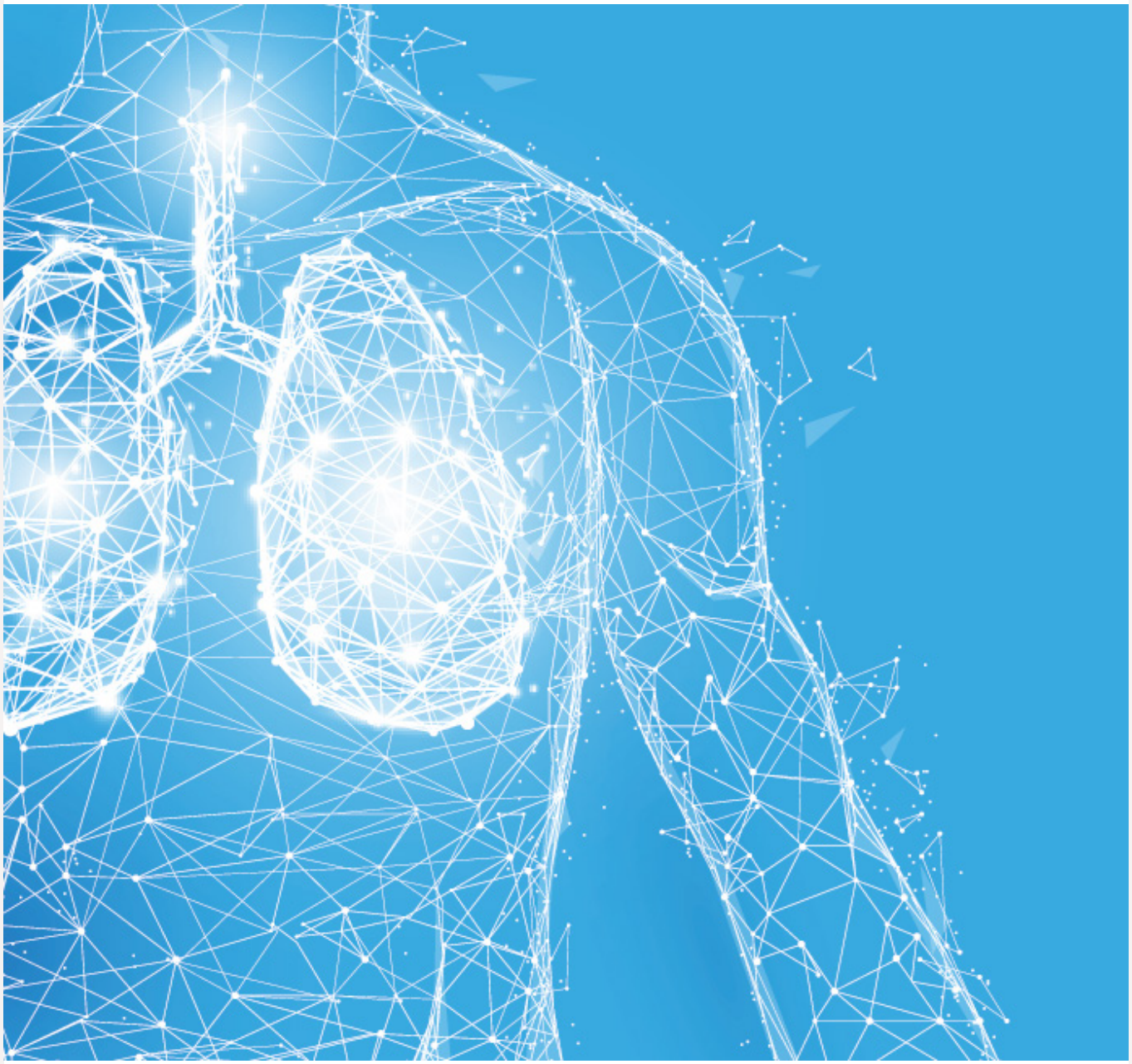
ROUNDTABLE

Respiratory conditions: a system approach

Victoria Vaughan, editor of Healthcare Leader, talks to four experts on the ICB role in tackling respiratory health and how ICBs are working with primary care in this area.



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HEALTHCARE LEADER

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Delegates

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Dr Neil Banik
Former respiratory lead for NHS Kent and Medway ICB, current ICB board member and GP

OVERVIEW

Victoria Vaughan (VV) Let's start with an overview of respiratory care in your respective areas.

Dr Neil Banik (NB) Kent and Medway ICB have got quite a big agenda for respiratory. We've got a 10-point programme for diagnostics and an enhanced service for spirometry at diagnosis and selected follow-up because some patients are unstable on follow-up.

And we've got an enhanced service for FeNO, which is new from April. I think that can transform asthma and NICE decided was one of the core asthma diagnostic strategies.

The other part, of course, is education. For patients, we have very active Breathe Easy groups and Kent has been very active in singing for lungs with a large number of singing groups. In Canterbury alone, we've got three or four.

For healthcare professionals, there's spirometry training and guideline reeducation, webinars and an annual conference. There's quite a lot available, but it's needed because there's been, I'd say, a 50% turnover in staff since Covid. The people who have been treating asthma and COPD for decades have vanished and now we've got a large cohort of new people who need training.

We've got a big digital monitoring programme, partly through [national] My COPD app, and in winter we used a separate platform, which allows patients to enter their symptoms every week or when they have flare-ups. That comes back to nurse practitioners to see whether the patients need rescue antibiotics and steroids.

I think digital is the way forward. It's a misconception that the elderly are not very good digitally. About 80% of patients can manage digital.

Dr Andy Whittamore (AW) I am clinical lead with Asthma + Lung UK and one of the key things we're doing is working with ICBs to help them prioritise and do more with the limited resources they've got. We do that on an ad hoc basis and through our respiratory champion network.

Asthma + Lung UK has just produced an ICB respiratory review and some of the key findings around diagnostics are that only a quarter of ICBs thought they actually had capacity to meet the needs of their entire area for spirometry and only one-third were commissioning anything for children and young people (CYP) with spirometry. And that's despite it being a major part of the new guidelines that have come out for asthma.

Ravijyot Saggu (RS) It's really about the implementation of the asthma guidance and how we get the uptake and change in the system. The last couple of weeks' announcements [about cuts to ICB budgets] have made it really difficult and I'm just worried about how the shifts are going to impact practically on how we're delivering and making a difference.

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> Dr Andy Whittamore

I'm working on the whole health inequalities piece, the CYP transitions of care and those preventable deaths and harm. I'm leading some work nationally around biologics for COPD.

I think equity of care is probably what I'm thinking about. I want that accessibility for treatments and diagnostics.

Dr Louise Ryan (LR) In the system, we're very much focusing on diagnostics for both adults and children – so spirometry, FeNO accessibility and building that into our planning for CDCs (community diagnostic centres) as well. We've got a CDC about to open, which will be providing spirometry and we're getting that set up for both adults and children. Additionally, we're building a breathlessness pathway that will be provided at our CDCs.

We're looking at how we implement the new asthma guidelines and make sure that that's embedded in practice. We're looking at inequalities and starting to think about how we bring in the neighbourhood MDTs for children with asthma.

Within Leicester, Leicestershire and Rutland ICB (LLR), we have commissioned an enhanced service – a cardio-respiratory diagnostics service – where PCNs are funded to provide FeNO, ECGs, 24-hour blood pressure and 24-hour holter monitors. Doing it at PCN level means it's closer to patients' homes, which is much better than going to the hospital. That's what was happening before and the waiting times were huge.

We're monitoring that so we can get really good data. We're monitoring levels of activity – we're paying the tariff per item of activity – but, even with that, the uptake has been slow in PCNs.

VV What impact has the CDC pathway coupled with the PCN work had on waiting times and the numbers of patients going into hospital?

LR We are seeing a definite reduction in waiting times. We need to monitor the quality of the performance in the community because that's always been a concern for our consultants in the respiratory department. They might see somebody who might have had spirometry, but it was poor quality so they just end up doing it again, which is duplication and a complete waste of time.

> Nationally, there were tens of thousands of delays in spirometry, which matches what we found in our area.
>
> Dr Neil Banik

CHALLENGES

VV So, there are some challenges in moving some of these services into primary care. What other challenges or barriers have you come across?

LR There are many barriers to overcome with this. It's a national problem.

The first is the financial barrier. Prior to Covid, many GP practices would do spirometry and training at a variable level of quality – unfunded. This is why there are such challenges in general practice because we can't carry on doing unfunded work. It's not part of the core GMS contract so it's been down to individual ICBs to decide how they fund and commission spirometry.

The big barrier, after finance, is the training and education of staff.

Many people have cited the Association for Respiratory Technology & Physiology (ARTP) accreditation process as a barrier to them taking on spirometry. So even though there's been regional and national funding to pay for the training and accreditation, it's still been a slow uptake.

In LLR, it wasn't being taken up because of the training requirements and we made the decision to say that our providers didn't need to undertake ARTP and that they could undertake training locally to be quality assured. One of our community COPD providers is commissioned to provide support in training and to quality-assure practices, to go in and provide support if there's concern around quality.

AW In many areas, quality diagnosis isn't happening. And when you think maybe as many as a third of people with asthma don't actually have asthma, we need to get the diagnostics right.

Unfortunately, QOF over the last few years has skewed primary care and it's become very box ticky because the workforce is struggling and practices are struggling for finances and therefore doing the bare minimum. Even though lots of practices are getting 90 or 100% of their points for asthma and COPD, if you look deeper into the QOF figures, there are a lot of exclusions – 30 or 40% in some cases. It's called personalised care adjustments. And it means that for whatever reason – patients not engaging because of mental health or where they live or language – they're not getting those basic parts of care which will keep them well and out of hospital.

And the COPD diagnosis indicator has been removed completely from the new GP contract for this year coming, so lots of practices are going to stop investing time and workforce into their respiratory population, which means things are going to get worse. We're not going to be looking at quality diagnosis for COPD so we're going to stop picking up people and their breathlessness, comorbidities and everything else will get worse over time, which means they'll be presenting in hospital for the first time when they're more severe.

They'll be adding to the winter pressures and unscheduled care. They'll be more disabled. They won't be working. There's lots of things they won't be able to do because we've not identified them and got them on the right treatment path quickly enough.

NB There's a mismatch between the ICB regarding the distribution of the diagnostics; it looks like we've got 90% cover across Kent and Medway, but many patients at practices are either not having it done or there are long delays. So, there is a significant mismatch.

Many practices have had to access third-party providers because of the long waiting times. We had a backlog of 200 out of 500 spiros. So, it's not just saying it's available. Of course, it's available for all 500 patients but 200 of them would have had to wait more than a year. A third-party provider has already cleared half of that backlog very nicely in just 100 days. So that is, I think, the reality, as opposed to the projections.

Nationally, I think it showed there were tens of thousands of delays in spirometry for COPD diagnosis, which matches what we found in our area.

RS All I'm hearing from ICB colleagues is that it's just core business because there is so much uncertainty. ICBs have got plans for three years to five years and, in some cases, it completely screws up the plans and programmes of work.

While we do look at cost effectiveness, there's the clinical effectiveness side of it as well. That's using the best available evidence in population health to reduce variation. That's going to go out of the window because it will just be core functions.

I've heard rumours that the long-term plan is now not going to include respiratory. And where you've got something mentioned in the plan then you have money that follows. So, I'm really concerned that we're on a downward slide.

VV But respiratory diseases impact people with social deprivation more than they do other parts of the population; to ignore that feels counter to the health inequalities agenda of a neighbourhood health service. And COPD is part of the Core 20 plus Five. So don't these factors help mitigate risk?

LR It's really only the vaccinations for people with COPD that's on

the core 20 – nothing about disease optimisation or modifiable risk factors. Even pulmonary rehab, which is one of the most evidence-based and value-for-money interventions that you can get for COPD and was a deferred indicator, has now been permanently retired.

In light of what's happening with QOF, I've already asked my teams to give me the figures on referral rates for pulmonary rehab and to keep monitoring it in light of the retirement of that QOF indicator. Luckily, we've not seen a huge drop but that's down to the hard work of our rehab teams in promoting their services.

I do feel that there needs to be recognition centrally of the impact of respiratory disease, a recognition that it affects people living in poverty so much more, and, actually, that so much of it is modifiable and treatable, especially when we're talking about asthma. It's not like it's a disease that we have no treatment for and we can't manage with the right treatment and education, and involving social care, housing, environmental health, and all the things that are required to help improve respiratory health.

It's not just down to doctors. It's a whole system thing, and it needs to be prioritised within the whole system.

OPPORTUNITES

VV Is there a cost barrier to the devices used in the diagnostics? Maybe industry should step up to work in partnership with the NHS to address this or are there already deals being done now?

RS If I'm thinking about medicine and device procurement across the country, it is fragmented. There isn't a standardised approach. There is still this perception that FeNO is so expensive that we just can't do it. But the key thing is we want to be able to provide the service and it shouldn't be that there are massive disparities in the cost.

I think industry is trying. We've got investors and companies trying to step in to fill the gap. I have been contacted recently about various companies that are trying to bring these diagnostic services to the country. Some are foreign companies who don't understand the NHS and they're coming in at a time where it's very uncertain. So there's definitely an appetite there. It's just how we are then able to commission and how we can make it cost-effective, coming to some arrangement.

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>
> Dr Louise Ryan

There are ways of making it more cost-effective and available. When the Health Innovation Networks were called AHSNs (Academic Health Science Networks), there was a Wessex FeNO programme with lots of useful information – a kind of toolkit there for people to look at.

South London is an example now. It has an arrangement – a kind of purchase agreement, a deal for two or three years – with a company that provides, say, sensors.

AW I was the clinical lead for the AHSN programme for rolling out FeNO and by making FeNO more available, companies did change their business model. It was initially very, very costly and NICE actually came against it many years ago. One of the reasons was because people weren't using enough. They had to have high prices to justify keeping the business going but once you start getting into the majority of practice, which according to NICE it should be, we can start to drive costs down. And companies are very amenable to negotiation on that.

LR The difficulty is primary care is so pressured, so overworked, and unless there is adequate incentivisation to prioritise respiratory work, it's not going to be top of the list for general practice.

A lot more incentive is going into cardiovascular disease – understandably because there's a lot of risk. But there is within respiratory as well, particularly the impact of uncontrolled chronic respiratory disease on winter pressures.

That's how I frame things when I'm trying to get things to happen in my system. I say, you know the impact this will have on winter pressures, on ED, on beds, on flow, and on ambulances waiting outside. You know the proactive work that we could, and should, be doing throughout the year could have a huge impact on that.

So, systems really need to think about this in light of what's happening with QOF.

AW Yeah, that's where we need experts to have the data, to work with ICBs and talk about health inequalities.

When they talk about long-term conditions, we need people to actually write in brackets 'COPD' and 'asthma' or 'lung cancer' or 'respiratory conditions' because you're always going to get mentions of diabetes and heart disease but respiratory is falling off the radar.

And it will be detrimental to the rest of the NHS if we don't manage respiratory better. I mean, it's the highest cause of hospital admissions, more than heart disease, more than cancer, so we need to keep it on the radar.

RS If there's the potential for ICBs to be merging to become super ICBs, it might be that there's more of a regional approach taken. At least that would provide a little bit of consistency. And it might be that if a PCN can't afford a FeNO machine in every surgery, then it has them in one or two practices and others refer their patients to them. It's about finding the best and most effective way of delivering.

LR There's obviously discussion around whether ICBs will merge as one way of trying to overcome the 50% cuts at ICBs. That really worries me. If we expand things too far, you lose sight of the people you're trying to serve.

For me, an ICB is a large geographical area and we know our patients and we know our areas. I know which parts of Leicester, Leicester and Rutland have the highest areas of deprivation. I almost know which streets I could walk down and find the problem.

If you expand ICBs further, you're not going to have that level of intelligence or insight into local needs and local populations. You're not going to have that relationship with schools, local authority, environmental health.

AW Primary care is where you should be doing it because it's in the NICE guidelines and we all think you should do it, but ICBs haven't got the headspace or the funding to do it, and NHS England won't put their hands in their pocket either.

But actually, the business cases are there on a practice level. There are some business cases within the toolkit that we put together at the AHSN to show that practices can save money and ICBs can save money because you start to drive down prescribing as well. And if you look at the Asthma + Lung UK report – Saving Your Breath – FeNO and better diagnostics will drive down on a system-wide level as well.

So the business case is there for everybody to invest in. The problem is nobody's got the money to invest in the first place.

LR If you look at diabetes, there are brilliant enhanced services for that. They not only encompass incentives around numbers and bringing levels down but also prevention schemes – education schemes for patients to access before they get diabetes to prevent it. We don't have anything like that for respiratory.

So in terms of enhanced services, for sure, that would be great, but equally, working for the ICS, I know that there's no money in the system and we don't know the future of ICBs or NHS England for now, do we? So it's a really tricky time.

> The blue sky would be standardised national commissioning so that we can make it less hard to get hold of these diagnostics.
>
> Ravijyot Saggu

FUTURE

VV What about the future? What do you want to see happen, how can things change and what would help?

LR I was going to come back on what you said about industry and their support because we've had lots of conversations with pharma and, actually, we are doing some joint working with pharma around a lot of our pathways.

So, I know for sure that pharma has got a lot of resource and it's in their interest to collaborate with us. I think systems need to be quite a bit more savvy. I think there's a fear of collaborating with pharma that we need to overcome. They've got resource to offer that can help us in what we need to do, particularly if you think about the biologics coming out for COPD. Obviously, the pharma companies need to understand how it's going to fit into pathways and how we're going to redesign pathways to allow that to become part of what we do. We're working to map out and look at what exists at the moment.

There's definite potential for those sorts of collaborations with pharma and industry. We've got to look at any resources available to us.

NB We did a three-year project where pharmaceuticals were loaning machines to practices, including consumables, but the uptake was actually very poor because of other factors – the staff time, the training and funding, the nurses and so on. So, we had loads of machines that were left unused.

Hopefully now we're moving to a fixed tariff – £20 per FeNO test – which is profitable, practices will be more keen on that approach as it funds both the machines and the consumables and the staff. Fingers crossed because we pushed hard for that.

I do hope at some point, respiratory again becomes a priority and this huge influx of patients being picked up by lung cancer screening with emphysema are coded as pre-COPD, and we have a programme like pre-diabetes, so that things can really take off and prevent a deluge of patients ending up in hospitals.

AW Respiratory conditions have got the highest mortality gap between rich and poor compared to any other long-term condition. The top three conditions are COPD, asthma and lung cancer. And we know that you are 4.7 times more likely to die of COPD in a more deprived area compared to the least deprived and 4.3 times more likely to be admitted with COPD compared to less deprived areas.

So for that reason, inequalities and respiratory need to be closely intertwined, and it needs to be something the ICBs are aware of. They need the data so they know what their neighbourhoods and their different populations are struggling with and then address that.

It's access to health care, it's housing, it's affordable medicines – there's so many different aspects to it, but actually understanding how big the problem is for your area is a good starting point in how you can start to address that.

I think the important thing is we get ICBs the right data and the right people who understand the whole patient journey. So, it's not just a specialist from tertiary care telling primary care how to do things, but actually representatives from primary care, secondary care and tertiary care all working together to improve the pathway.

We've got opportunities around Core 20 Plus Five and around the development of neighbourhoods to focus on the populations who have become disadvantaged by the way the NHS has struggled over last year. We can identify the populations who really need our input and, in parallel, identify the patients at highest risk by using stratification techniques rather than doing the same thing for everybody.

And finally, I think we can use neighbourhoods to develop an economy of scale. So we can have PCNs or neighbourhoods sharing the resource of FeNO machines and spirometry and the training for the higher levels of skill, and then working with secondary care like an MDT-type model as well.

RS The blue sky would be that there is standardised national commissioning so that we can make it less hard to get hold of these diagnostics. And we need to think about the wraparound – the end-to-end pathways, population health approaches, etc.

I'd like the government to put their money where their mouth is. Yes, they're wanting to cut ICBs and abolish NHS England, but is that going to make it better? I haven't seen anything tangible that inspires confidence that it will make a difference to a patient's waiting time. They can say it, but what does that look like? What are the steps that are going to be taken in real time?

If I'm thinking about the asthma guidelines, I'd like the patient to get the right treatment at the right time so that they're not just left for a long time in between tests that they might get out of order rather than sequentially.

LR I think we need a national respiratory strategy. We need targets, incentives and a strategy from the centre so that ICBs are accountable. At present, ICBs aren't necessarily accountable for waiting times for spirometry, unlike a lot of other diagnostics. We need to have accountability and incentivisation to really target the underserved populations – and not just COPD and immunisations on the Core 20, but around other interventions that we know can have a huge impact.