ACADEMIC HEALTH SCIENCE NETWORK
NORTH EAST AND NORTH CUMBRIA

NHS
North East Quality Observatory Service

AHSN Respiratory Programme
Intelligence for the North East & North Cumbria AHSN

Version 1.0 Final

December 2017

RESPIRATORY PROGRAMME
Ongoing monitoring report

Report content

This report has been developed by NEQOS in order to monitor and evaluate progress against the objectives of the AHSN Respiratory Programme.

This report covers the following activity:

> COPD prevalence
> QOF achievement for COPD and smoking indicators
> Hospital activity for COPD
> Deaths
> British Lung Foundation passport uptake

Also included:

Local respiratory interest group for COPD meeting evaluation (July '17)

Information relating to primary care management of COPD (analysis of work taking place within the North East and North Cumbria)

Findings from the National COPD Audit Programme are included for benchmarking where relevant.

Analysis notes

It has been necessary to abbreviate the names of some CCGs to shortened versions for formatting and presentation purposes.

For all QOF indicators included in this report the data includes excepted cases in the denominator as this is a better indication of the real clinical picture and will therefore not be the same as the published QOF achievement for each CCG.

The purpose of this report is to enable the AHSN to understand to what extent the initiatives in place are meeting the Programme objectives over time.

Summary

	Significantly Better		Similar		Significantly Worse

Values highlighted in GREEN and RED indicate when an area is statistically significantly better or worse than the England value for that particular indicator. AMBER indicates where an area's value is not significantly different to the England value.

Indicator	Time Period	Update Frequency	North East (& Cumbria) Value	National Average
Introduction				
The National COPD Audit Programme	2014/15	Ongoing		
Objective 1 - To reduce variation and improve standards of care for COPD				
1. COPD Recorded Prevalence	2016/17	Annual	2.8%	1.9%
2. Gap between expected & actual prevalence of COPD	2016/17	Annual	-0.06%	-0.53%
3. % of COPD patients with confirmation of diagnosis by post bronchodilator spirometry (COPD002)	2016/17	Annual	81.3%	81.0%
4. % of COPD patients who have had a review in the previous 12 months (COPD003)	2016/17	Annual	80.2%	80.1%
5. % of COPD patients with a record of FeV1 in the previous 12 months (COPD004)	2016/17	Annual	69.7%	72.4%
6. % of COPD patients with MRC dyspnoea grade ≥3 in latest 12 months, with a record of oxygen saturation in latest 12 months (COPD005)	2016/17	Annual	96.0%	95.6%
7. % of COPD patients with influenza immunisation in the preceding 1 September to 31 March (COPD007)	2016/17	Annual	79.1%	79.2%
8. % of patients with any or a combination of the following: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (SMOKE002)	2016/17	Annual	95.3%	94.5%
9. % of patients with any or a combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses, who smoke	2016/17	Annual	16.5%	15.1%
10. % of patients with any or a combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers with an offer of support and treatment within the preceding 12 months (SMOKE005)	2016/17	Annual	95.9%	95.2%
11. Other metrics relating to COPD				
12. Exception rate (%) for QOF COPD indicators	2016/17	Annual		
Objective 2 - To reduce demands on secondary care inpatient and outpatient activity for conditions related to COPD				
13. a. Emergency COPD admissions per 100 patients on disease register	Q1 2017/18	Quarterly	13.3	11.7
b. Emergency COPD admissions (short stay) per 100 patients on disease register	Q1 2017/18	Quarterly	4.4	3.7
14. a. Emergency readmissions (all) within 30 days of admission for COPD	2016/17	Quarterly	29.9%	27.5%
b. Emergency readmissions (for COPD) within 30 days of admission for COPD	2016/17	Quarterly	16.2%	14.2%
Objective 3 - To develop measures of the quality of care in health and social care for people with COPD				
15. Under 75 mortality rate from respiratory disease considered preventable in persons less than 75 years	2014-16	Annual	25.6	18.6
16. Rate of deaths from respiratory disease among people aged 65 years and over	2013-15	Annual	764.0	646.2
Objective 4 - To develop information for the public about the quality of care they receive for COPD				
17. British Lung Foundation passport	2017	Ongoing		
Objective 5 - To provide support at scale for implementation of improvement across the region through education				
18. Local respiratory interest group for COPD	2017	Ongoing		

The National COPD Audit Programme

The National COPD Audit Programme is a programme of work that aims to drive improvements in the quality of care and services provided for COPD patients in England and Wales and is commissioned by the Health Quality Improvement Partnership (HQIP). It comprises a number of audit workstreams, looking at COPD care across the patient pathway, and bringing together key elements from the primary, secondary and community care sectors.
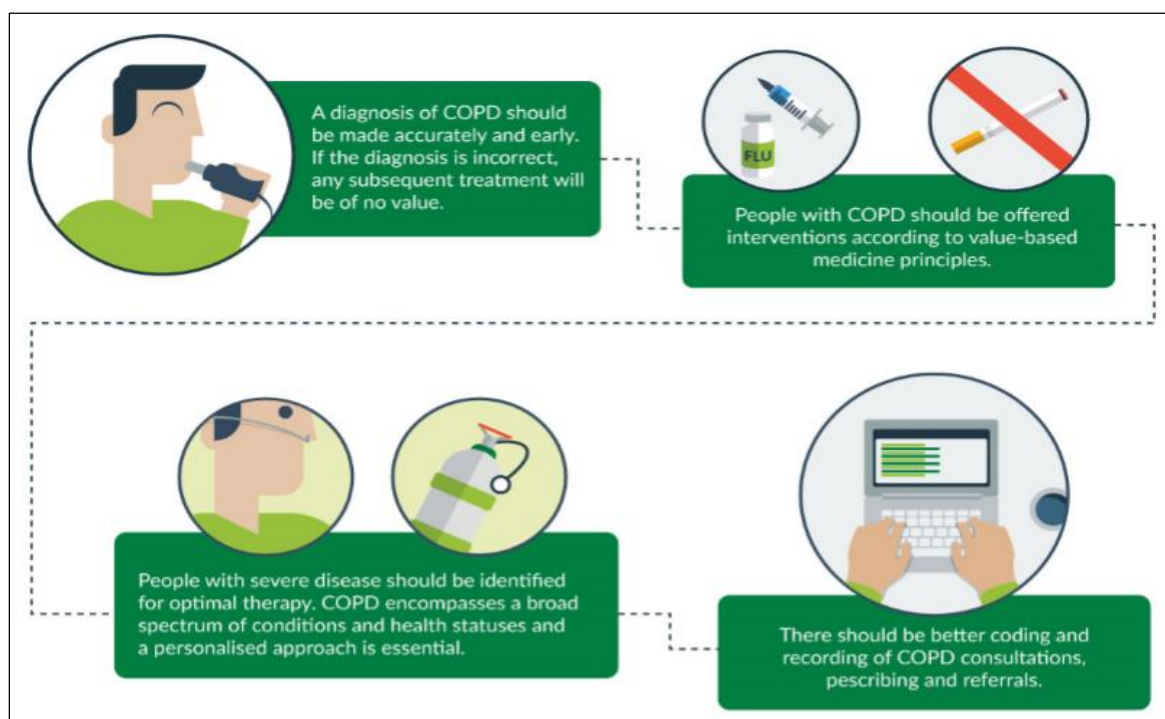
The aim is to increase the impact that clinical audit has on healthcare quality in England and Wales. Information on the programme can be found here:
 https://www.rcplondon.ac.uk/projects/national-copd-audit-programme

Previous national COPD audits concentrated on the acute management of COPD in secondary and tertiary care, but the current programme includes an audit of primary care. The primary care audit metrics were based on NICE Clinical Guidelines and Quality Standards and go beyond the data provided by publicly available sources. Limitations on data extraction from practices in England has resulted in only data from Wales being available however it is likely that these findings still have relevance to England.

A set of reports is available (*https://www.rcplondon.ac.uk/projects/national-copd-audit-programme-primary-care-workstream*) to support primary care clinicians who are working to deliver the standard of care for people with COPD.

The Primary care report for England 2014-15 makes the following recommendations and key findings from the primary care audit have been included throughout this report where relevant:
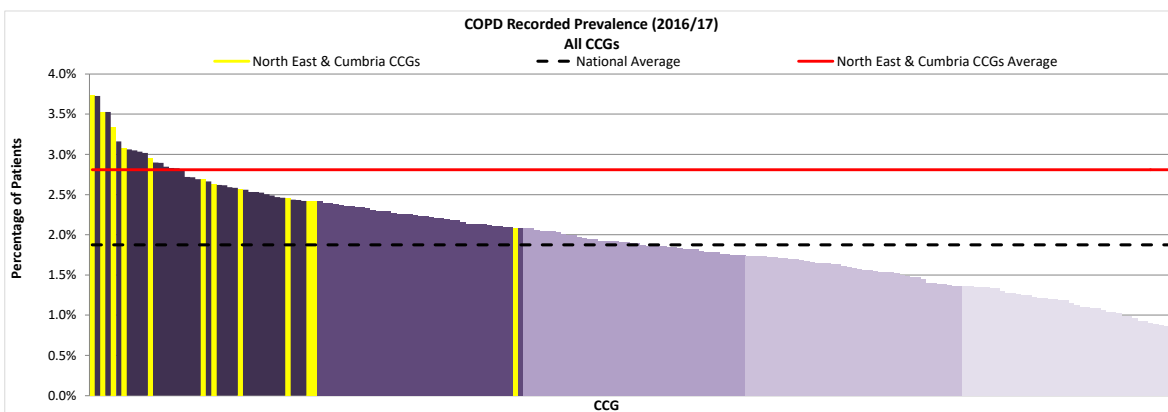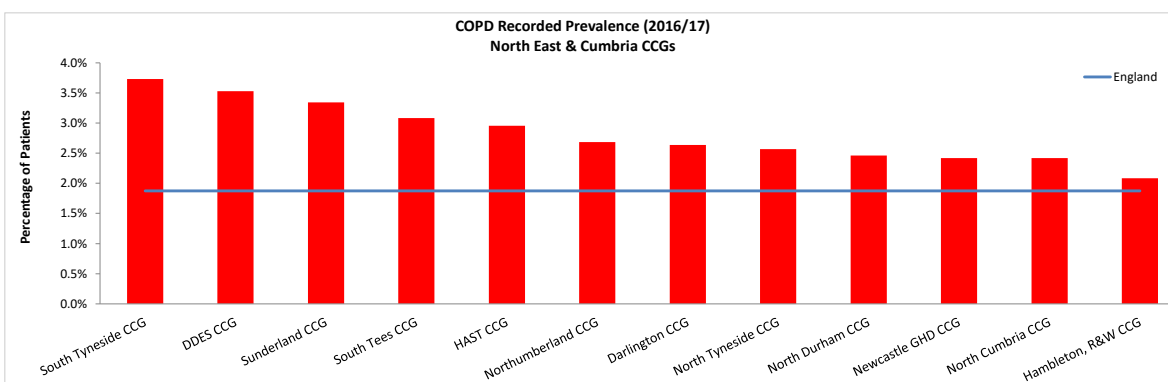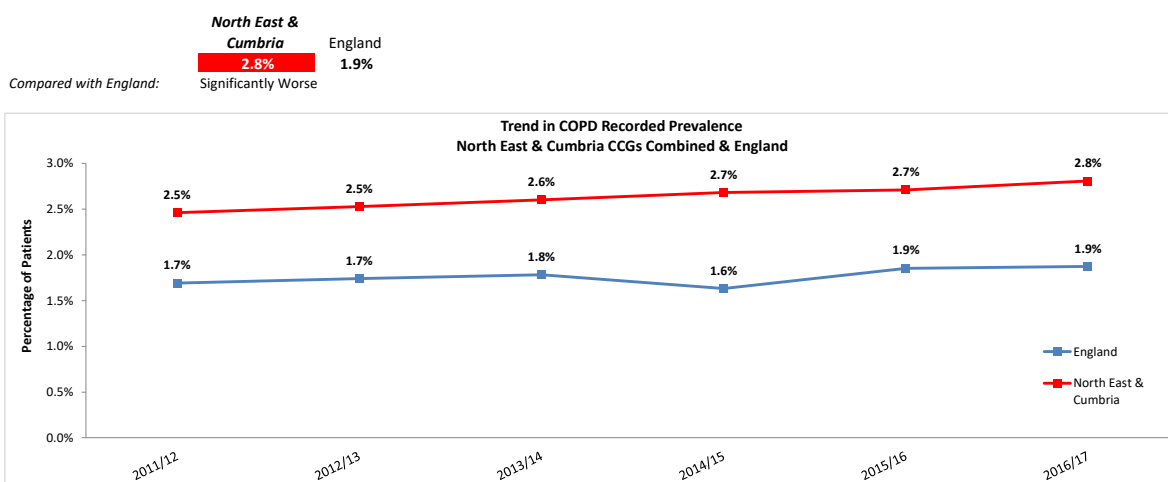

Source: https://www.rcplondon.ac.uk/projects/outputs/primary-care-copd-england-finding-measure-success

Objective 1 - To reduce variation and improve standards of care for COPD

Records

1. COPD Recorded Prevalence (2016/17)

The percentage of patients on the GP register who have COPD

North East & Cumbria	England
2.8%	**1.9%**

Compared with England: **Significantly Worse**

Trend in COPD Recorded Prevalence
North East & Cumbria CCGs Combined & England

COPD Recorded Prevalence (2016/17)
North East & Cumbria CCGs

COPD Recorded Prevalence (2016/17)
All CCGs

Data source: Quality and Outcomes Framework (QOF), NHS Digital (http://content.digital.nhs.uk/gof). © NHS Digital. QOF is licensed under the Open Government Licence v3.0 except where otherwise stated.

Definitions / Notes

The QOF is a component of GP practice contracts. Although voluntary, most practices in England participate in the QOF, therefore coverage is virtually 100 per cent. QOF information is collected in order to calculate QOF payments to GP practices as part of contracts. Information from QOF is published annually.

The boundary of Cumbria CCG changed in April 2017, and North Cumbria CCG was created, which covers Allerdale, Carlisle, Copeland and Eden, with Morecambe Bay CCG covering north Lancashire, and South Lakes and Furness in south Cumbria. The 2016/17 QOF data has been reported by NHS Digital based on these new organisations and their boundaries.

Expected outcome

COPD registers to improve through validation (although improvement may be difficult to measure).

What is the data telling us?

The COPD prevalence for CCGs in the North East and North Cumbria (NE&NC) is higher than the England level and is increasing slowly over time. For the NE&NC area the CCG level COPD prevalence ranges from 2.1% to 3.7% and the quintile chart shows the relative position of each NE&NC CCG compared to all CCGs in England.
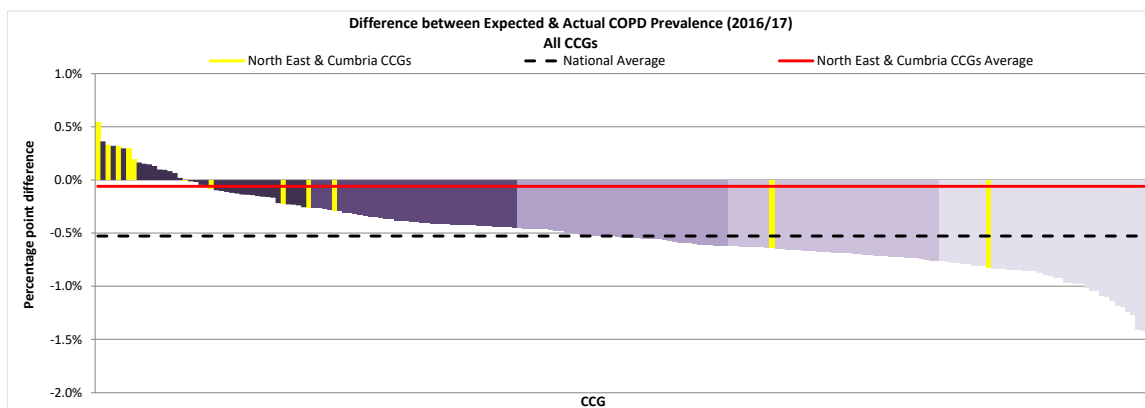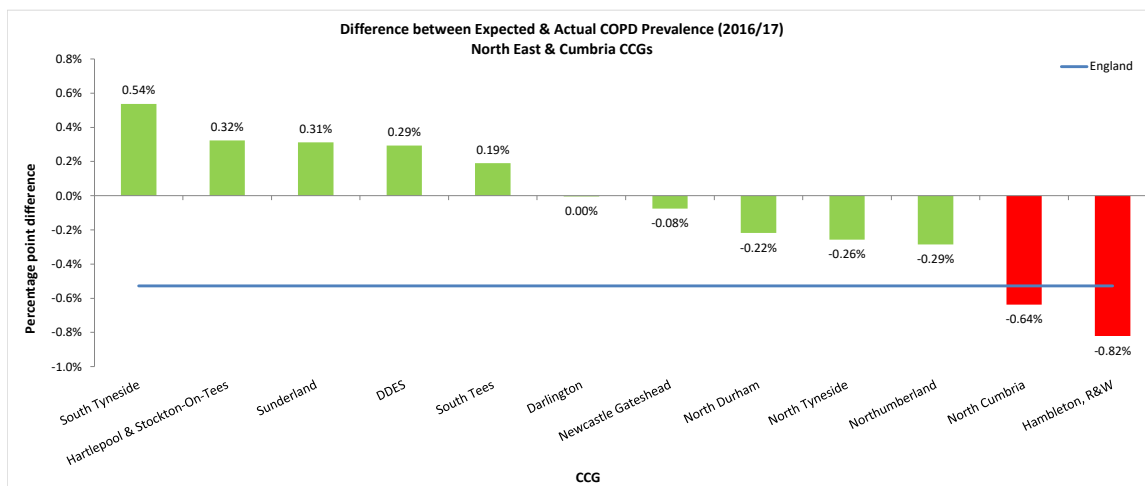
Additional analysis to include:

Practice level data is available and can be presented using SPC charts.

Objective 1 - To reduce variation and improve standards of care for COPD

Records

2. Gap between expected & recorded prevalence of COPD (2016/17)

The percentage point difference between the expected COPD prevalence and the actual COPD prevalence.

	North East & Cumbria	England
	-0.06%	-0.53%
Compared with England:	Significantly Better	

Difference between Expected & Actual COPD Prevalence (2016/17)
North East & Cumbria CCGs

Difference between Expected & Actual COPD Prevalence (2016/17)
All CCGs

Data sources: Quality and Outcomes Framework (QOF), NHS Digital (http://content.digital.nhs.uk/qof). © NHS Digital. QOF is licensed under the Open Government Licence v3.0 except where otherwise stated.
COPD prevalence estimates (2015) from Public Health England (https://fingertips.phe.org.uk/profile/prevalence).

Definitions / Notes

Prevalence models provide estimates of underlying prevalence derived from population statistics and scientific research on the risk factors for each disease and can help commissioners to assess the true needs of their community, calculate the level of services needed and invest the appropriate level of resources for prevention, early detection, treatment and care.

The models can also be used to support case-finding by identifying those areas where detection rates are low and targeting enhanced diagnostic activity on them.

Negative bars indicate that there may be more cases to find as the CCG **expected** prevalence is **higher** than the actual prevalence.

Positive bars show that the disease register is larger than expected and the CCG **expected** prevalence is **lower** than the actual prevalence.

Red bars indicate that the CCG has a significantly higher difference between expected and actual than the England rate.

Expected outcome

COPD observed / actual rates to move towards expected rates and reduce the gap as registers become more accurate. This could mean an increase or a decrease in the existing register size.

What is the data telling us?

For England overall, the expected prevalence of COPD is 0.53 percentage points greater than the actual prevalence and for the NE&C overall this is only 0.06 percentage points, but there is variation across the CCGs.

There are six CCGs in the NE&C where the actual prevalence is lower than expected levels (two of these have a percentage point difference that is significantly higher than England) and this relates to a potential 'missing' 10,000 patients, but there are also five CCGs in NE&C with higher actual COPD prevalence than expected levels, where almost 5,000 more patients may be on registers than expected, assuming that the prevalence models are correct.

The quintile chart shows the relative position of each CCG in England for this measure, with the percentage point difference for NE&C CCGs ranging from +0.54 to -0.82 between the actual and expected prevalence. This chart indicates that there are a large number of CCGs where the COPD register is lower than expected. South Tyneside CCG has actual COPD prevalence which is 0.54 percentage points higher than the expected prevalence of 3.2%, whereas Hambleton, Richmondshire and Whitby CCG has an expected prevalence of 2.91% but actual of only 2.09% (0.82 percentage points lower).

Findings from the National COPD Audit programme *(https://www.rcplondon.ac.uk/projects/outputs/primary-care-copd-england-finding-measure-success)* demonstrate that system leaders should look for unwarranted variation in expected and observed prevalence of COPD at practice and CCG level.
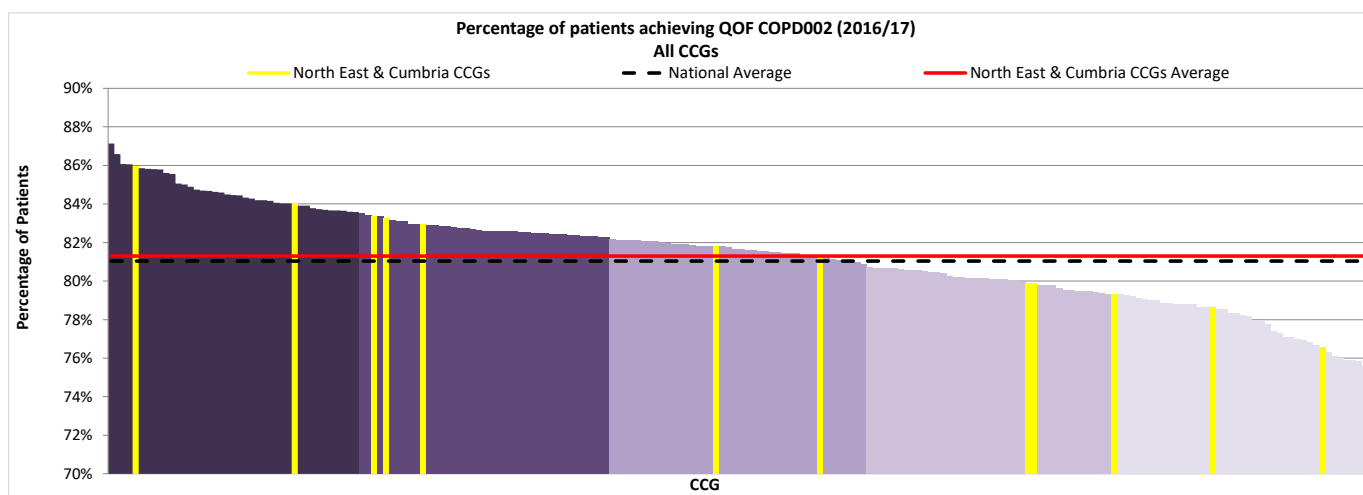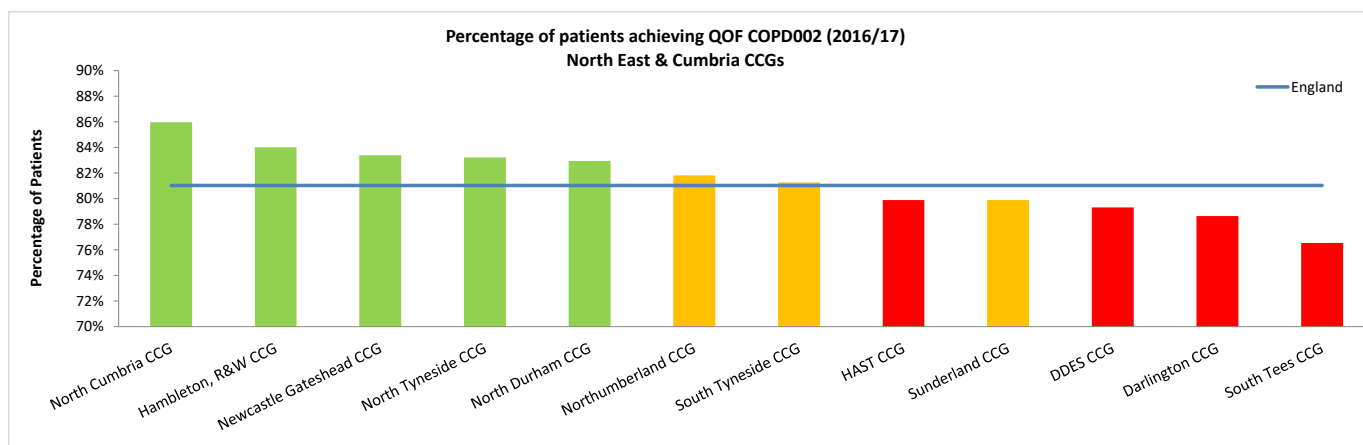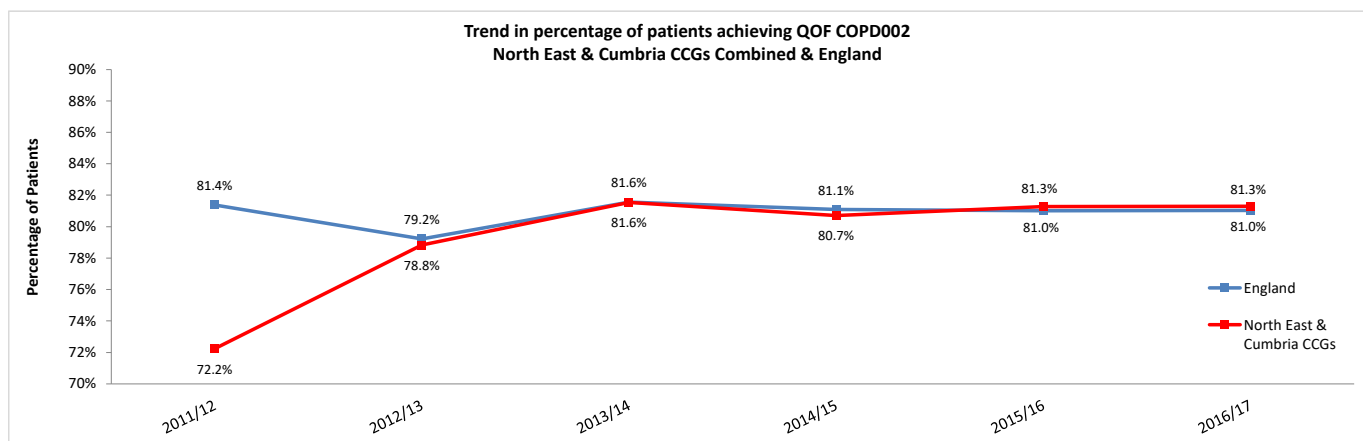
Objective 1 - To reduce variation and improve standards of care for COPD

Initial diagnosis

3. Percentage of patients achieving QOF COPD002 (2016/17)

COPD002: The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register

	North East & Cumbria CCGs	England
	81.3%	**81.0%**
Compared with England:	Similar	

Trend in percentage of patients achieving QOF COPD002
North East & Cumbria CCGs Combined & England

Percentage of patients achieving QOF COPD002 (2016/17)
North East & Cumbria CCGs

Percentage of patients achieving QOF COPD002 (2016/17)
All CCGs

Definitions / Notes
A diagnosis of COPD relies on clinical judgement based on a combination of history, physical examination and confirmation of the presence of airflow obstruction using spirometry. The data presented here includes excepted cases in the denominator.

Expected outcome
Report improvement in achievement at CCG / practice level.

What is the data telling us?
Achievement of this indicator in NE&C has improved from 72.2% to 81.3% over the last six years and has been similar to the England level for the latest five years. At CCG level the achievement ranges from 86.0% to 76.5% with four CCGs having achievement which is significantly lower than the England level.

Findings from the Primary Care COPD audit
1. Wales (2014/15) slidepack
Source: Primary care audit - quality improvement slide set (https://www.rcplondon.ac.uk/projects/outputs/primary-care-time-take-breath)
Key results: diagnosis
    Approximately 4 in 5 (80.3%) patients did not have the correct test (post-bronchodilator FEV1/FVC) performed/recorded.
    Where the right test was recorded, it **was not** consistent with COPD (ratio of 0.2-0.7) in around 1 in 4 (26.9%) of cases.

Diagnosis: better measures - codes and templates
    Could low number of FEV1/FVC recorded be due to coding issues?
    Analysis of a further 10 additional Read codes suggested this may be the case (results went from 14.4% to 58%).
Suggestion:
    Use Read code *339m* (FEC1/FVC ratio) as diagnostic code.
    Use a value <1.0 (i.e. 0.68 rather than 68%)
    If it's not <0.7 its probably not COPD.

Diagnosis: Quality improvement (PDSA)
    Plan: Investigate the % of patients at your practice who have had a post-bronchodilator FEV1/FVC result recorded
    Do: Make changes based on your findings: implement a template, ensure Read code *339m* is used
    Study: Plot the change over time
    Act: Identify gaps in your improvement & speak to those who can help

2. COPD in England report
Source: National COPD Audit Programme: Primary care report for England 2014-15 (p16-17) (https://www.rcplondon.ac.uk/projects/outputs/primary-care-copd-england-finding-measure-success)
Key findings: Accurate and early diagnosis
Data from QOF (England) show that spirometry was used to confirm the diagnosis of COPD in approximately 90% of people with COPD (of those not exception reported). Spirometry was used to confirm diagnosis in a similar proportion of patients in the Welsh QOF data (90.4%), however, data extracted directly from GP practices was less reassuring.

These data show that **only 19.7%** of people on the COPD register (Wales) had an electronic record of post-bronchodilator FEV1/FVC ratio. Where people had this test recorded, 26.9% had a value that <u>was not </u>consistent with COPD.

In summary the data extraction from Wales provided **confidence in the quality of COPD diagnosis for only 14.4% of people on the COPD register**.

Findings from a local audit of spirometry services
Spirometry is an essential investigation for diagnosis and severity assessment in people with COPD and other respiratory conditions.
A qualitative audit of spirometry services was undertaken to determine whether routine spirometry performed on respiratory patients in primary care achieved nationally recommended standards (Association of Respiratory Technology and Physiology, ARTP).

The key steps in performing spirometry include:
(https://www.pcc-cic.org.uk/sites/default/files/articles/attachments/spirometry_e-guide_1-5-13_0.pdf)
1. **Reason for testing and type of test performed** - prior specification of the type of test is required (pre-test advice depends on the purpose of the spirometry) and reason for the test should be documented.
2. **Test performance** (calibration and reproducibility) - calibration should be verified prior to each clinic / session or after every 10th patient, and reproducibility criteria are met when there is no more than 100ml (150ml max) difference between each blow, with 3 blows performed.
3. **Interpretation of results** - should consider whether spirometry was reproducible, FEV1/Vital Capacity(VC) ratio should be used if VC is greater than FVC, and diagnosis data should be provided for interpretation.

Local audit findings concluded that routine spirometry performed on respiratory patients in primary care does not achieve nationally recommended standards and recommendations include:

- the need to provide appropriate training and assessment of competency for those who perform and / or interpret spirometry,

- the requirement for a standard infection prevention and control policy across practices,

- standardisation in maintenance and calibration policies.

Objective 1 - To reduce variation and improve standards of care for COPD

Ongoing management
4. Percentage of patients achieving QOF COPD003 (2016/17)

COPD003: The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months

	North East & Cumbria CCGs	England
	80.2%	**80.1%**
Compared with England:	Similar	

Trend in percentage of patients achieving QOF COPD003
North East & Cumbria CCGs Combined & England

Percentage of patients achieving QOF COPD003 (2016/17)
North East & Cumbria CCGs

Percentage of patients achieving QOF COPD003 (2016/17)
All CCGs
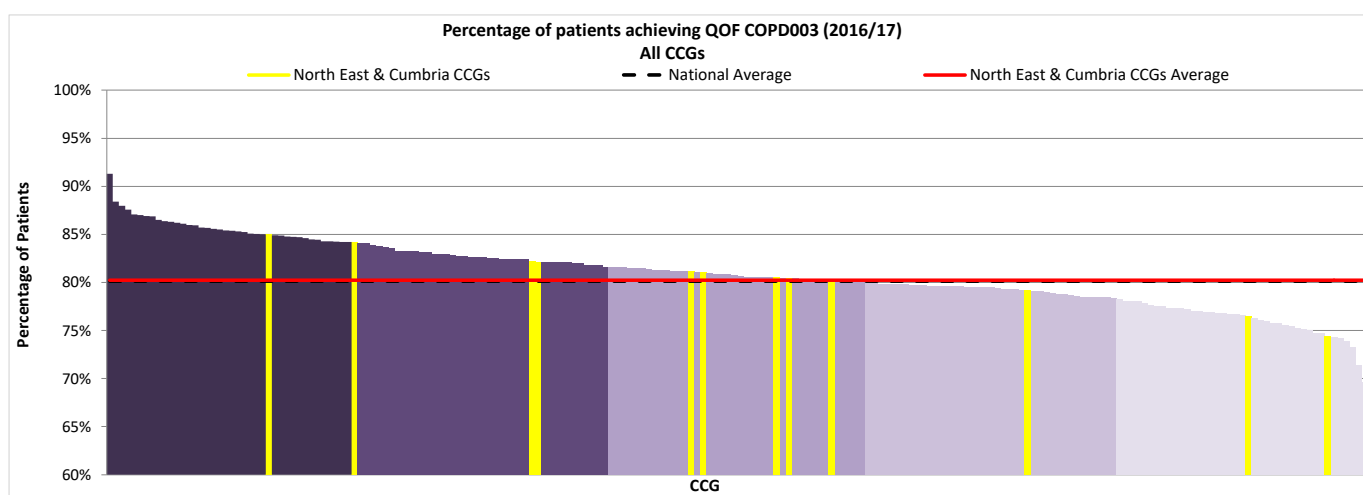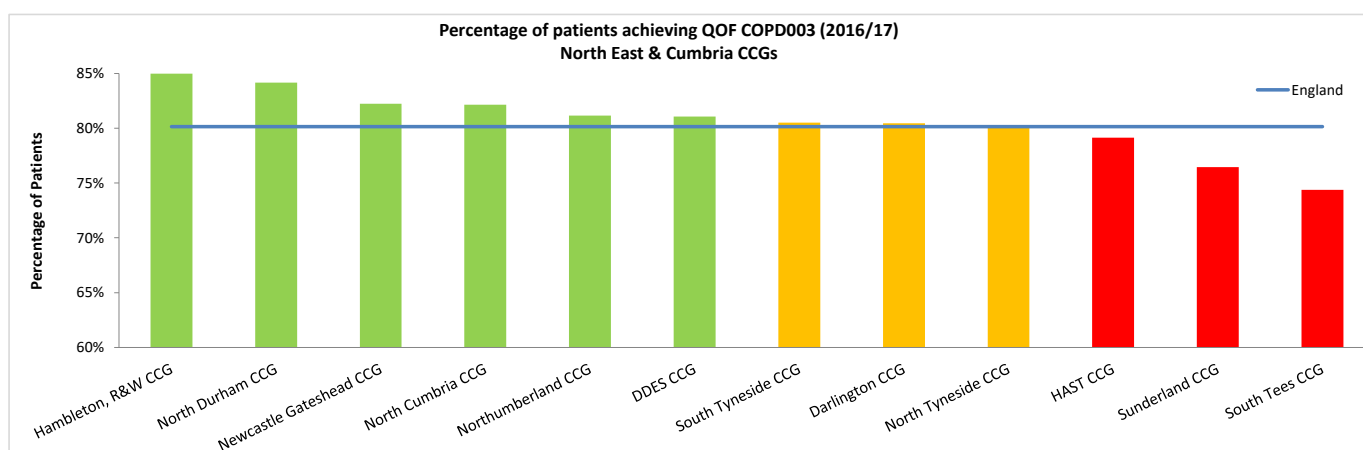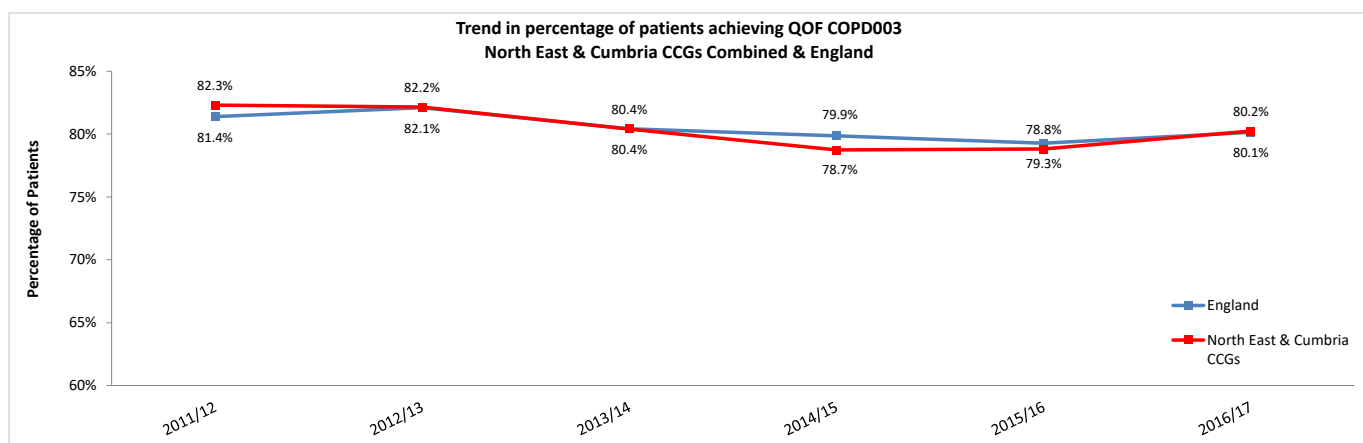
Definitions / Notes

COPD is increasingly recognised as a treatable disease with large improvements in symptoms, health status, exacerbation rates and even mortality if managed appropriately. Appropriate management is based on NICE clinical guideline CG101 (*https://www.nice.org.uk/Guidance/CG101*) and international GOLD guidelines in terms of both drug and non-drug therapy.

For all QOF indicators included in this report the data includes excepted cases in the denominator as this is a better indication of the real clinical picture and will therefore not be the same as the published QOF achievement for each CCG.

Expected outcome

Report improvement in achievement at CCG / practice level.

What is the data telling us?

Achievement of this indicator in NE&C has reduced from 82.3% to 80.2% over the last six years and the achievement level for England is currently 80.1%. At CCG level the achievement ranges from 85.0% to 74.4% with three CCGs having achievement which is significantly below the England level.

Findings from the Primary Care COPD audit

1. Wales (2014/15) slidepack

Source: Primary care audit - quality improvement slide set (https://www.rcplondon.ac.uk/projects/outputs/primary-care-time-take-breath)

Key results: optimal therapy

Identify those closer to death or admission to help them live well at home: the DOSE score

Breathlessness (**D**yspnoea) - % of people with an MRC scale of 1-5 within the last year	58.2%
Obstruction - % of people with COPD with any spirometry test code within the last year	50.1%
Smoking - % of people with COPD with a smoking status recorded within the last year	71.7%
Exacerbations - % of people with COPD with at least 1 exacerbation recorded within the last year	10.8%

Know your population - GOLD (*http://goldcopd.org/*)

GOLD classifies people with COPD by degree of breathlessness, number of exacerbations in the last year and airflow limitation.

Extracted data suggest only **21%** of people have data recorded that would allow a prescriber to follow this guideline.

Annual recording of all 3 metrics is key to providing individualised therapeutic plans.

Exacerbations: better measures - codes and templates

Use *H3122: Acute exacerbation of chronic obstructive airways disease* to record each acute event

Use *66Yf: Number of COPD exacerbations in past year* once per year when counting up the events (exacerbations)
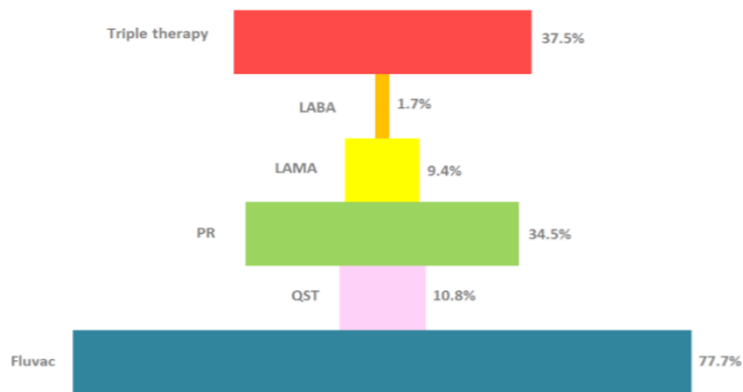
High value interventions in COPD

- The value pyramid for COPD interventions. This pyramid is based on cost-effectiveness.

http://thorax.bmj.com/content/thoraxjnl/69/11/973/F1.large.jpg
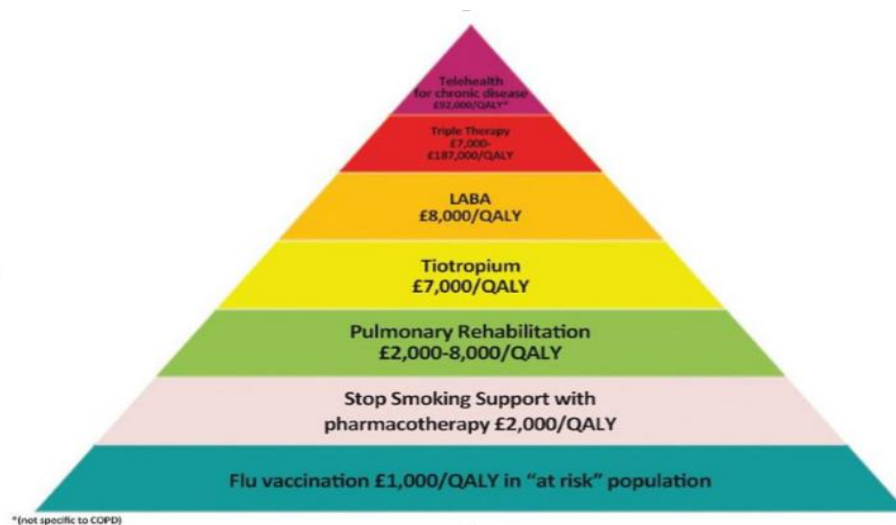
Value pyramid representing those receiving value-based interventions for COPD in Wales (2014/15)

High value interventions: Quality improvement (PDSA)
    Plan: Investigate the % of patients at your practice who have had all elements of the DOSE score recorded in the last year
    Do: Agree codes and alerts within a template to ensure this is recorded
    Study: Has the rate improved?
    Act: Which element is recorded less? What needs to happen next?

2. COPD in England report

Source: National COPD Audit Programme: Primary care report for England 2014-15 (p20-21) (https://www.rcplondon.ac.uk/projects/outputs/primary-care-copd-england-finding-measure-success)

Key findings: Annual review and severity assessment

The England QOF data shows that 10.2% of people with COPD were exception reported for review (QOF 2014/15), and a further 11.1% did not get a review despite being 'eligible'. There is no further data from England regarding the essential items of a review, such as assessment of breathlessness, tobacco dependency and exacerbation frequency.

The Welsh GP extracted data shows:
        Current smoking status was recorded for 71.7% of people with COPD (2014/15)
        An MRC grade was recorded for 58.2% of people with COPD (2014/15)
        10.8% of people with COPD had at least one exacerbation in the 2014/15 period.

Findings from a local audit of COPD and its management in primary care

In 2014-15 a local audit was undertaken of the care given to COPD patients, aiming to assess the management of these patients as measured against recommendations from NICE guidance. A key conclusion drawn from Phase 1 of this work was that there was wide variation in the coding and recording of COPD reviews and management and as part of the agreed plan of actions arising from these findings, a standardised COPD Annual Review template was developed and shared with practices for implementation within their clinical systems.

To determine the impact of this template, two data extractions took place, the first was prior to implementation of the template and the second was post implementation. Key findings relating to this QOF indicator are described below:

- MRC breathlessness scale recording

There was a net increase in coding of the MRC Breathlessness Scale across all practices, with an additional 125 COPD patients (2.9% increase) having the relevant codes added in the latest 12 months. Recording of this measure was already relatively high in the baseline period, at 68.1% of patients. The total increase in data recording for the MRC Breathlessness Scale based solely on those practices who have improved on the baseline position is 234 COPD patients.

- Exacerbation recording

There was a net increase in coding of exacerbations across all practices, with an additional 294 COPD patients (11% increase) having the relevant codes added in the latest 12 months. The total increase in data recording for exacerbations based solely on those practices who have improved on the baseline position is 510 COPD patients.

Based on analysis of the audit findings, the following statements have been made:

- Exacerbation management: In order to reduce unnecessary hospital admissions it is essential to identify those patients who experience frequent exacerbations. Practice staff are being encouraged to evaluate the number of exacerbation events in partnership with the patient at review.

- Inhaler technique training for patients: Most patients believe that they are able to use their inhaler device correctly, however multiple studies confirm that this is not the case. In COPD, guideline medication may cost up to £100 per patient per month, this represents a significant sum of money wasted on ineffective inhaler technique.
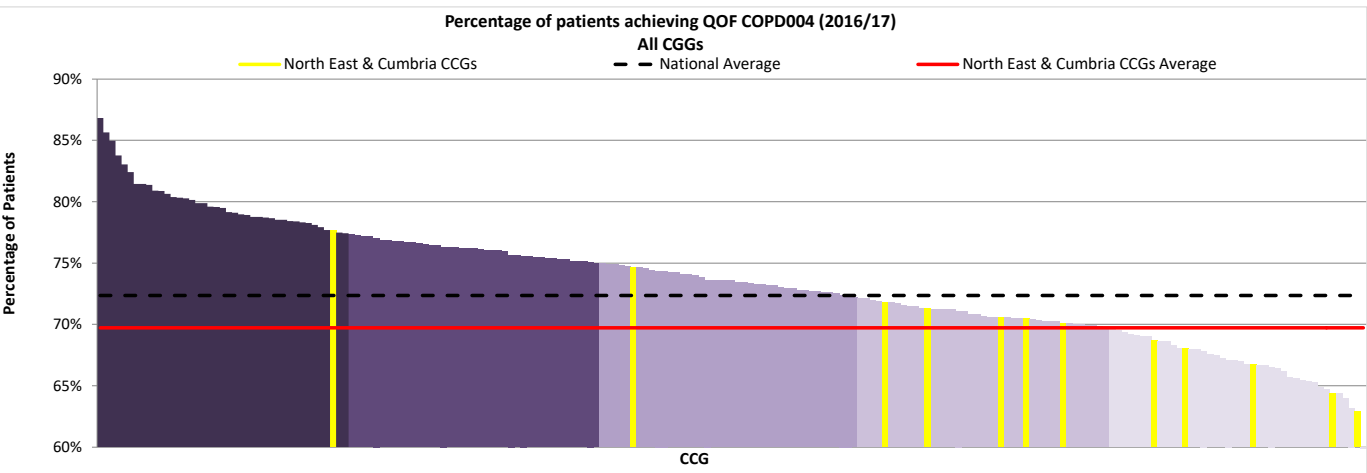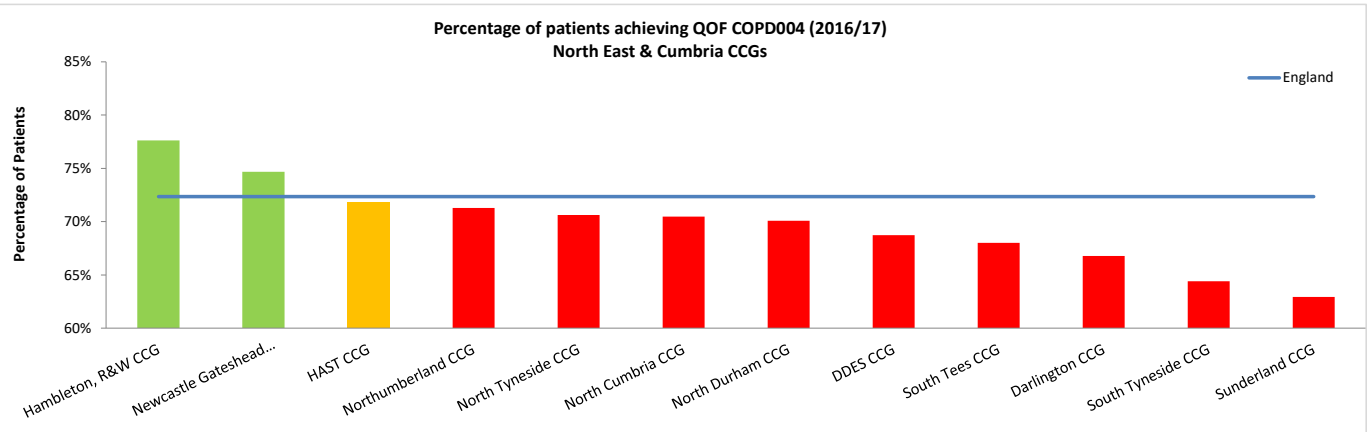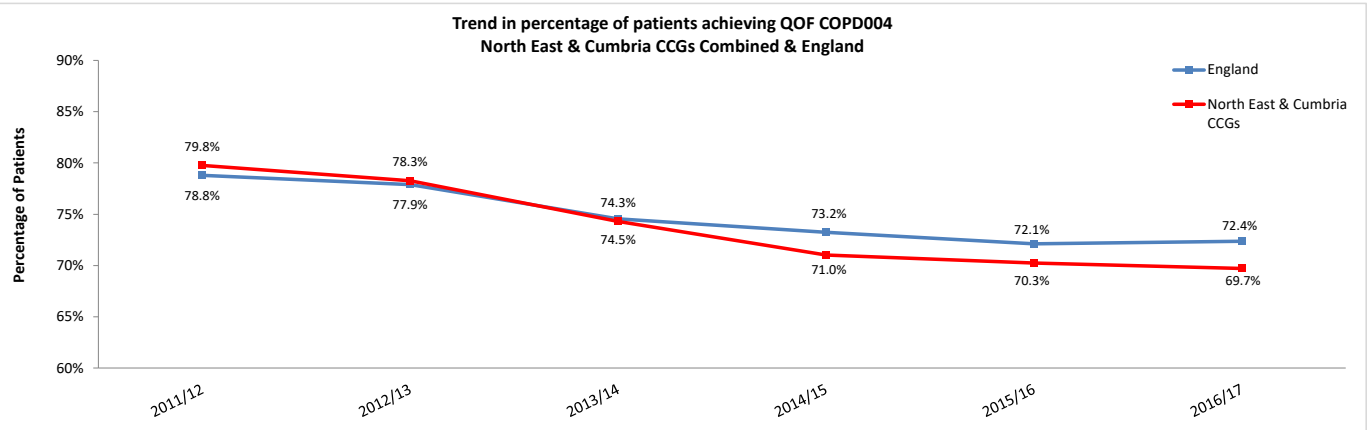
Objective 1 - To reduce variation and improve standards of care for COPD

Ongoing management

5. Percentage of patients achieving QOF COPD004 (2016/17)

COPD004: The percentage of patients with COPD with a record of FEV1 in the preceding 12 months

North East & Cumbria CCGs	England
69.7%	**72.4%**

Compared with England: **Significantly Worse**

Trend in percentage of patients achieving QOF COPD004
North East & Cumbria CCGs Combined & England

Percentage of patients achieving QOF COPD004 (2016/17)
North East & Cumbria CCGs

Percentage of patients achieving QOF COPD004 (2016/17)
All CGGs

Definitions / Notes
There is a gradual deterioration in lung function in patients with COPD. This deterioration accelerates with the passage of time. There are important interventions which can improve quality of life in patients with severe COPD. It is therefore important to monitor respiratory function in order to identify patients who might benefit from additional investigations or interventions. The data presented here includes excepted cases in the denominator.

Expected outcome
Report improvement in achievement at CCG / practice level.

What is the data telling us?
Achievement of this indicator in NE&C has decreased from 79.8% to 69.7% over the last six years and is currently lower than the England rate of 72.4%. At CCG level the achievement ranges from 77.6% to 62.9% with nine CCGs having achievement which is significantly lower than the England average.

Findings from the Primary Care COPD audit
1. Wales (2014/15) slidepack
Source: Primary care audit - quality improvement slide set (https://www.rcplondon.ac.uk/projects/outputs/primary-care-time-take-breath)
Coding and data recording (QOF versus audit findings)
Differences have been found between QOF figures (excepted patients have been removed from the denominator) and the findings from the audit.
QOF: the % of patients with COPD in whom the diagnosis has been confirmed by post-bronchodilator spirometry **= 90.4%**
Audit: the % of people with COPD with a post-bronchodilator FEV1/FVC ever recorded, where the code was consistent with COPD **= 14.4%**

2. COPD in England report
Source: National COPD Audit Programme: Primary care report for England 2014-15 (p20-21) (https://www.rcplondon.ac.uk/projects/outputs/primary-care-copd-england-finding-measure-success)
Key findings: Annual review and severity assessment
Overall 15.1% of patients were exception reported for the FEV1 measure, and a further 13.7% did not have the test despite being 'eligible'.
It is important to note that full diagnostic spirometry is not required annually once the diagnosis is accurately confirmed, unless the health professional thinks an additional cause of breathlessness is present and reassessment is required, Attaining an FEV1 is helpful for management and can be performed on cheaper and more portable equipment such as micro spirometers, which can be used in patients' homes and take less time than full spirometry.
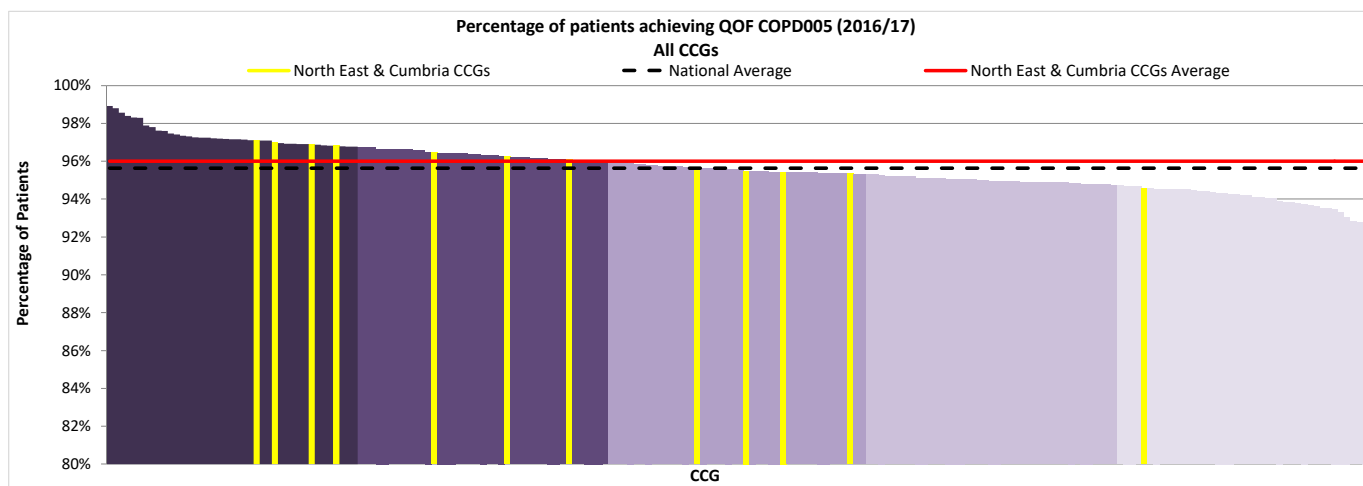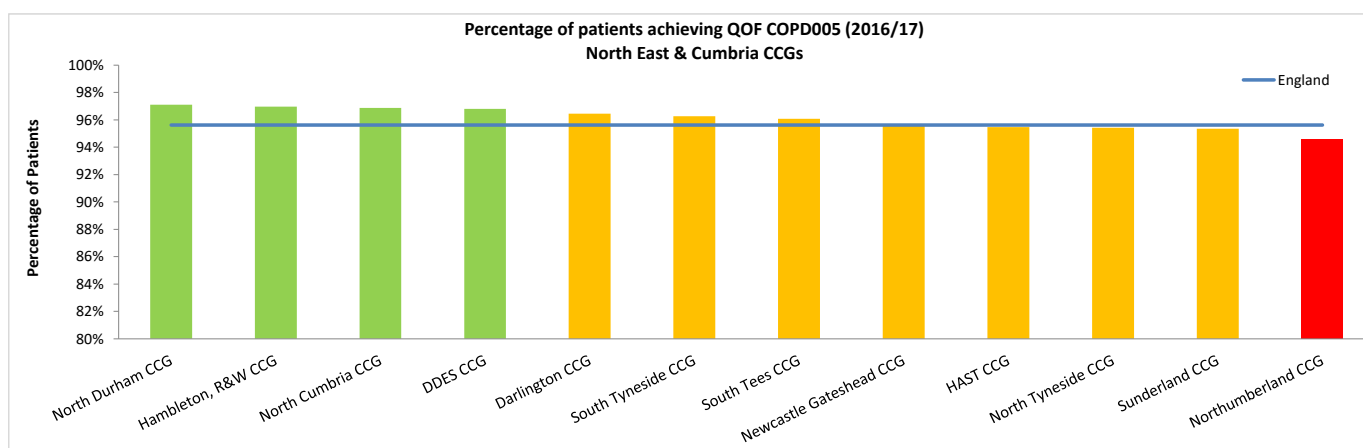
Objective 1 - To reduce variation and improve standards of care for COPD

Ongoing management

6. Percentage of patients with MRC dyspnoea grade ≥3 in latest 12 months with a record of oxygen saturation, COPD005 (2016/17)

COPD005: The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months

	North East & Cumbria CCGs	England
	96.0%	**95.6%**
Compared with England:	Significantly Better	

Trend in percentage of patients achieving QOF COPD005
North East & Cumbria CCGs Combined & England

Percentage of patients achieving QOF COPD005 (2016/17)
North East & Cumbria CCGs

Percentage of patients achieving QOF COPD005 (2016/17)
All CCGs

Definitions / Notes

As COPD progresses, patients often become hypoxaemic. Many patients tolerate mild hypoxaemia well, but once the resting partial pressure of oxygen in arterial blood (PaO_2) falls below 8 KPa patients begin to develop signs of right-sided heart failure (corpulmonale), principally peripheral oedema. The prognosis is poor and if untreated the five year survival rate is less than 50 per cent.

In stable COPD, patients use oxygen therapy for long periods during the day and night. Long-term oxygen therapy can improve survival in patients with COPD who have severe hypoxaemia. It can also reduce the incidence of raised red cell count, reducing the progression of pulmonary hypertension and improving psychological wellbeing.

No trend chart is available for this indicator as it has only been in QOF since 2013/14. The data presented here includes excepted cases in the denominator.

Expected outcome

Report improvement in achievement at CCG / practice level.

What is the data telling us?

Achievement of this indicator in NE&C has increased from 93.9% to 96.0% over the last four years and is currently higher than the England rate of 95.6%. At CCG level the achievement for this indicator ranges from 97.1% to 94.6% with Northumberland CCG having achievement which is statistically significantly lower than the England level.

This data also shows that across the North East and Cumbria CCGs the proportion of COPD patients with an MRC value of 3+ ranges from 33.1% - 44.3% (average 40.1%) and the England figure is 38.3%.

Findings from the Primary Care COPD audit

1. Wales (2014/15) slidepack

Source: Primary care audit - quality improvement slide set (https://www.rcplondon.ac.uk/projects/outputs/primary-care-time-take-breath)

Key results: Optimal therapy

Know your population - Breathlessness. The distribution of breathlessness within the COPD population using the MRC breathlessness scale is shown below. At least 42.2% of the population have a value of 3 or greater::

MRC value 1	10.5%
MRC value 2	36.2%
MRC value 3	24.3%
MRC value 4	14.7%
MRC value 5	3.2%
Unknown value	11.1%

2. COPD in England report

Source: National COPD Audit Programme: Primary care report for England 2014-15 (p20-21) (https://www.rcplondon.ac.uk/projects/outputs/primary-care-copd-england-finding-measure-success)

Key findings: Annual review and severity assessment

The audit found that pulse oximetry is now being performed almost universally in breathless people with COPD.

People with COPD should be asked about their breathlessness using the MRC scale because those with higher grades have more serious disease and consequently need more intensive monitoring and therapies (e.g. pulmonary rehabilitation).

Long term oxygen therapy prolongs and improves quality of life for people with COPD who have chronic hypoxia. Check that patients identified as having long-term hypoxia (persistent SpO_2 <92%) when stable are being referred for assessment by a specialist oxygen team.

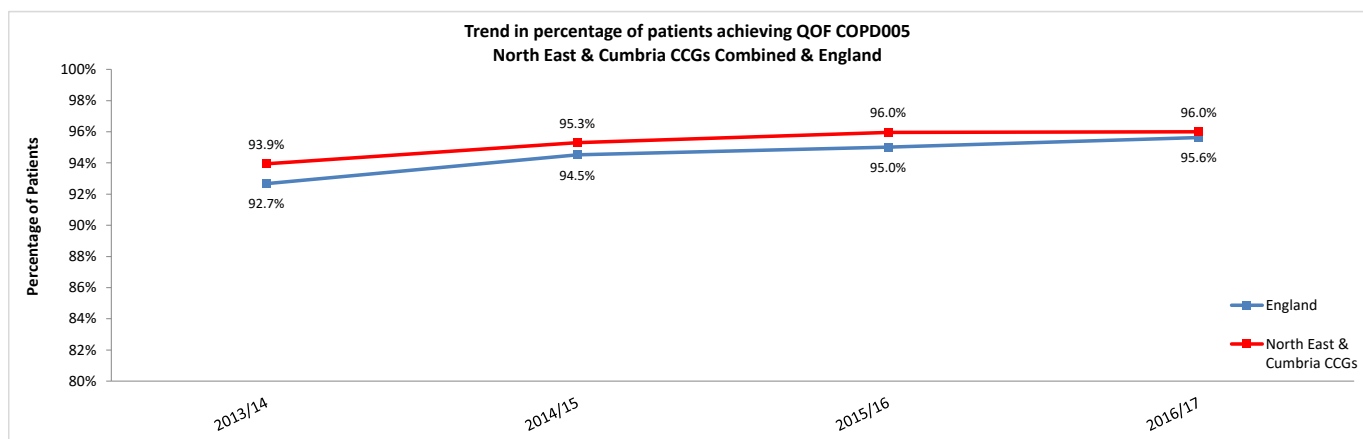# Objective 1 - To reduce variation and improve standards of care for COPD

Ongoing management

7. Percentage of patients with influenza immunisation, COPD007 (2016/17)

COPD007: The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March

	North East & Cumbria CCGs	England
	79.1%	**79.2%**
Compared with England:	Similar	
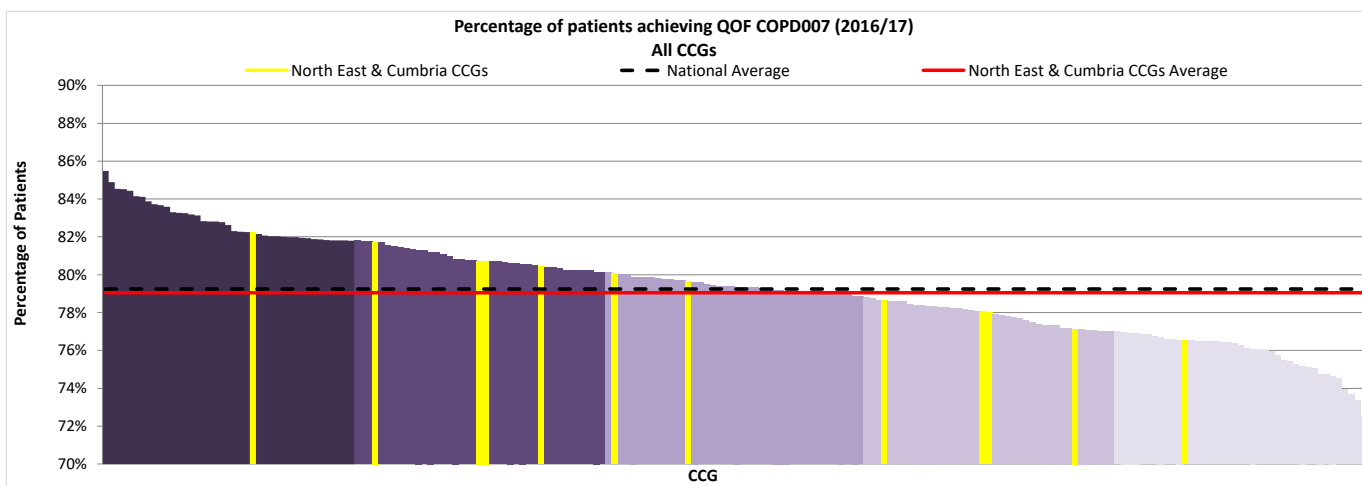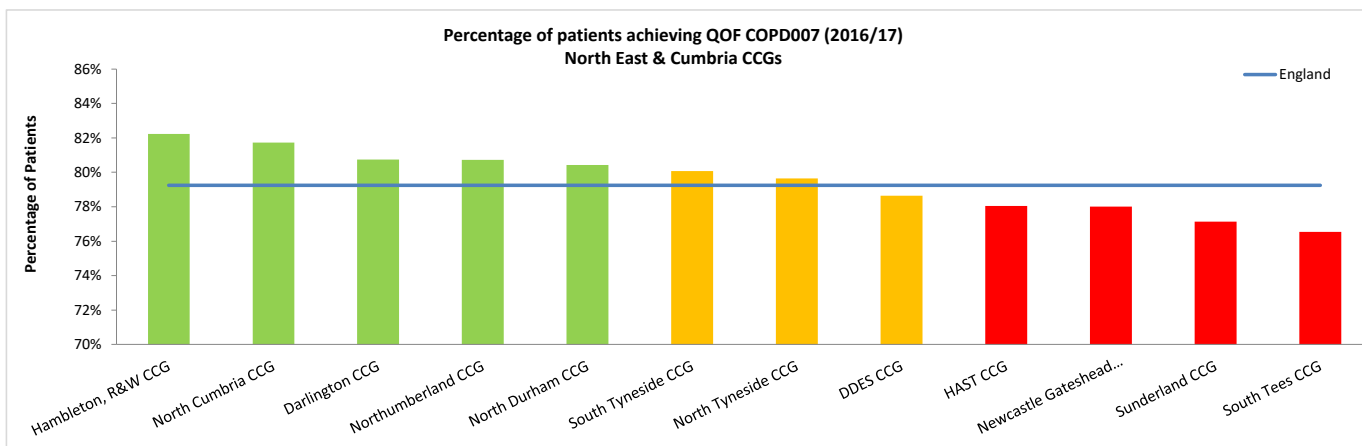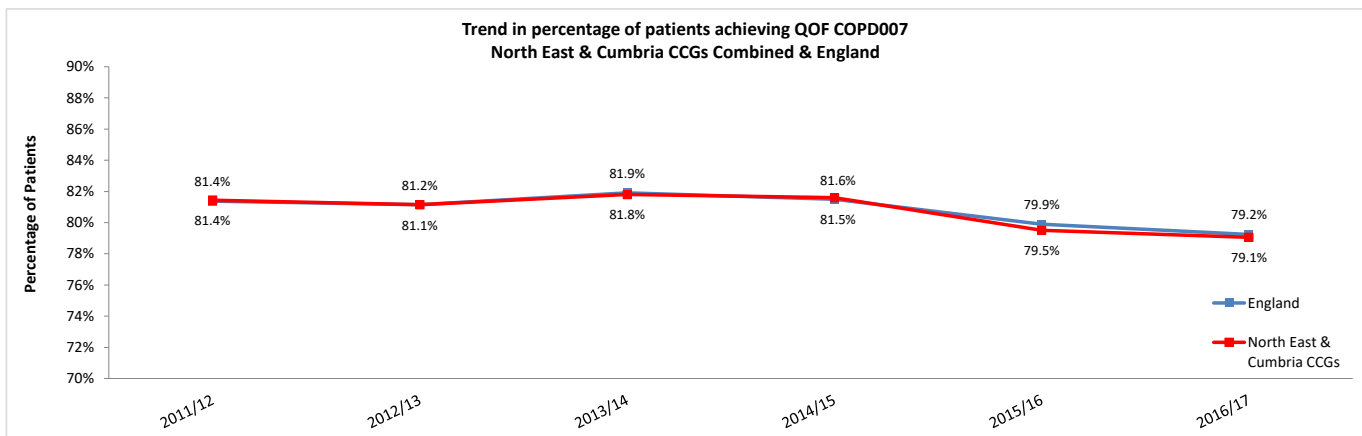
Trend in percentage of patients achieving QOF COPD007
North East & Cumbria CCGs Combined & England

Percentage of patients achieving QOF COPD007 (2016/17)
North East & Cumbria CCGs

Percentage of patients achieving QOF COPD007 (2016/17)
All CCGs

Definitions / Notes
This is a current recommendation from the Chief Medical Officer and the Joint Committee on Vaccination and Immunisation. The data presented here includes excepted cases in the denominator.

Expected outcome
Report improvement in achievement at CCG / practice level.

What is the data telling us?
Achievement of this indicator in NE&C has been steady at 81-79% over the last six years and reflecting the England rate. At CCG level the achievement ranges from 82.2% to 76.5% with four CCGs having achievement which is significantly lower than the England level.

Findings from the Primary Care COPD audit

1. Wales (2014/15) slidepack
Source: Primary care audit - quality improvement slide set (https://www.rcplondon.ac.uk/projects/outputs/primary-care-time-take-breath)
Key results: High value interventions
19.2% of people were exception reported for the flu vaccine.

2. COPD in England report
Source: National COPD Audit Programme: Primary care report for England 2014-15 (p23, 27-29)
(https://www.rcplondon.ac.uk/projects/outputs/primary-care-copd-england-finding-measure-success)
The influenza vaccine has variable effectiveness, according to the season and the patient's current health status when the vaccine is given. It is safe and is the highest value intervention for the treatment of COPD, but is used less than some other COPD interventions that have less value.

Overall, 15.8% of people with COPD in England were exception reported for flu vaccine in 2014-15; 96.8% of the 'eligible' group (i.e. those not exception reported) received this vaccine.

Do systems support primary care recording of the flu vaccines given elsewhere, such as in a pharmacy?

Where variation exists between practices or CCGs, is there a difference in implementation of the national flu campaign?

Objective 1 - To reduce variation and improve standards of care for COPD

8. Percentage of patients achieving QOF SMOKE002 (2016/17)

SMOKE002: The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months

	North East & Cumbria	England
	95.3%	**94.5%**
Compared with England:	Significantly Better	

Trend in percentage of patients achieving QOF SMOKE002
North East & Cumbria CCGs Combined & England

Percentage of patients achieving QOF SMOKE002 (2016/17)
North East & Cumbria CCGs

Percentage of patients achieving QOF SMOKE002 (2016/17)
All CCGs
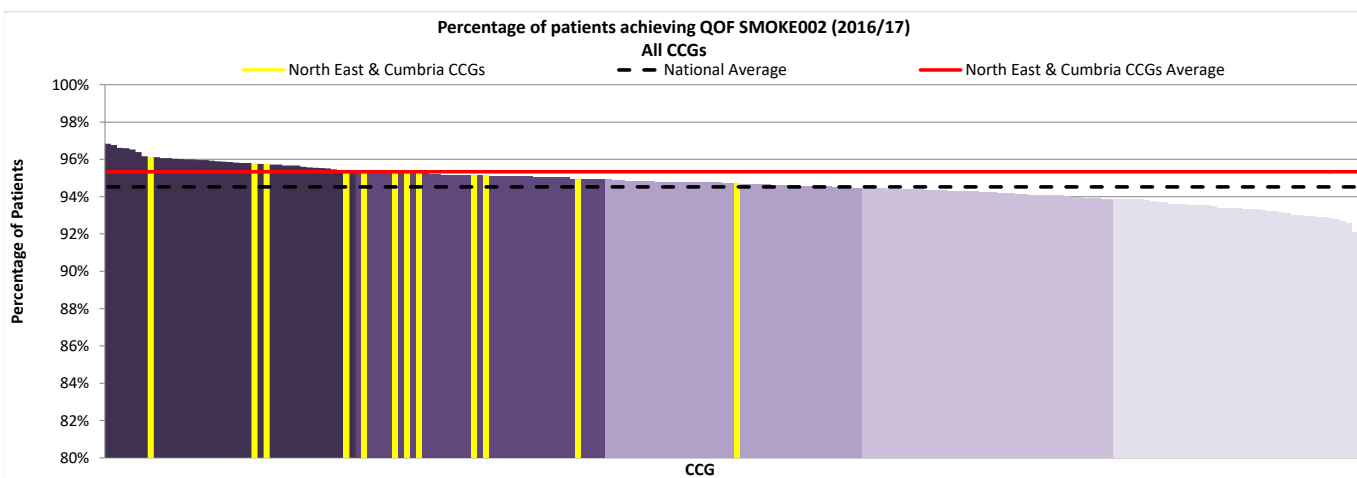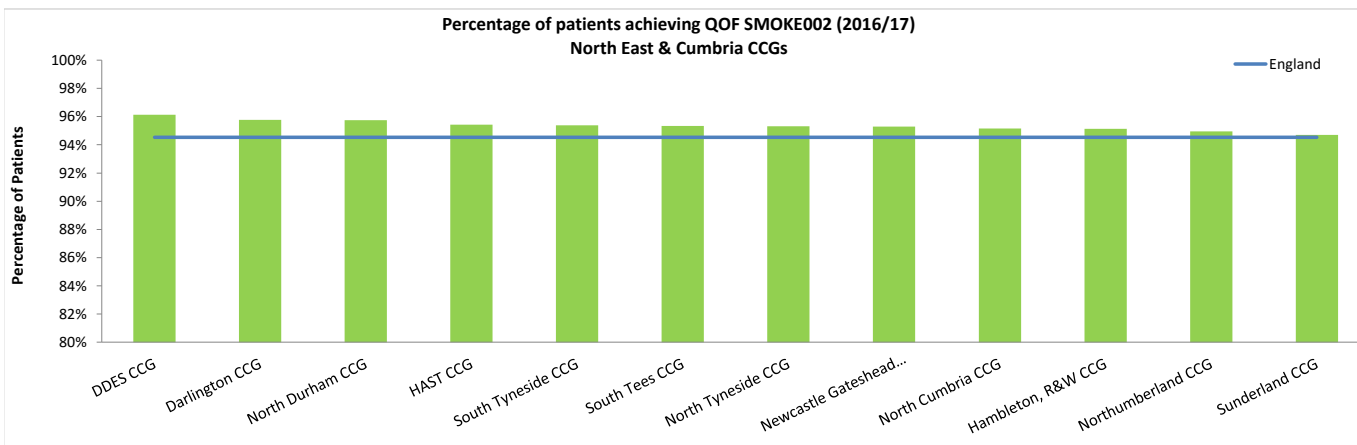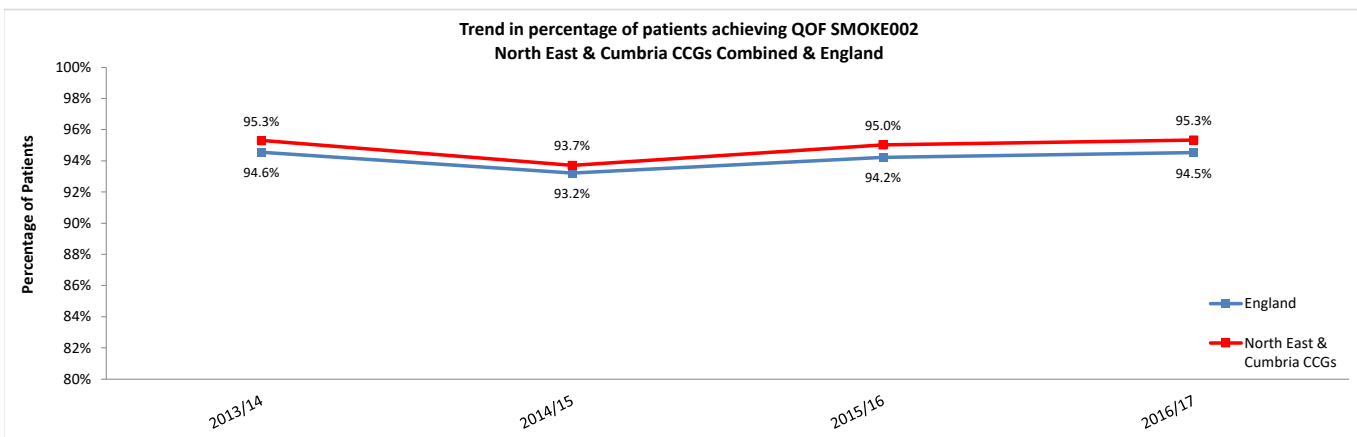
Definitions / Notes

The disease register is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicator. Any patient who has one or more co-morbidities e.g. diabetes and CHD, is only counted once on the register. This indicator is not specific to COPD.

Expected outcome

Report improvement in achievement at CCG / practice level.

What is the data telling us?

At CCG level the current achievement for this indicator ranges from 96.1% to 94.7% with all CCGs having achievement which is significantly higher than the England level. The quintile chart shows the relative position of each CCG in England in relation to this measure.

Findings from the Primary Care COPD audit

1. Wales (2014/15) slidepack

Source: Primary care audit - quality improvement slide set (https://www.rcplondon.ac.uk/projects/outputs/primary-care-time-take-breath)

Key results: Optimal therapy

The DOSE score (as mentioned in the COPD003 section of this report relating to COPD reviews) contains a question relating to smoking: The percentage of people with COPD with a smoking status recorded within the last year. In the Wales audit the figure was 71.7%.

Key results: High value interventions

One third (33.5%) of people with COPD were listed as current tobacco smokers.

Approximately 10% of people with COPD who smoke received tobacco dependency treatment in the last year.

2. COPD in England report

Source: National COPD Audit Programme: Primary care report for England 2014-15 (p24-25, 27-29)
(https://www.rcplondon.ac.uk/projects/outputs/primary-care-copd-england-finding-measure-success)

For people with COPD who smoke tobacco, cessation is accepted as the only intervention that will slow the rate of lung decline.

Routine and manual workers are a population group more likely to suffer from COPD, and the current smoking prevalence in this group (source: www.tobaccoprofiles.info/tobacco-control) in the North East is 26.5% (95%CI 24.9, 28.0), which is the same as the England rate (95%CI 26.1, 27.0) based on 2016 data.

Audit key findings

Tobacco use in people with COPD is highly prevalent and under treated.

Tobacco dependency needs to be considered as a relapsing condition and status should be recorded and help offered every year.

NICE recommends pharmacotherapy and behavioural support to help people quit smoking. Although a high proportion of smokers have been referred for pharmacotherapy and behavioural support, only a small proportion receive a stop-smoking prescription and therefore the full therapeutic intervention as recommended by NICE.

Health professionals should receive training that enables them to feel confident to have the right conversation about tobacco smoking and that empowers them to feel effective in helping someone quit smoking.

Objective 1 - To reduce variation and improve standards of care for COPD

9. Prevalence of smoking in patients with long-term conditions (2016/17)

The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses, who smoke

North East & Cumbria 16.5%   **England** 15.1%

Compared with England: Significantly Worse

Trend in Prevalence of smoking in patients with long-term conditions
North East & Cumbria CCGs Combined & England

Prevalence of smoking in patients with long-term conditions (2016/17)
North East & Cumbria CCGs
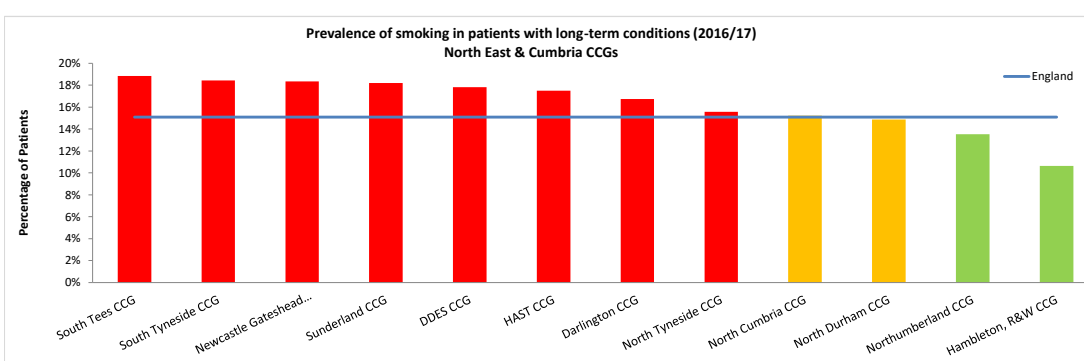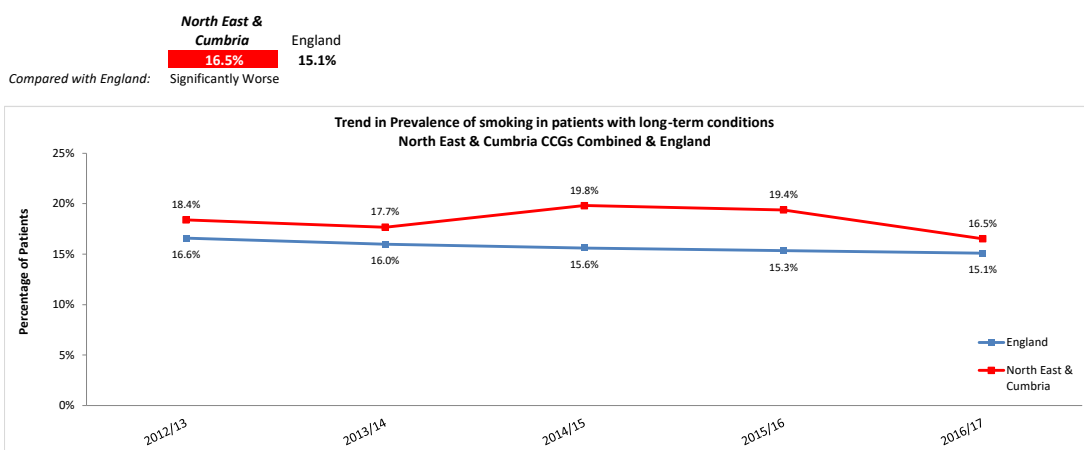
10. Percentage of patients achieving QOF SMOKE005 (2016/17)

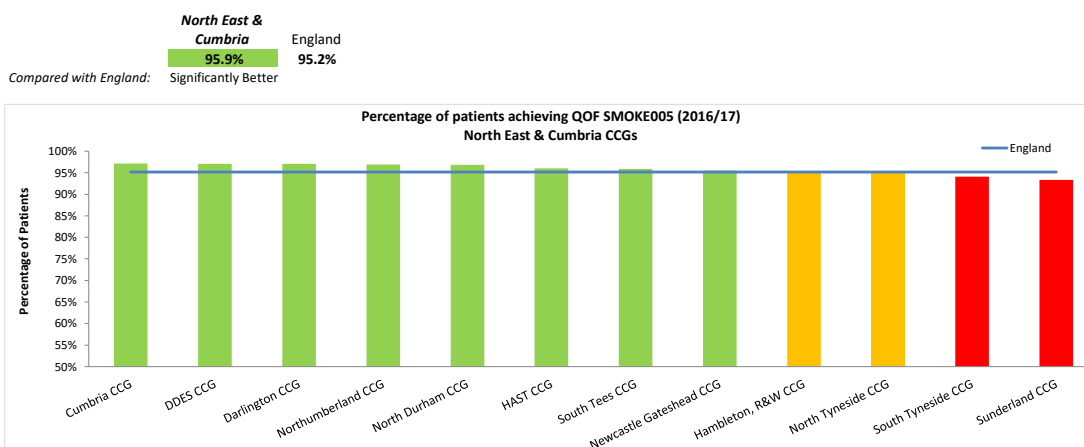SMOKE005: The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months

North East & Cumbria 95.9%   **England** 95.2%

Compared with England: Significantly Better

Percentage of patients achieving QOF SMOKE005 (2016/17)
North East & Cumbria CCGs

Data source: Quality and Outcomes Framework (QOF), NHS Digital (http://content.digital.nhs.uk/qof).© NHS Digital. QOF is licensed under the Open Government Licence v3.0 except where otherwise stated.

Definitions / Notes

The disease register is defined as the sum of the number of patients on the disease registers for each of the conditions listed in the indicators. Any patient who has one or more co-morbidities e.g. diabetes and CHD, is only counted once on the register. The indicators above are not specific to COPD.

Expected outcome

Report reduction in smoking prevalence and improvement in achievement of providing an offer of cessation support at CCG / practice level. A regional Task Force - Smoke Free NHS has recently been established (April 2017). The regional ambition is to reduce prevalence of smoking to 5% by 2025 which requires organisations to support the implementation of NICE Public Health guidelines PH48 and PH4 (*https://www.nice.org.uk/guidance/ph48, https://www.nice.org.uk/guidance/ph45*).

What is the data telling us?

The smoking prevalence in patients with long term conditions is significantly higher in the north east and Cumbria (16.5%) than in England overall (15.1%) with variation across the NE&C CCGs from 18.8% in South Tees CCG to 10.6% in Hambleton, Richmondshire and Whitby CCG.

Regarding the smoking cessation indicator, at CCG level the current achievement for this indicator ranges from 97.2% to 93.4% with two CCGs having achievement which is significantly lower than the England level.

Objective 1 - To reduce variation and improve standards of care for COPD

11. Other metrics relating to COPD

- **Pulmonary rehabilitation**

Findings from a local audit of COPD and its management in primary care

The findings from the local COPD audit described earlier in this report (described in the section relating to COPD003) identified that referral to pulmonary rehabilitation remains low (4.6% of patients with COPD). Pulmonary rehabilitation is one of the most cost effective treatments currently available to patients with COPD however the majority of primary care clinicians often miss referral opportunities.

Findings from the Primary Care COPD audit

1. Wales (2014/15) slidepack

Source: Primary care audit - quality improvement slide set (https://www.rcplondon.ac.uk/projects/outputs/primary-care-time-take-breath)

Key results: High value interventions

   2 in 3 people with COPD who are eligible for pulmonary rehabilitation have yet to be referred (65.5%)

2. COPD in England report

Source: National COPD Audit Programme: Primary care report for England 2014-15 (p26-29) (https://www.rcplondon.ac.uk/projects/outputs/primary-care-copd-england-finding-measure-success)

Findings from this audit indicate that there is under-referral of eligible people for pulmonary rehabilitation. GPs are responsible for 50% of referrals to pulmonary rehabilitation based on this data. Variation in referral between practices and CCGs should be reviewed.

For those who are unwilling or unable to attend PR, consider providing appropriate information regarding the importance of physical activity.

- **British Lung Foundation COPD patient passport**

The Wales (2014/15) slidepack includes information and links to the BLF COPD passport (data from this tool are presented in a subsequent section of this COPD report).

- **Networking and education**

A Respiratory Network has been established across the North East and North Cumbria AHSN area. The latest meeting was held in July 2017 and the evaluation of this event is included in a subsequent section of this COPD report.

The Wales (2014/15) slidepack includes a slide promoting quality improvement through education and networking. Links to the Primary Care Respiratory Society UK website are available.

Objective 1 - To reduce variation and improve standards of care for COPD

12. Exception rate (%) for QOF COPD indicators (2016/17)

CCG Code	CCG Name	Overall Exception Rate	COPD002 %	COPD003 %	COPD004 %	COPD005 %	COPD007 %
00P	Sunderland CCG	17.1%	9.6%	13.7%	25.7%	1.6%	20.5%
00K	Hartlepool and Stockton-On-Tees CCG	15.6%	11.8%	14.1%	20.4%	2.1%	19.9%
00M	South Tees CCG	16.9%	13.0%	15.9%	21.5%	1.3%	21.5%
01H	North Cumbria CCG	13.9%	7.3%	11.8%	21.4%	1.1%	16.8%
00C	Darlington CCG	15.8%	12.4%	12.3%	24.8%	0.8%	18.1%
00D	Durham Dales, Easington and Sedgefield CCG	14.7%	11.5%	10.2%	21.0%	0.8%	20.5%
00L	Northumberland CCG	13.3%	9.0%	11.5%	17.5%	1.2%	17.8%
99C	North Tyneside CCG	13.0%	7.5%	11.9%	16.4%	1.1%	18.8%
13T	Newcastle Gateshead CCG	13.1%	7.8%	10.6%	16.0%	1.3%	20.2%
00J	North Durham CCG	13.2%	7.9%	9.0%	20.5%	0.4%	18.0%
00N	South Tyneside CCG	15.4%	8.4%	10.9%	24.9%	0.6%	18.7%
03D	Hambleton, Richmondshire and Whitby CCG	11.0%	7.9%	8.6%	13.6%	0.7%	16.7%
England	England	13.2%	8.9%	11.3%	16.6%	1.1%	18.5%

Key to exception rate reporting colour codes

<10%		10-20%		>20%	

Data sources: Quality and Outcomes Framework (QOF), NHS Digital (http://content.digital.nhs.uk/qof). © NHS Digital. QOF is licensed under the Open Government Licence v3.0 except where otherwise stated.

Definitions / Notes
Exception reporting applies to indicators within the clinical domain of the QOF where the level of achievement is determined by the percentage of patients receiving the designated level of care. It ensures that practices are not penalised where, for example, patients do not attend for review, or where a medication cannot be prescribed due to a contraindication or side effect.

Expected outcome
Exception reporting for the NE&C CCGs to be lower than the England rates.
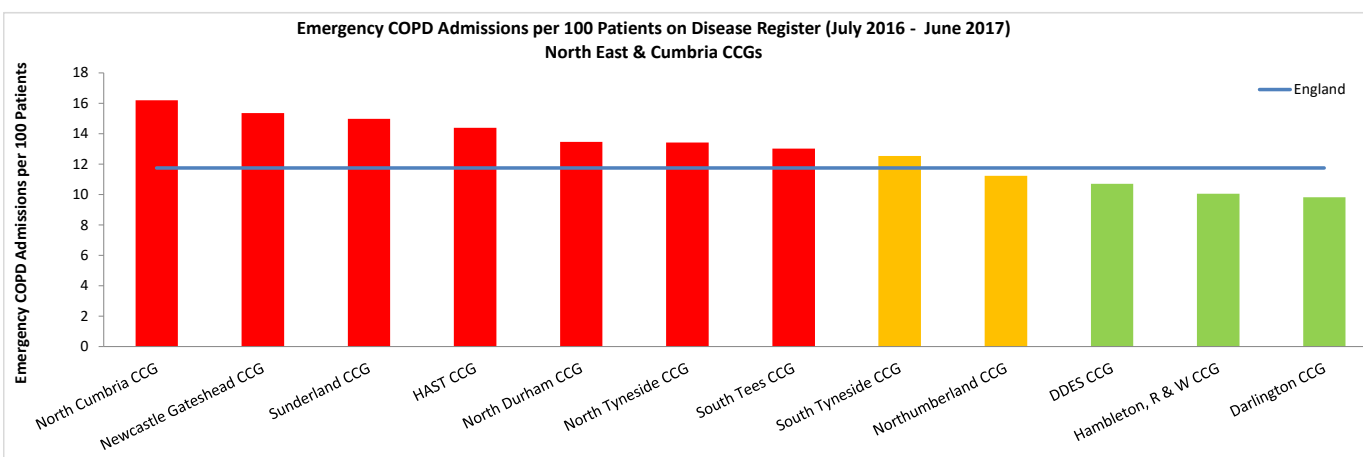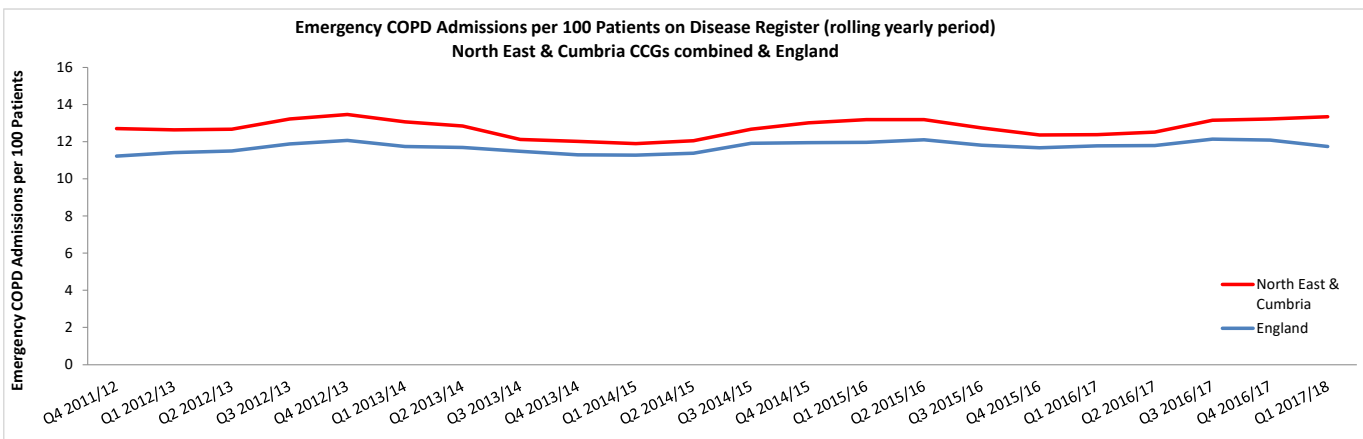
What is the data telling us?
The level of exception reporting within COPD varies by indicator and also by CCG.
COPD005 (patients with MRC score >=3 with a record of oxygen saturation value) has a low level of exception reporting however COPD004 (record of FEV1) has a high level, and 3 CCGs (Sunderland, South Tyneside and Darlington) have exception rates greater than 24%.

2. Quality of care in health and social care for people with COPD

13. a. Emergency admissions for COPD (Q4 2011/12 - Q1 2017/18)

	North East & Cumbria	England
	13.3	**11.7**

Compared with England: Significantly Worse

Emergency COPD Admissions per 100 Patients on Disease Register (rolling yearly period)
North East & Cumbria CCGs combined & England

Emergency COPD Admissions per 100 Patients on Disease Register (July 2016 - June 2017)
North East & Cumbria CCGs

Data sources: Quality and Outcomes Framework (QOF), NHS Digital (http://content.digital.nhs.uk/qof). © NHS Digital. QOF is licensed under the Open Government Licence v3.0 except where otherwise stated.
Hospital Episode Statistics (from HDIS), Copyright © 2017, re-used with the permission of NHS Digital. All rights reserved.

Definitions / Notes
Latest HES data (2017/18) is still provisional. COPD emergency admissions are defined by those with a primary diagnosis ICD-10 code in the range J40-J44, based on episode 1 of the spell, where the admission method is 2* (emergency).

Expected outcome
Reduction in the emergency admission rate for COPD over time.

What is the data telling us?
The emergency COPD admission rate per 100 patients on the disease register has remained reasonably constant for England since Q4 2011/12, with the North East and Cumbria rate following a similar trend but becoming closer to the national rate in recent quarters.
In the latest period (to Q1 2017/18) the gap has widened slightly and the COPD admission rate ranges by CCG from 9.8 to 16.2 admissions per 100 patients on the disease register. There are 7 CCGs with COPD admission rates which are significantly higher than the England rate.
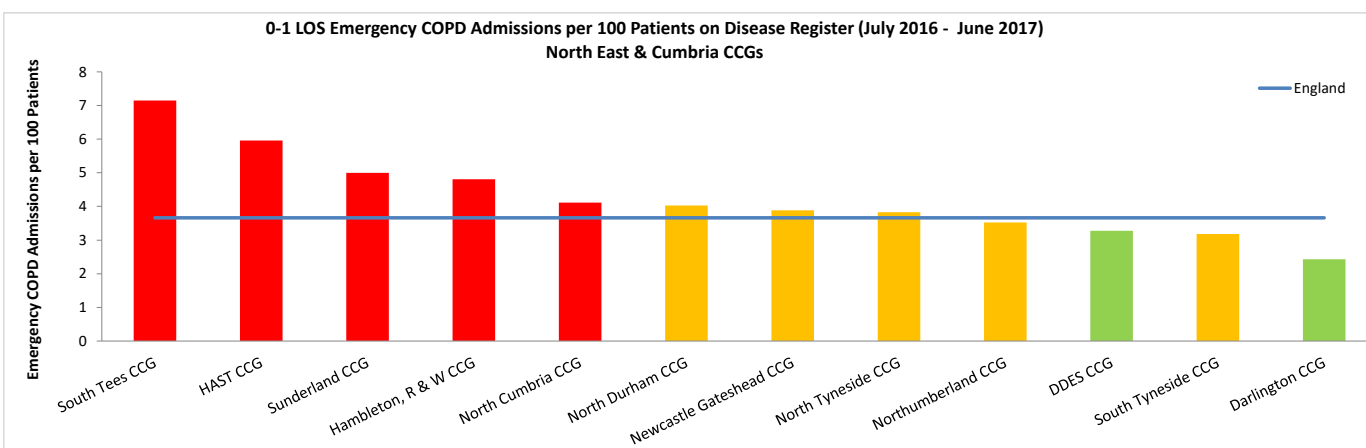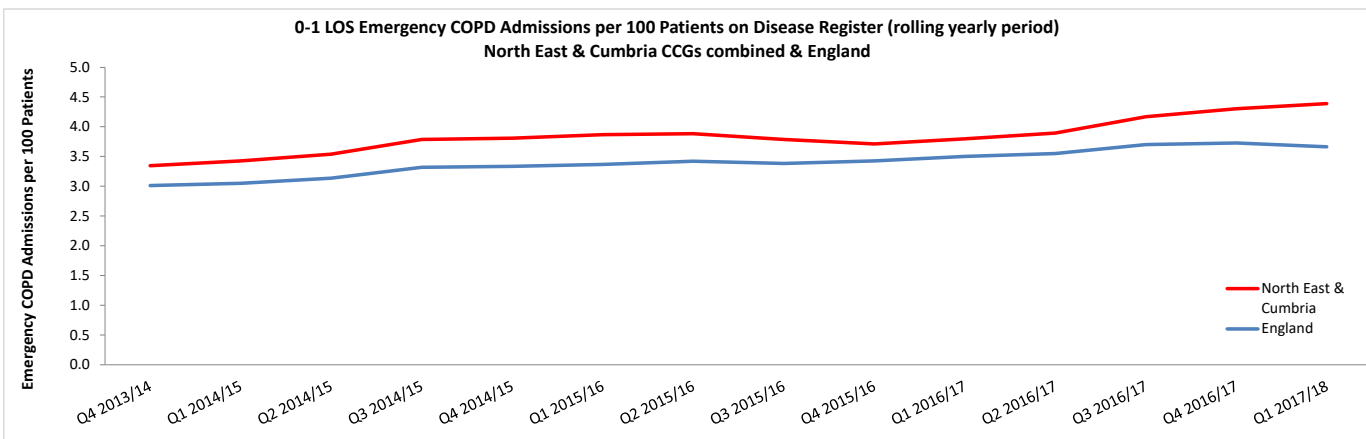
AHSN objective
Links to objective 2 - To reduce demands on secondary care inpatient and outpatient activity for conditions related to COPD.

13. b. Emergency admissions for COPD (short stay)

	North East & Cumbria	England
	4.4	3.7
Compared with England:	Significantly Worse	

0-1 LOS Emergency COPD Admissions per 100 Patients on Disease Register (rolling yearly period)
North East & Cumbria CCGs combined & England

0-1 LOS Emergency COPD Admissions per 100 Patients on Disease Register (July 2016 - June 2017)
North East & Cumbria CCGs

Data sources: Quality and Outcomes Framework (QOF), NHS Digital (http://content.digital.nhs.uk/qof). © NHS Digital. QOF is licensed under the Open Government Licence v3.0 except where otherwise stated.
Hospital Episode Statistics (from HDIS), Copyright © 2017, re-used with the permission of NHS Digital. All rights reserved.

Definitions / Notes
Latest HES data (2017/18) is still provisional. There are multiple reasons for having a high proportion of short stay admissions. COPD emergency admissions are defined by those with a primary diagnosis ICD-10 code in the range J40-J44, based on episode 1 of the spell, where the admission method is 2* (emergency).

Expected outcome
Reduction in the short stay (0-1 days) emergency admission rate for COPD over time

What is the data telling us?
The short stay emergency COPD admission rate per 100 patients on the disease register has slowly but steadily increased for England since Q4 2013/14, with the North East and Cumbria rate following a similar trend but becoming closer to the national rate, although the gap has recently widened.
In the latest period (to Q1 2017/18) the short stay admission rate ranges by CCG from 2.4 to 7.2 admissions per 100 patients on the disease register. There are 5 CCGs with short stay admission rates which are significantly higher than the England rate.

AHSN objective
Links to objective 2 - To reduce demands on secondary care inpatient and outpatient activity for conditions related to COPD

Findings from a local audit of COPD and its management in primary care
The findings from the local COPD audit described earlier in this report indicate that 33% of patients admitted for COPD exacerbation were discharged on the same day that they were admitted. A further 25% were discharged the following day.
Based on the average cost of a COPD admission (£2,000 - £2,500, *https://improvement.nhs.uk/*), a reduction in the number of unscheduled admissions which resulted in discharge within 36 hours by 33%, could save £148,000, and a reduction in this type of unscheduled admissions by 50% could save £221,000, in the audited CCG alone.

2. Quality of care in health and social care for people with COPD

14. a. Percentage of admissions <u>for any reason</u> that were within 30 days of discharge following a prior admission for COPD

	North East & Cumbria	England
	29.9%	**27.5%**

Compared with England: Significantly Worse
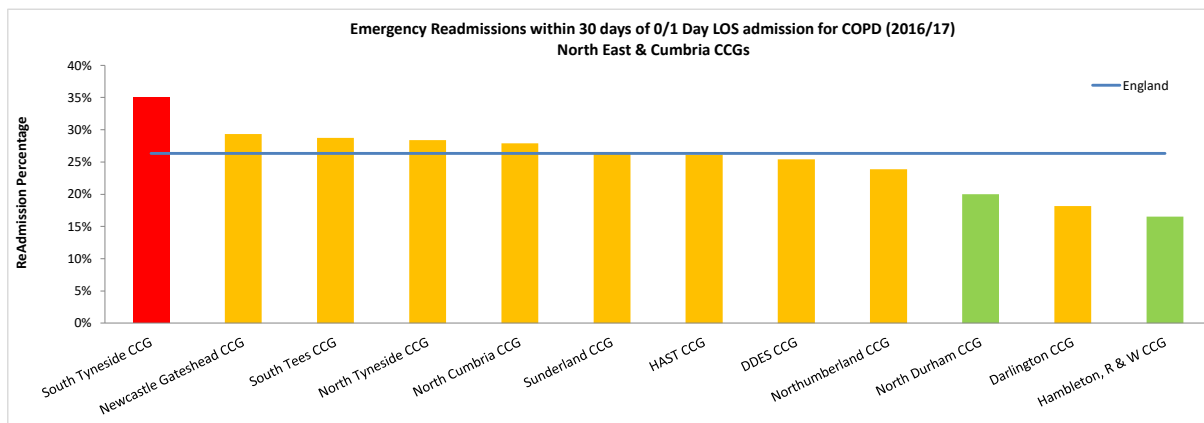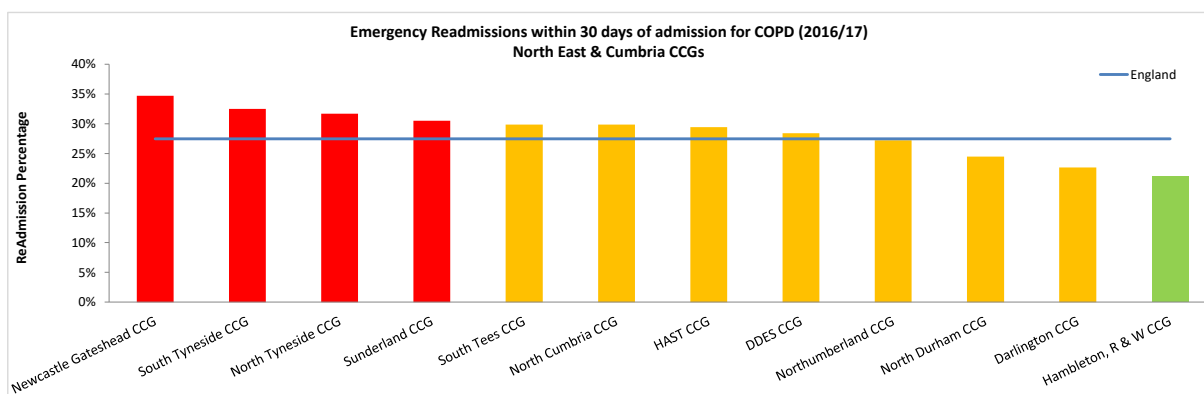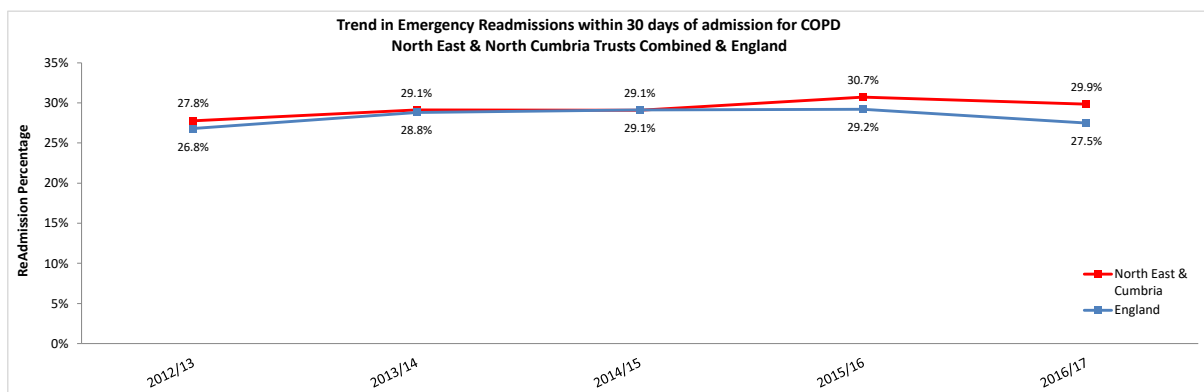
**Trend in Emergency Readmissions within 30 days of admission for COPD
North East & North Cumbria Trusts Combined & England**

**Emergency Readmissions within 30 days of admission for COPD (2016/17)
North East & Cumbria CCGs**

**Emergency Readmissions within 30 days of 0/1 Day LOS admission for COPD (2016/17)
North East & Cumbria CCGs**

Data sources: Hospital Episode Statistics, Copyright © 2017, re-used with the permission of NHS Digital. All rights reserved.

Definitions / Notes
HES data (2016/17) is final. COPD emergency admissions are defined by those with a primary diagnosis ICD-10 code in the range J40-J44, based on episode 1 of the spell, where the admission method is 2* (emergency).

Expected outcome
Reduction in the percentage of admissions within 30 days of discharge for a prior admission for COPD.

What is the data telling us?
The readmission rate following an admission for COPD for the North East and Cumbria is slightly higher than that for England and has remained relatively constant over the first three years of the period shown but an increase has been observed for the North East and Cumbria in 2015/16 and 2016/17.
At CCG level the readmission rate for the latest period (2016/17) varies from 21.1% in Hambleton, Richmondshire and Whitby CCG to 34.7% in Newcastle Gateshead CCG. Four CCGs have readmission rates which are significantly higher than the England rate.
The proportion of 0-1 day length of stay emergency admissions for COPD for which there is a readmission within 30 days (lower chart) ranges from 16.5% at Hambleton, Richmondshire and Whitby CCG to 35.1% at South Tyneside CCG and only one CCG (South Tyneside) has a rate which is significantly higher than the England rate.

AHSN objective
Links to objective 2 - To reduce demands on secondary care inpatient and outpatient activity for conditions related to COPD.

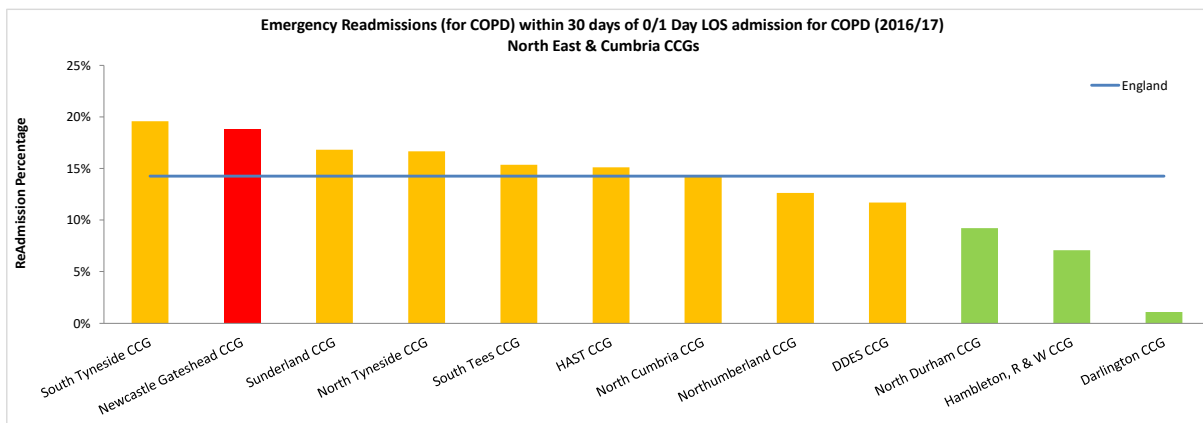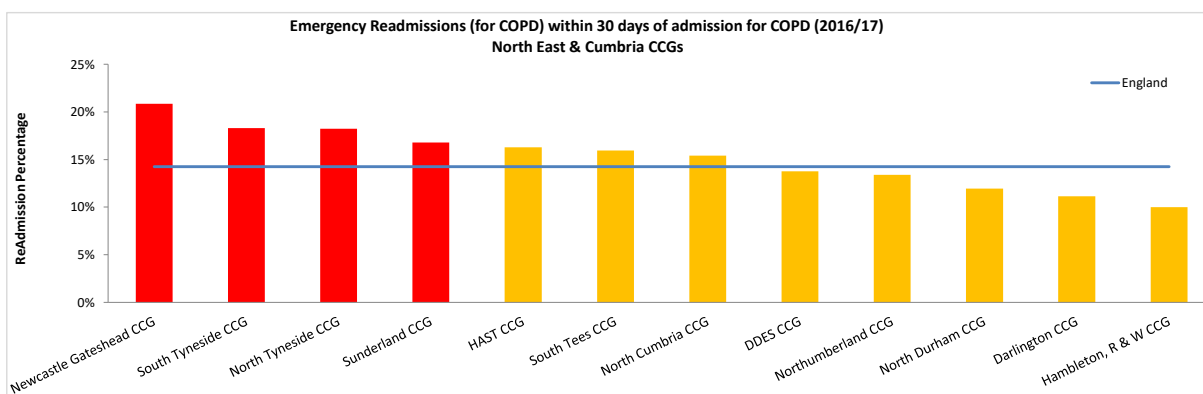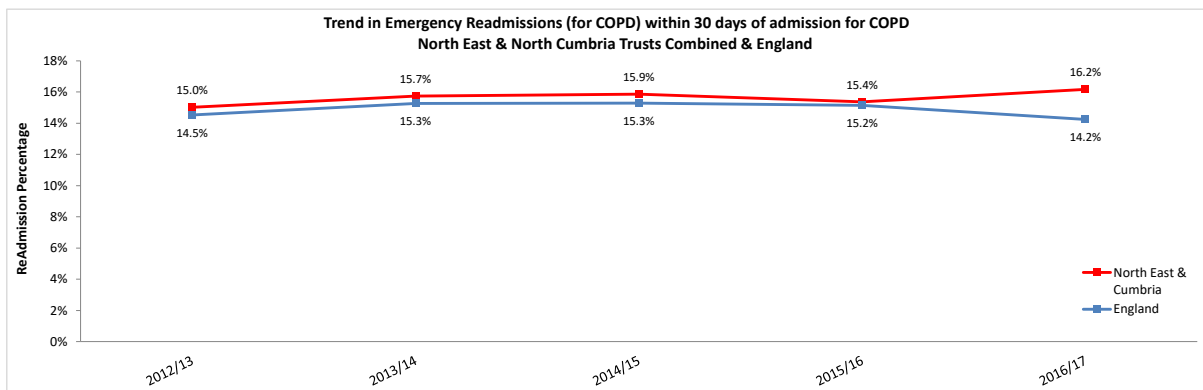Page 24 of 30

2. Quality of care in health and social care for people with COPD

14. b. Percentage of admissions for COPD that were within 30 days of discharge following a prior admission for COPD

	North East & Cumbria	England
	16.2%	**14.2%**

Compared with England: **Significantly Worse**

Trend in Emergency Readmissions (for COPD) within 30 days of admission for COPD
North East & North Cumbria Trusts Combined & England

Emergency Readmissions (for COPD) within 30 days of admission for COPD (2016/17)
North East & Cumbria CCGs

Emergency Readmissions (for COPD) within 30 days of 0/1 Day LOS admission for COPD (2016/17)
North East & Cumbria CCGs

Data sources: Hospital Episode Statistics, Copyright © 2017, re-used with the permission of NHS Digital. All rights reserved.

Definitions / Notes
HES data (2016/17) is final. COPD emergency admissions are defined by those with a primary diagnosis ICD-10 code in the range J40-J44, based on episode 1 of the spell, where the admission method is 2* (emergency).

Expected outcome
Reduction in the percentage of admissions for COPD within 30 days of discharge for a prior admission for COPD.

What is the data telling us?
The COPD readmission rate for the North East and Cumbria is much higher than that for England, although it has remained relatively constant over the earlier four years of the period. At CCG level the readmission rate for the latest period (2016/17) varies from 20.9% in Newcastle Gateshead CCG to 10.0% in Hambleton, Richmondshire and Whitby CCG.

The proportion of 0-1 day length of stay emergency admissions for COPD for which there is a readmission within 30 days for COPD ranges from 19.6% at South Tyneside CCG to 1.1% at Darlington CCG.

Research suggests that early COPD readmission appears to be driven by demographics, severity of the index admission and disease severity, which cannot be influenced by care delivery or organisation of care[1].

AHSN objective
Links to objective 2 - To reduce demands on secondary care inpatient and outpatient activity for conditions related to COPD.
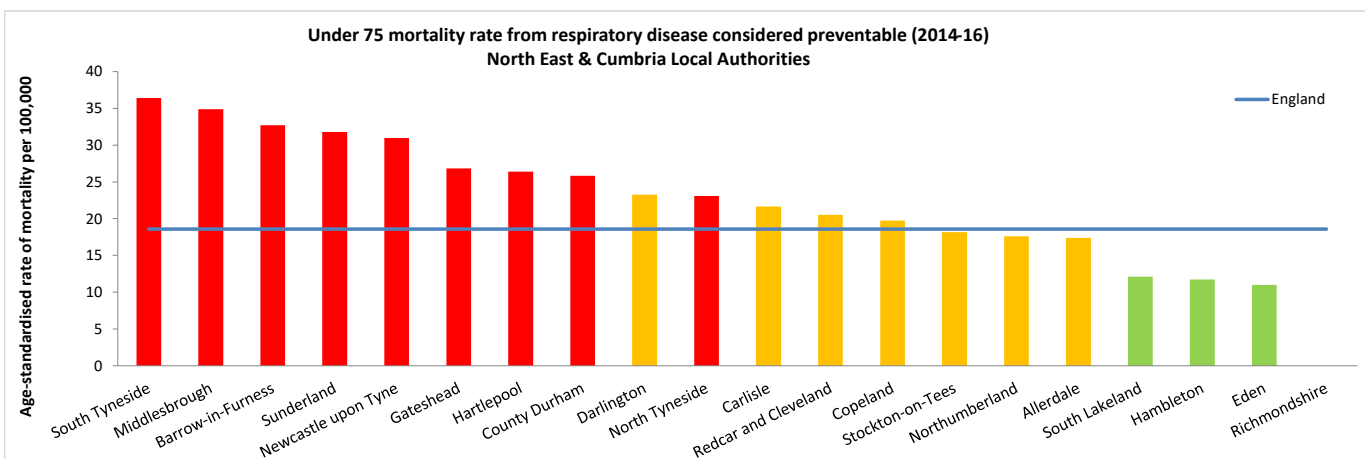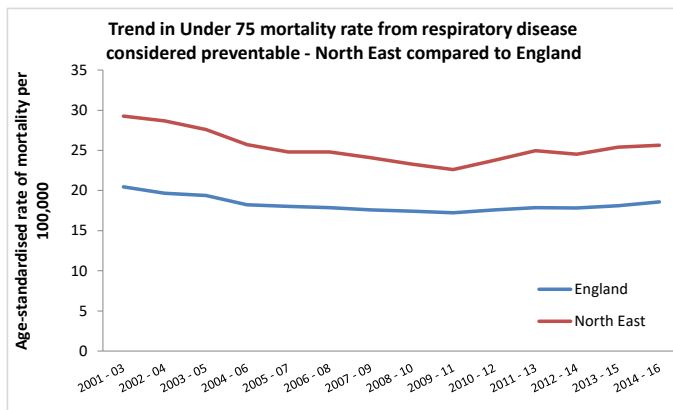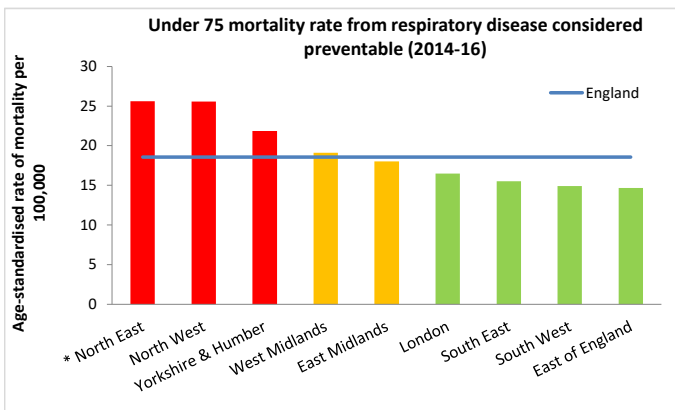
1. Thorax 2011;66:A107-A108

3. To develop measures of the quality of care in health and social care for people with COPD

15. Under 75 mortality rate from respiratory disease considered preventable (2014-16)

Age-standardised rate of mortality that is considered preventable from respiratory disease in persons less than 75 years per 100,000 population

North East	North West	Yorkshire & Humber	West Midlands	East Midlands	London	South East	South West	East of England	England
25.6	25.6	21.9	19.1	18.0	16.5	15.5	14.9	14.7	18.6

Compared with England: Significantly Worse | Similar | Significantly Better

Under 75 mortality rate from respiratory disease considered preventable (2014-16)

Trend in Under 75 mortality rate from respiratory disease considered preventable - North East compared to England

Under 75 mortality rate from respiratory disease considered preventable (2014-16)
North East & Cumbria Local Authorities

Data source: Public Health Outcomes Framework Data tool. Indicator Portal (http://www.phoutcomes.info).

Definitions / Notes

Premature mortality from respiratory disease is a problem in the North East region and widely considered to reflect its industrial legacy (mining and ship building) as well as smoking rates. The basic concept of preventable mortality is that deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense.

Data for Richmondshire has been suppressed, as the numbers of deaths on which the rates are based are less than 25, which is considered too few deaths on which to calculate rates reliably.

What is the data telling us?

Premature mortality rates from respiratory disease in the North East region are the highest of all the English health regions and are statistically significantly higher than those observed nationally.

During the period 2014-16, mortality rates varied considerably within the region, ranging from 11.0 per 100,000 in Eden to 36.4 per 100,000 in South Tyneside which is more than a three-fold difference.

Trends over time indicate that during the last 15 years, the premature mortality rate in this region fell from 29.3 per 100,000 by 23% to 22.6 per 100,000 but has recently risen again to 25.6 per 100,000. By comparison, the national rates fell by only 9% from 20.4 per 100,000 to 18.6 per 100,000 population.
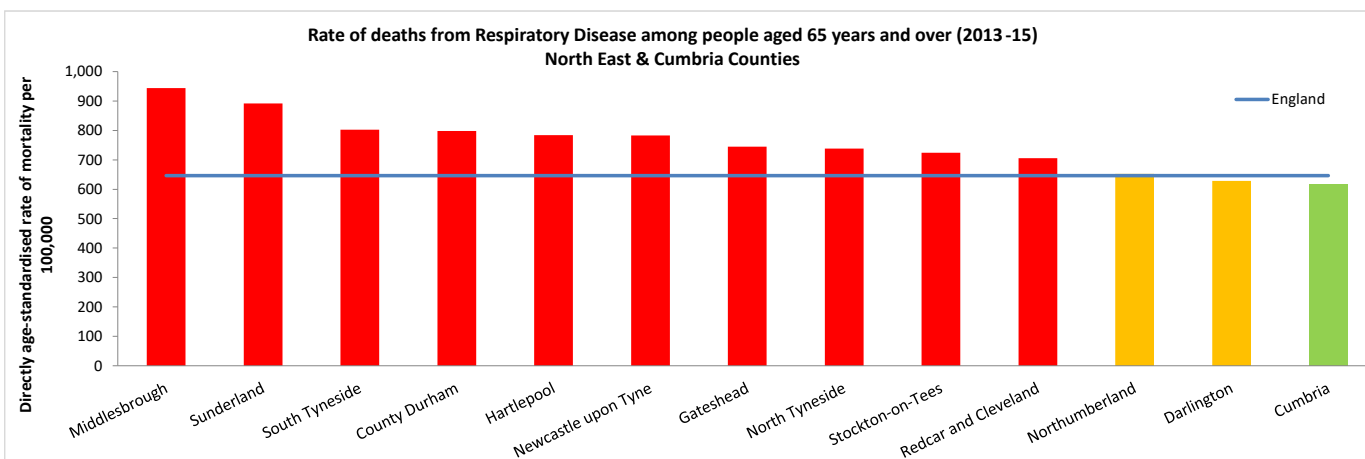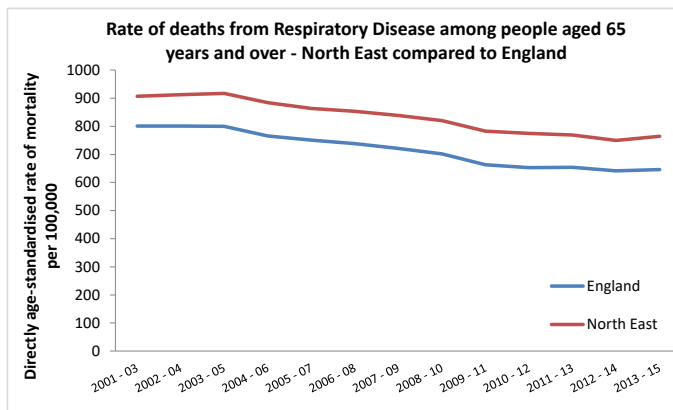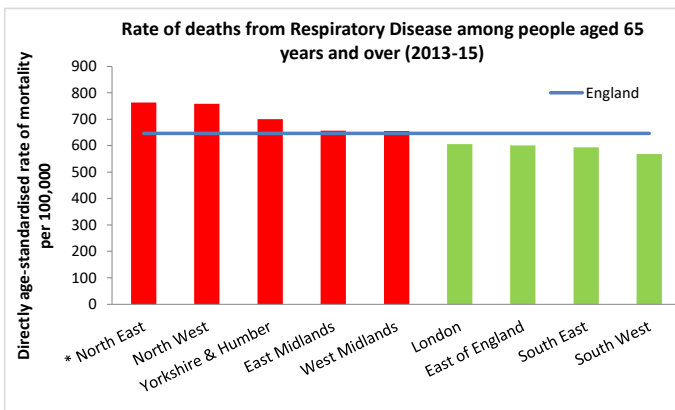
3. To develop measures of the quality of care in health and social care for people with COPD

16. Rate of deaths from respiratory disease among people aged 65 years and over (2013-15)

Directly age-standardised rate of deaths from Underlying Cause of respiratory disease (ICD10 codes J00-J99) among people aged 65 years and over

North East	North West	Yorkshire & Humber	East Midlands	West Midlands	London	East of England	South East	South West	England
764.0	758.6	700.6	656.9	656.0	606.1	600.5	593.3	568.9	646.2

Compared with England: Significantly Worse   Significantly Better

Rate of deaths from Respiratory Disease among people aged 65 years and over (2013-15)

Rate of deaths from Respiratory Disease among people aged 65 years and over - North East compared to England

Rate of deaths from Respiratory Disease among people aged 65 years and over (2013-15)
North East & Cumbria Counties

Data source: Public Health Outcomes Framework Data tool. Indicator Portal (http://www.phoutcomes.info).

Definitions / Notes

Respiratory disease is one of the main causes of death in the over 65s in England and smoking is one of the major causes of COPD, a major respiratory diseases. This indicator has been developed to support the understanding of variation across England in the rate of deaths in older people with respiratory disease.

What is the data telling us?

Premature mortality rates from respiratory disease in the North East region are the highest of all the English health regions and are statistically significantly higher than those observed nationally.

During the period 2013-15, mortality rates varied considerably within the region, ranging from 615.6 per 100,000 in Cumbria to 944.0 per 100,000 in Middlesbrough.

Trends over time indicate that during the last 13 years, the premature mortality rate in this region fell from 907.0 per 100,000 by 16% to 764.0 per 100,000. By comparison, the national rates fell by 19% from 800.4 per 100,000 to 646.2 per 100,000 population. There is a plateau in the trend since 2012-14 for both the North East and for England overall.

Objective 4 - To develop information for the public about the quality of care they receive for COPD

17. British Lung Foundation passport

The British Lung Foundation have developed a COPD Patient Passport. This tool is designed to help patients with COPD to get the best possible care and manage their condition as effectively as possible, through enabling shared decision-making with healthcare professionals. The COPD passport is available as a digital tool and as a paper version. There are 13 questions posed to patients.

To date (November 2017), 27,049 people have used the digital tool[2] and a table showing the questions and proportion of respondents answering 'yes' to each question is shown below for England. Further geographical breakdown is also possible (region and CCG) however it must be noted that these findings may not be entirely representative of the area they cover as the data is limited to only those people who included their postcode when using the tool.

Nationally, the question answered highest in the affirmative was Q6 (importance of keeping active and eating well) followed by Q1 (diagnosis confirmed by spirometry) and Q9 (knowing what all medicines are for). Similar findings are seen in the limited region data, with the same three questions having the highest scores. The question with the lowest response was Q3 (I am supported to manage my care and have agreed and have a copy of my self-management plan).

Total Response Summary		England total	North East	Yorkshire & the Humber
Q1	My Diagnosis of COPD was confirmed with a lung function test (spirometry).	80.8%	85.9%	86.7%
Q2	I understand my COPD and my health care professional has explained where to find information, advice and emotional support.	40.6%	43.2%	34.0%
Q3	I am supported to manage my care, and I have agreed and been given a copy of my self-management plan.	24.0%	21.1%	16.3%
Q4	I have contacted my GP to get a free flu vaccination by November each year. I have also had the one-off pneumonia jab.	74.5%	75.3%	76.8%
Q5	If I smoke, I am offered support and treatment to stop every time I meet with a health care professional.	24.6%	68.5%	65.5%
Q6	I know the importance of keeping active and eating well.	81.0%	81.2%	80.5%
Q7	I have had a referral to pulmonary rehabilitation.	32.9%	29.6%	30.0%
Q8	I have received advice about ongoing exercise and nutrition.	37.9%	35.5%	34.0%
Q9	I know what all my medicines are for and when to take them.	76.9%	81.4%	82.0%
Q10	My health care professional reviews how I use My inhaler every time I meet with them.	53.9%	62.6%	54.0%
Q11	I can spot the signs of a flare-up - this is sometimes called an exacerbation.	50.9%	52.6%	50.9%
Q12	If I have a flare-up, I know who to contact and what medicines to take.	48.1%	49.0%	41.9%
Q13	I see My nurse or doctor at least once a year to review My health, care and treatment, and to discuss all the points mentioned previously.	70.2%	76.5%	71.3%

Although the overall number of responses (where a postcode was provided) for the north east and Cumbria CCGs are low, the information at CCG level has been reported below. For each CCG, questions with the highest positive response rates are in green and lowest positive response rates in red and there is substantial variation between CCGs for each question.

Total Response Summary		Cumbria	Darlington	Durham Dales, Easington & Sedgefield	Hartlepool & Stockton-on-Tees	Newcastle Gateshead	North Durham	North Tyneside	Northumberland	South Tees	South Tyneside	Sunderland	Hambleton, Richmondshire & Whitby
Q1	My Diagnosis of COPD was confirmed with a lung function test (spirometry).	83.9%	94.1%	87.2%	93.5%	83.6%	73.1%	79.4%	93.3%	82.5%	96.3%	83.8%	94.7%
Q2	I understand my COPD and my health care professional has explained where to find information, advice and emotional support.	51.8%	47.1%	34.0%	32.3%	43.6%	53.8%	47.1%	56.7%	38.6%	37.0%	51.4%	47.4%
Q3	I am supported to manage my care, and I have agreed and been given a copy of my self-management plan.	30.4%	29.4%	10.6%	9.7%	12.7%	38.5%	20.6%	33.3%	24.6%	29.6%	18.9%	5.3%
Q4	I have contacted my GP to get a free flu vaccination by November each year. I have also had the one-off pneumonia jab.	76.8%	88.2%	74.5%	77.4%	69.1%	88.5%	82.4%	73.3%	66.7%	77.8%	75.7%	73.7%
Q5	If I smoke, I am offered support and treatment to stop every time I meet with a health care professional.	76.0%	85.7%	75.0%	66.7%	56.0%	100.0%	88.9%	77.8%	57.1%	62.5%	77.8%	75.0%
Q6	I know the importance of keeping active and eating well.	82.1%	58.8%	87.2%	83.9%	80.0%	88.5%	79.4%	86.7%	80.7%	74.1%	81.1%	84.2%
Q7	I have had a referral to pulmonary rehabilitation.	39.3%	47.1%	36.2%	32.3%	23.6%	30.8%	32.4%	33.3%	24.6%	33.3%	18.9%	31.6%
Q8	I have received advice about ongoing exercise and nutrition.	39.3%	41.2%	42.6%	25.8%	34.5%	42.3%	38.2%	50.0%	28.1%	37.0%	24.3%	31.6%
Q9	I know what all my medicines are for and when to take them.	89.3%	94.1%	89.4%	74.2%	74.5%	80.8%	82.4%	76.7%	77.2%	88.9%	86.5%	84.2%
Q10	My health care professional reviews how I use My inhaler every time I meet with them.	66.1%	88.2%	55.3%	54.8%	54.5%	84.6%	58.8%	73.3%	57.9%	63.0%	64.9%	47.4%
Q11	I can spot the signs of a flare-up - this is sometimes called an exacerbation.	58.9%	64.7%	44.7%	48.4%	56.4%	65.4%	50.0%	63.3%	49.1%	55.6%	43.2%	42.1%
Q12	If I have a flare-up, I know who to contact and what medicines to take.	60.7%	47.1%	42.6%	35.5%	50.9%	69.2%	58.8%	63.3%	42.1%	44.4%	45.9%	36.8%
Q13	I see My nurse or doctor at least once a year to review My health, care and treatment, and to discuss all the points mentioned previously.	82.1%	94.1%	74.5%	71.0%	76.4%	88.5%	79.4%	86.7%	68.4%	74.1%	70.3%	89.5%

[2] Personal communication, Bev Wears (Service Development Manager, British Lung Foundation North.
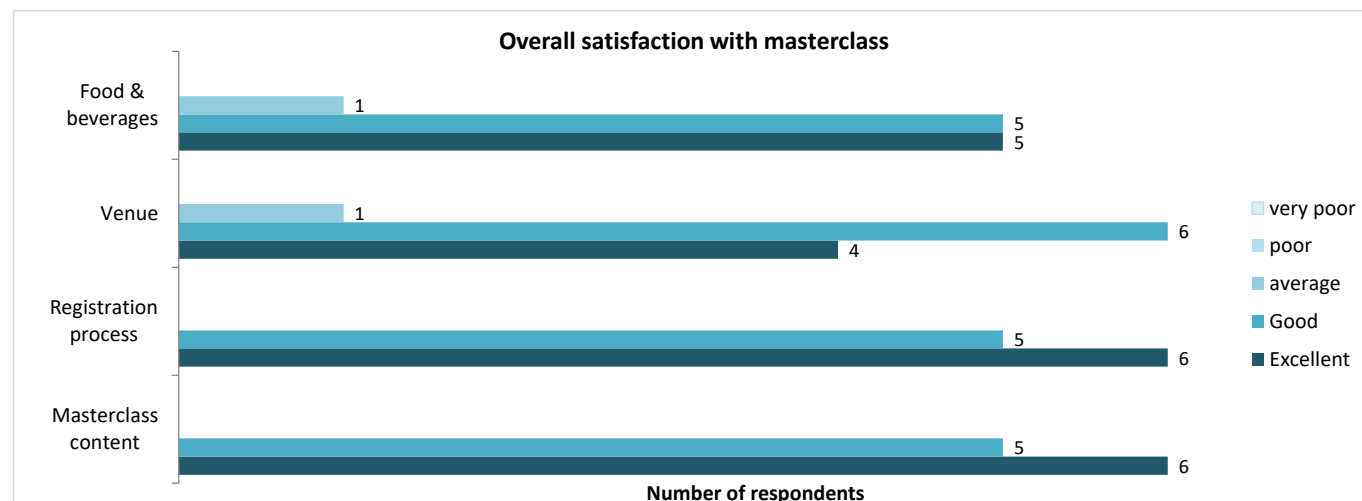
Objective 5 - To provide support at scale for implementation of improvement across the region through education

18. Local respiratory interest group for COPD

Primary Care Respiratory Care Management Network Meeting Feedback
19th July 2017, Marriott Hotel Metrocentre, Gateshead
11 evaluation forms were submitted

Overall satisfaction with masterclass

Food & beverages: 1, 5, 5
Venue: 1, 6, 4
Registration process: 5, 6
Masterclass content: 5, 6

Legend: very poor, poor, average, Good, Excellent

Number of respondents

All 11 respondents said that:
- the information received prior to attending the meeting was useful and informative
- the event highlighted areas of opportunity
- they would like to be contacted regarding future events

7/11 respondents (64%) stated that the masterclass had provided suitable networking opportunities, and the remaining respondents stated that this was maybe the case.

Subjects which were of most interest were:
- All of the subjects
- CBT
- Digital advances
- Future of PR

Subjects not covered in the event that the attendees would like the AHSN NENC to follow up:
- Understand how the CCG had received the MyHealth presentation
- Diagnostic spirometry
- Guidance launch with implementation measures in region (upskilling workforce)
- Understanding how to work together as a region on population condition management
- How well PR is proving to work in the community of Newcastle

Other comments made:
How do we translate to improved care
If possible, for everyone to introduce themselves to highlight which professionals are in the room and the perspectives that they are speaking from.

DOCUMENT GOVERNANCE	
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