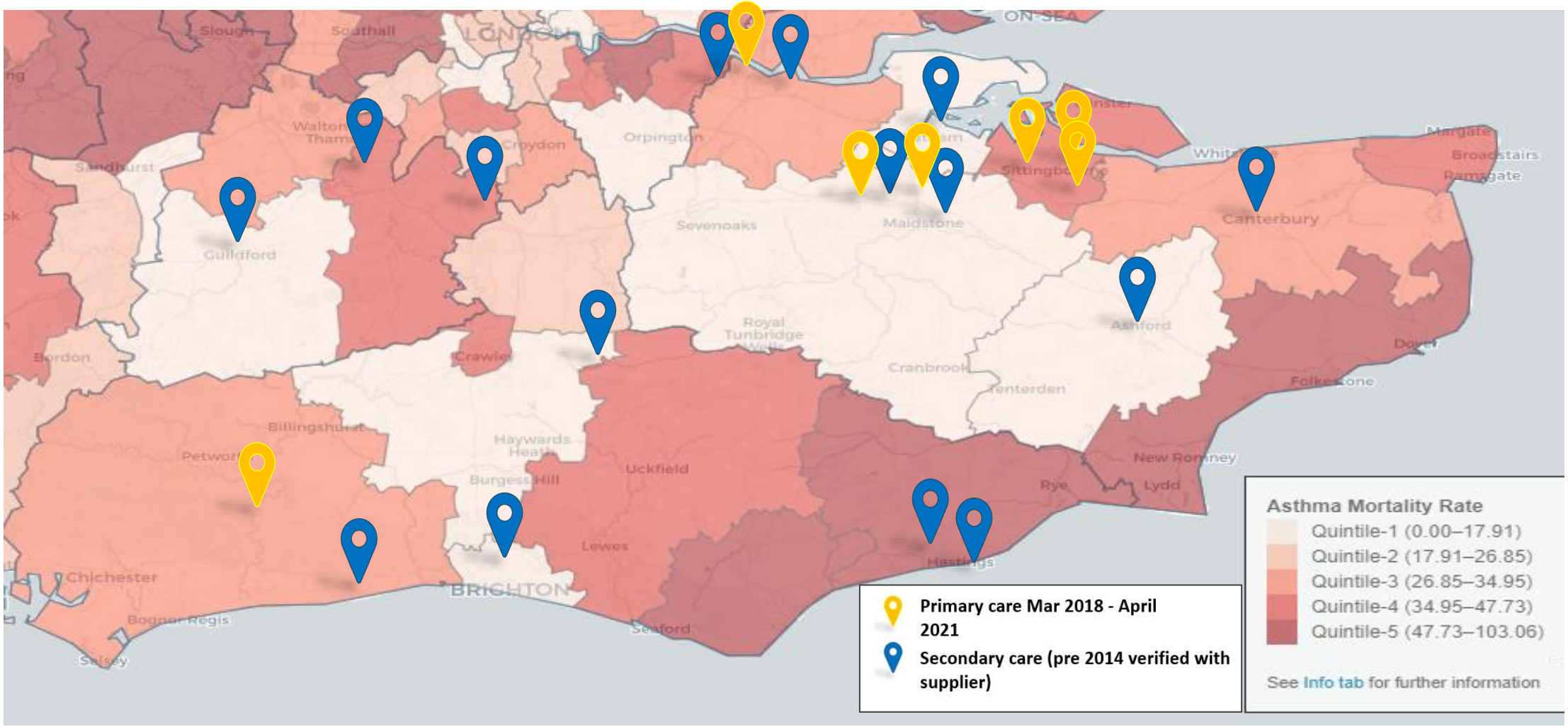






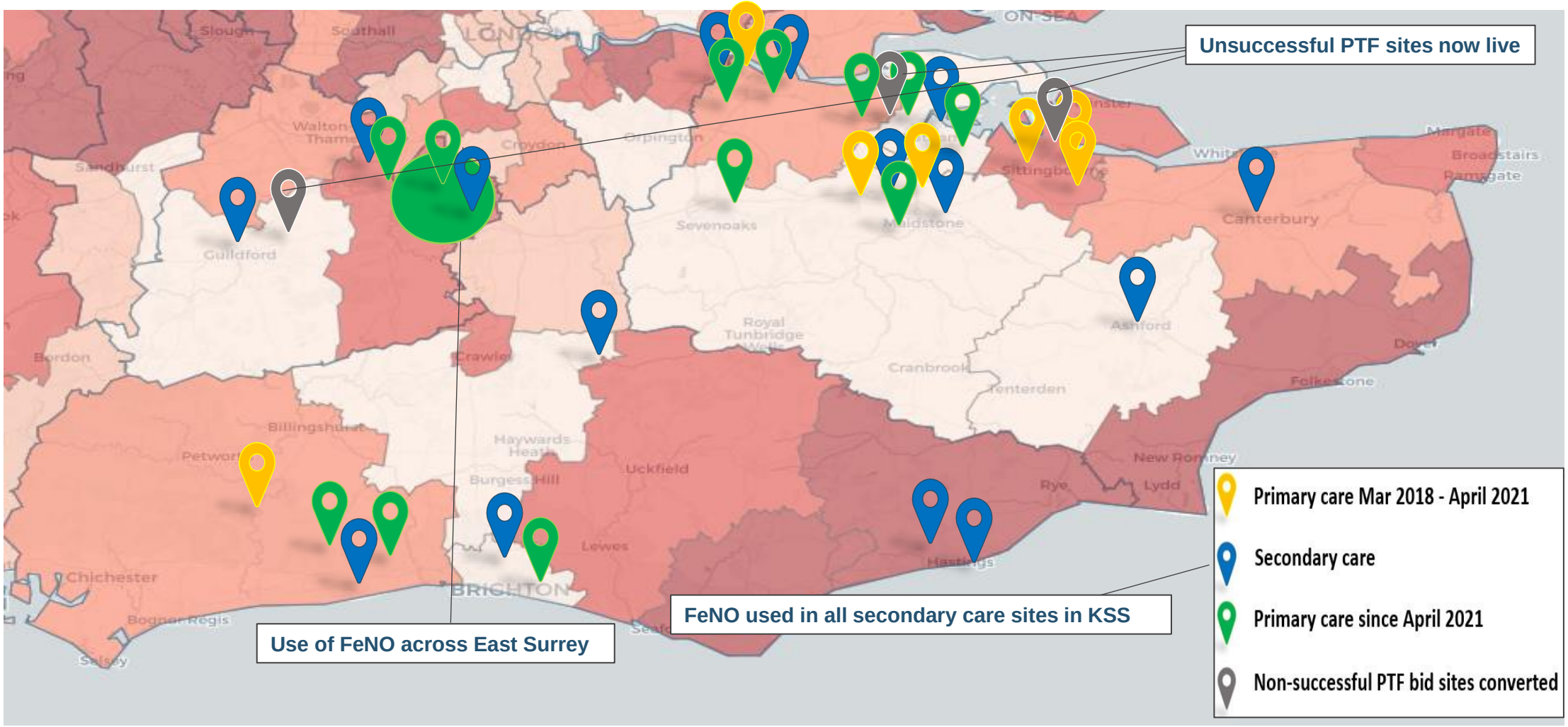
Data source Accelerated Access Collaborative (AAC) April '22

Use of FeNO prior to the programme

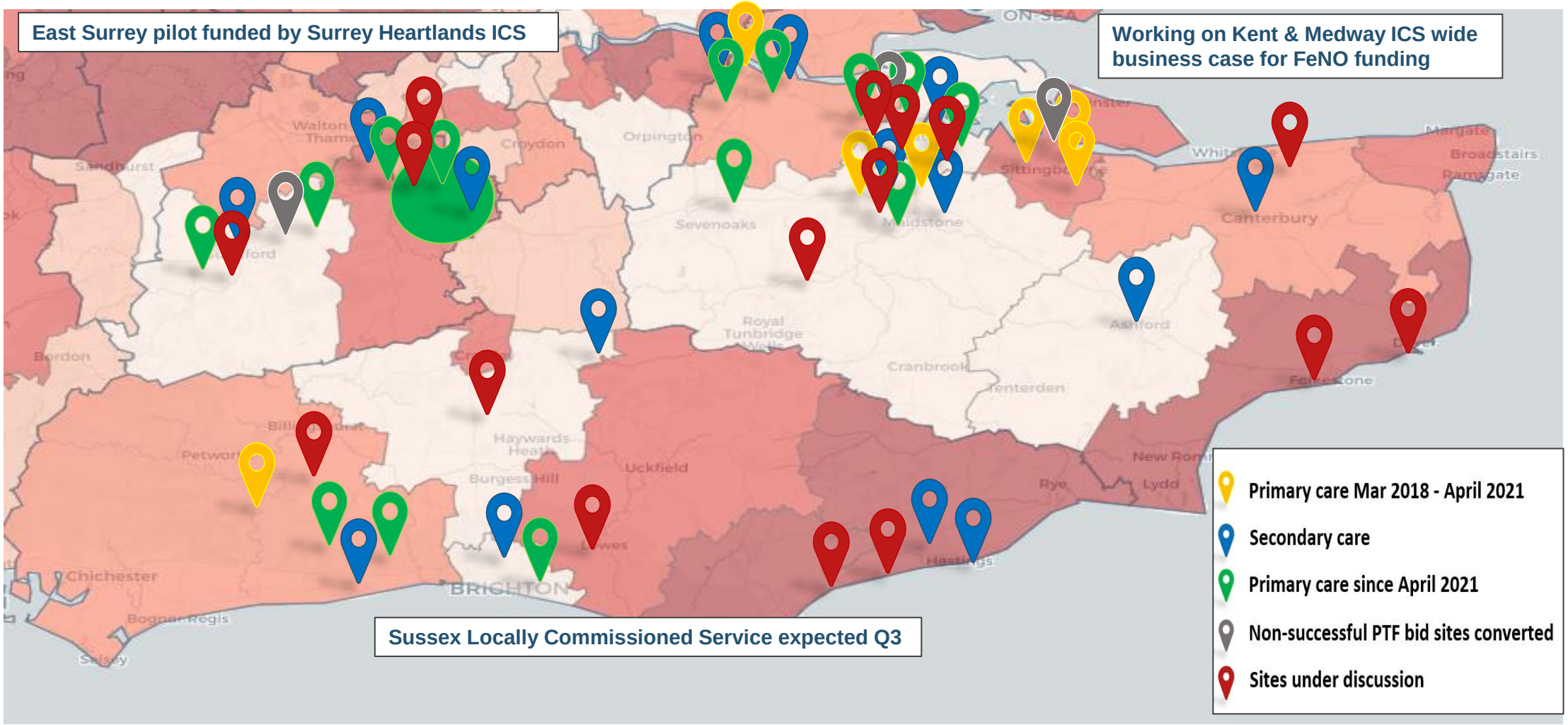


Reference : AZ Respiratory Outcomes heat maps , AAC data for device location (April ‘22)

Year 1 – Use of FeNO in KSS AHSN



Year 2 – Use of FeNO in KSS AHSN



Reference : AZ Respiratory Outcomes heat maps , AAC data for device location (April ‘22)

Next Level

2022 and onwards

How the KSS Respiratory Programme adapts moving forwards

Changing landscape:

- Emerging ICS Respiratory Networks
- Long Term Plan priorities

Strengths:

- Well connected across the KSS Respiratory Network
- Ability to deliver a user friendly data driven approach to inform quality improvement

Moving forwards:

- Sustainability and greener practice
- Health inequalities - pulmonary rehabilitation
- Continuing to support spread of best practice and innovation (e.g. Lung Health @ Home)
- Champion an integrated care approach

Next Level

Q&A