Primary Care Needs Assessment tool: indicator review

Google Chrome is advised to ensure this page displays/ functions as intended.

ⓘ You are now reviewing the PCNA indicator(s) for: **Prevalence of chronic obstructive pulmonary disease**

ⓘ **Caution**: The information on this page is provided for testing purposes and may be subject to amendment. It may contain errors or not be fully reflective of consensus public health advice or relevant services, therefore should only be used with care.

Strategic context

ⓘ Consider the national strategic context for prioritising improvement action in this area (in conjunction with your health board's IMTP and Regional Partnership Board's Area Plan):

- About 65% of the DALYs due to chronic respiratory diseases are attributable to known risk factors (*Health and its determinants in Wales*; PHW 2018; link); this underpins the importance of prevention efforts.
- Key policy on respiratory conditions including chronic obstructive pulmonary diseases (COPD) is set out in the *Respiratory health delivery plan 2018–2020* (WG 2018; link).

▼ ⓘ Tell me about: DALYs

What are DALYs?

- Disability-adjusted life years (DALYs) are a combined measure of early deaths (i.e. premature mortality) and disability-weighted impact on quality of live from living with poor health.
- Because DALYs capture both what kills us and what makes us ill, they describe the overall 'burden of disease' (reported by risk or condition) more effectively than mortality or disability prevalence does alone.

▼ ⓘ Tell me about: Prevention

Definitions:

- Zola's river analogy is a useful way of thinking about prevention of ill health (Zola 1970). It

describes **primary** prevention (stopping everyone from falling into a river and coming to harm e.g. never smoking), **secondary** prevention (ensuring any individuals at risk who do fall in get to safety quickly; minimising the chance of complications through early identification and intervention e.g. screening) and **tertiary** prevention (search-and-rescue for those taken downstream; mitigating the worst consequences of established disease e.g. vascular surgery).

- The Welsh Government definition of prevention is broader: working in **partnership** to co-produce the best outcomes possible, utilising the strengths and **assets** people and places have to contribute.

Building a healthier Wales (Feb 2019) sets out six key principles for implementing prevention in Wales:

- Adhere to the **five ways** of working (as outlined in the Well-being of Future Generation Act).
- Commit to investing in **evidence-based** interventions (where available or evaluate small and scale up if appropriate).
- Ensure evidence-based interventions have sufficient **scale** and **reach** to make a measurable population impact and to reduce inequalities.
- Ensure services are provided to a sufficient **quality** to achieve the best possible **outcomes** for each intervention; continually improve by drawing upon quality improvement techniques.
- Balance intervention benefits for **short and long-term** outcomes (including investing in one sector to realise a return in another).
- Optimise **value** by taking an agile approach to evaluating interventions and approaches and disinvesting in those that do not yield benefit/ value.

Improvement actions for GP practice cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ Modify behavioural risk factors to prevent COPD or limit disease progression

- Optimise primary/ secondary preventive actions for smoking (BRF-001) in particular; also for unhealthy diet (BRF-002), physical inactivity (BRF-003) and alcohol misuse (BRF-004) as contributors to overweight and obesity.
- The importance of reducing these behavioural risk factors is reiterated in the *Respiratory health delivery plan 2018–2020* (WG 2018; link). Of particular relevance to primary care clinicians, the plan recommends actions include improving referral rates to smoking cessation services, pulmonary rehabilitation programmes, and to the National Exercise Referral Scheme (NERS) or local exercise programmes.

▼ Modify clinical risk factors to limit COPD exacerbations

- Optimise primary/ secondary preventive actions for high body mass index (childhood [CRF-002] and adult [CRF-003] obesity).
- The *Respiratory health delivery plan 2018–2020* (WG 2018; link) describes the comorbidities of COPD and obesity as "overlap syndrome"; obesity is a factor in almost half (46%) of patients requiring domiciliary non-invasive ventilation.

▼ Modify other risk factors to limit COPD exacerbations

- As an ambulatory care-sensitive condition, when COPD is managed well and treated appropriately, severe acute exacerbations resulting in hospital admission can be avoided (The King's Fund 2012; link).
- The *Respiratory health delivery plan 2018–2020* (WG 2018; link) recommends prompt clinical treatment of exacerbations in primary care, an aspect of which includes encouraging appropriate use of antibiotics (see NICE guidance/ quality standards below).
- Avoidance of exacerbations would also include mitigating the contributory effects of unhealthy homes (WDH-002) and poor air quality (see NICE guidance below).

▼ Encourage uptake of vaccination against influenza to reduce comorbidity

- Optimise uptake of influenza vaccination (IDP-001).
- The *Respiratory health delivery plan 2018–2020* (WG 2018; link) notes people with COPD are at increased risk of serious influenza-related complications.
- People aged six months to less than 65 years with COPD were an eligible group within the National Influenza Immunisation Programme 2018-19 (WHC [2018] 023).

▼ Focus on improving detection of COPD

- Increased ascertainment of those at risk, with confirmation of a diagnosis of COPD, will affect prevalence proportion. Higher cluster prevalence may reflect one or more of higher population disease prevalence; opportunity to improve delivery of behaviour change interventions; opportunity to improve identification and/ or management of clinical risk factors; access to health care; or the effectiveness of case finding.
- The *Respiratory health delivery plan 2018–2020* (WG 2018; link) notes that early detection of COPD needs to occur in primary care and proposes a clinical system "red flag" suggesting a COPD assessment and spirometry for patients over the age of 40 years who present with repeated chest infections. The plan also notes that national audit indicates more than 25% of patients on COPD registers may not have the condition.

- For signposting to relevant NICE guidelines/ quality standards relating to detection of COPD as a source of potential improvement actions, see below.

▼ Focus on improving management of COPD to limit progression

- Improving the quality of COPD care will not lower prevalence, however, it may reduce the risk of complications/ future events; improve quality of life for the patient and their carers/ families; reduce inequity in health outcomes; or reduce (or increase) health and social care utilisation and costs.

- Indicator review for condition management (e.g. successful smoking cessation) is not included in the initial release of the PCNA tool; this is subject to improvements in PHW access to primary care data that would inform actionable intelligence.

- QOF guidance for 2017/18 identified COPD as a national clinical priority; proposed quality improvement action focussed on the national COPD audit finding that there should be better coding and recording of COPD consultations, prescribing and referrals (link). Activity to attain this (with discussion at cluster level) comprised: GP practices to reflect on their national COPD audit report; review of spirometry results for those on the practice COPD register to ensure accurate coding of results; collation of practice-level data on % correct/ incorrect diagnoses and reflective themes.

- For signposting to relevant NICE guidelines/ quality standards relating to secondary prevention of COPD as a source of potential improvement actions, see below.

▼ Ensure awareness and implementation of NICE guidance/ quality standards

- *Chronic obstructive pulmonary disease in over 16s: diagnosis and management*. NICE guideline [NG115] (Published date: December 2018) includes recommendations suitable for adoption by healthcare professionals. This guideline covers diagnosing and managing chronic obstructive pulmonary disease (COPD) in people aged 16 and older, which includes emphysema and chronic bronchitis. It aims to help people with COPD to receive a diagnosis earlier so that they can benefit from treatments to reduce symptoms, improve quality of life and keep them healthy for longer.

- *Chronic obstructive pulmonary disease in adults*. Quality standard [QS10] (Published date: July 2011; Last updated: February 2016) sets out eight quality statements, any of which could form a focus for collective local improvement action. This quality standard covers assessing, diagnosing and managing chronic obstructive pulmonary disease (COPD). It describes high-quality care in priority areas for improvement.

- *Chronic obstructive pulmonary disease (acute exacerbation): antimicrobial prescribing*. NICE guideline [NG114] (Published date: December 2018) includes recommendations suitable for adoption by healthcare professionals. This guideline sets out an antimicrobial prescribing strategy for acute exacerbations of chronic obstructive pulmonary disease (COPD). It aims to optimise antibiotic use and reduce antibiotic resistance.

STEP C Improvement actions for wider cluster members

ⓘ Consider which of the following actions could be taken forward:

▼ Modify behavioural risk factors to prevent COPD or limit disease progression

- Optimise primary/ secondary preventive actions for smoking (BRF-001) in particular; also for unhealthy diet (BRF-002), physical inactivity (BRF-003) and alcohol misuse (BRF-004) as contributors to overweight and obesity.
- The importance of reducing these behavioural risk factors is reiterated in the *Respiratory health delivery plan 2018–2020* (WG 2018; link).

▼ Modify clinical risk factors to limit COPD exacerbations

- Optimise primary/ secondary preventive actions for high body mass index (childhood [CRF-002] and adult [CRF-003] obesity).
- The *Respiratory health delivery plan 2018–2020* (WG 2018; link) describes the comorbidities of COPD and obesity as "overlap syndrome"; obesity is a factor in almost half (46%) of patients requiring domiciliary non-invasive ventilation.

▼ Modify other risk factors to limit COPD exacerbations

- Avoidance of exacerbations would include mitigating the contributory effects of unhealthy homes (WDH-002) and poor air quality.
- Small-area associations between air pollution (nitrogen dioxide and particulate matter), deprivation status and health outcomes exist in Wales; this includes respiratory disease mortality (*J Public Health (Oxf)*. 2017 Sep 1;39(3):485–497).
- PHW are supporting implementation of Welsh Government Clean Air Programme, which includes publication of public health-driven *Clean air plan for Wales*.
- For related NICE guidance, see below.

▼ Encourage uptake of vaccination against influenza to reduce comorbidity

- Optimise uptake of influenza vaccination (IDP-001).

- The *Respiratory health delivery plan 2018–2020* (WG 2018; link) notes people with COPD are at increased risk of serious influenza-related complications.
- People aged six months to less than 65 years with COPD were an eligible group within the National Influenza Immunisation Programme 2018-19 (WHC [2018] 023).

▼ **Ensure awareness and implementation of NICE guidance**

- *Air pollution: outdoor air quality and health*. NICE guideline [NG70] (Published date: June 2017) includes recommendations suitable for adoption by a broad audience. This guideline covers road-traffic-related air pollution and its links to ill health. It aims to improve air quality and so prevent a range of health conditions and deaths.
- *Air pollution: outdoor air quality and health*. Quality standard [QS181] (Published date: February 2019) sets out five quality statements, any of which could form a focus for collective local improvement action [see especially Statement 4: Advice for people with chronic respiratory or cardiovascular conditions]. This quality standard covers road-traffic-related air pollution and its impact on health. It describes high-quality actions in priority areas for improvement.
- *Community pharmacies: promoting health and wellbeing*. NICE guideline [NG102] (Published date: August 2018) includes recommendations suitable for a broad audience. This guideline covers how community pharmacies can help maintain and improve people's physical and mental health and wellbeing, including people with a long-term condition. It aims to encourage more people to use community pharmacies by integrating them within existing health and care pathways and ensuring they offer standard services and a consistent approach. It requires a collaborative approach from individual pharmacies and their representatives, local authorities and other commissioners.

What is happening in Wales?

ⓘ Consider whether shared learning/ local experience might guide your own implementation of the evidence:

▼ **Establishing a Respiratory Health Project**

- *What problem was being addressed?* Need to reduce inhaled corticosteroid use and improve COPD management.
- *What was done to address it?* 20% of the population of Blaenau Ffestiniog has been identified as being smokers. The practice was identified as one of the highest prescribers of inhaled corticosteroids within the Health Board, which prompted the cluster to identify ways to develop more effective strategies and treatments to improve respiratory health. Steffan John, an independent pharmacist prescriber specialising in respiratory health conducted 6 sessions which included identification of patients and inviting patients to respiratory clinics, education and training of healthcare professionals in COPD diagnosis and management and improved inhaler techniques.

- *Who did it or who can be contacted in the event of queries?* Meirionnydd cluster (Dr Jonathan Butcher; Ellen V Williams; Christine Carroll).
- *Source?* Primary Care Clusters 2019 (yearbook) [link].

▼ **Establishing point-of-care CRP testing**

- *What problem was being addressed?* Need to improve management of people with COPD exacerbations.
- *What was done to address it?* Early identification and proactive management of respiratory patients by introducing point of care CRP Testing.
- *Who did it or who can be contacted in the event of queries?* Bridgend North cluster (Dr Geoff Smith; Andrew Carrick).
- *Source?* Primary Care Clusters 2019 (yearbook) [link].

▼ **Working with a Respiratory Specialist Nurse**

- *What problem was being addressed?* Need to improve management of people with respiratory illnesses.
- *What was done to address it?* The Llanelli Cluster has particularly high respiratory disease and smoking rates and has secured a Respiratory Specialist Nurse to support practices with coding, data, training and education. The role works closely with each Practice to ensure their asthma and COPD services are compliant.
- *Who did it or who can be contacted in the event of queries?* Llanelli cluster (Dr Alan Williams; Laura Lloyd Davies).
- *Source?* Primary Care Clusters 2019 (yearbook) [link].

▼ **Establishing a Pulmonary Rehabilitation Pilot Programme**

- *What problem was being addressed?* Need to provide pulmonary rehabilitation services close to home.
- *What was done to address it?* People in poor respiratory health living in South Monmouthshire were expected to travel to Newport Stadium if they wanted to take part in PR. The NCN stepped in and agreed Â£7,500 funding to support a PR Pilot to run in Chepstow. The pilot, in partnership with Monmouthshire County Council National Exercise Referral Scheme (NERS) allowed participants the opportunity for gentle exercise, education about their condition, and to meet other people in a similar situation. The programme has also given people the confidence to go on and engage in activities after the PR programme has ended via the NERS.

- *Who did it or who can be contacted in the event of queries?* Monmouthshire South cluster (Dr Annabelle Holtham).
- *Source?* Primary Care Clusters 2019 (yearbook) [link].

▼ **Placeholder project description**

- *What problem was being addressed?* Placeholder.
- *What was done to address it?* Placeholder.
- *How does this evidence good practice?* Placeholder.
- *What key learning can be shared?* Placeholder.
- *Who did it or who can be contacted in the event of queries?* Placeholder.

ⓘ Have something to share? Please let us know here.

ⓘ **Caution**: Any text entered into the following sections will not be saved if you navigate away from this page, or close the browser window before selecting PRINT.

What do you know about community views on this?

ⓘ Consider any relevant citizen/ community voice information (e.g. from surveys, complaints, engagement events, or your health board's well-being or population needs assessments).
Summarise this into the following box:

Type here

What assets or partnership opportunities can you identify?

ⓘ Consider any relevant local assets or potential partner organisations that might facilitate co-production. Summarise this into the following box:

Type here

Do you need more data before making a decision?

ⓘ If relevant, consider any additional data (or information) requirements that might ensure a more informed decision on determining action. Summarise this into the following box:

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What is your provisional decision?

ⓘ Having reviewed indicator data on local needs and considered evidence-informed quality improvement options, please record initial thoughts on proposed actions. You may also wish to record related thoughts around potential service models, capacity requirements, workforce development or financial considerations. Ideally, discuss these with both the wider cluster and with your local public health team (LPHT). Summarise your proposals for action into the following box:

Type here

ⓘ Now PRINT this page (e.g. to PDF) so you have a record of your entries (Steps E-H). You may then close the Print view browser window and return to the PCNA workbook to review another indicator.