NHS
North West London
Collaboration of
Clinical Commissioning Groups

WHOLE SYSTEMS INTEGRATED CARE (WSIC) DASHBOARDS COLLABORATION OF NWL CCGS

A S T H M A

North West London
Whole Systems Integrated Care

Information Sharing

"Today we see too many missed opportunities to prevent a persons health from deteriorating or to stop their problems from reoccurring....."

British Red Cross – In and out of hospital report

Our Partners

Key facts • Over 2 Million People • Over £4bn Annual Health & Care Spend • 8 Local Boroughs • 8 CCGs & Local Authorities • 354 GP Practices • 10 Acute & Specialist Hospitals • 2 Mental Health Trusts • 4 Community Health Trusts

CCGs

- Central London Clinical Commissioning Group
- West London Clinical Commissioning Group
- Hammersmith and Fulham Clinical Commissioning Group
- Hounslow Clinical Commissioning Group
- Ealing Clinical Commissioning Group
- Brent Clinical Commissioning Group
- Harrow Clinical Commissioning Group
- Hillingdon Clinical Commissioning Group

Out Of Area

19 Out Of Area providers are used by our North West London Patients

Acute

- The Hillingdon Hospitals NHS Foundation Trust
- Chelsea and Westminster Hospital NHS Trust
- London North West Healthcare NHS Trust
- Imperial College Healthcare NHS Trust

Social Care

Brent · Harrow Council London · Hillingdon London · The Royal Borough of Kensington and Chelsea · City of Westminster · h&f hammersmith & fulham · London Borough of Hounslow · Ealing www.ealing.gov.uk

Community

- Central London Community Healthcare NHS Trust
- Hounslow and Richmond Community Healthcare NHS Trust
- Central and North West London NHS Foundation Trust
- London North West Healthcare NHS Trust

Mental Health

- Central and North West London NHS Foundation Trust
- West London NHS Trust

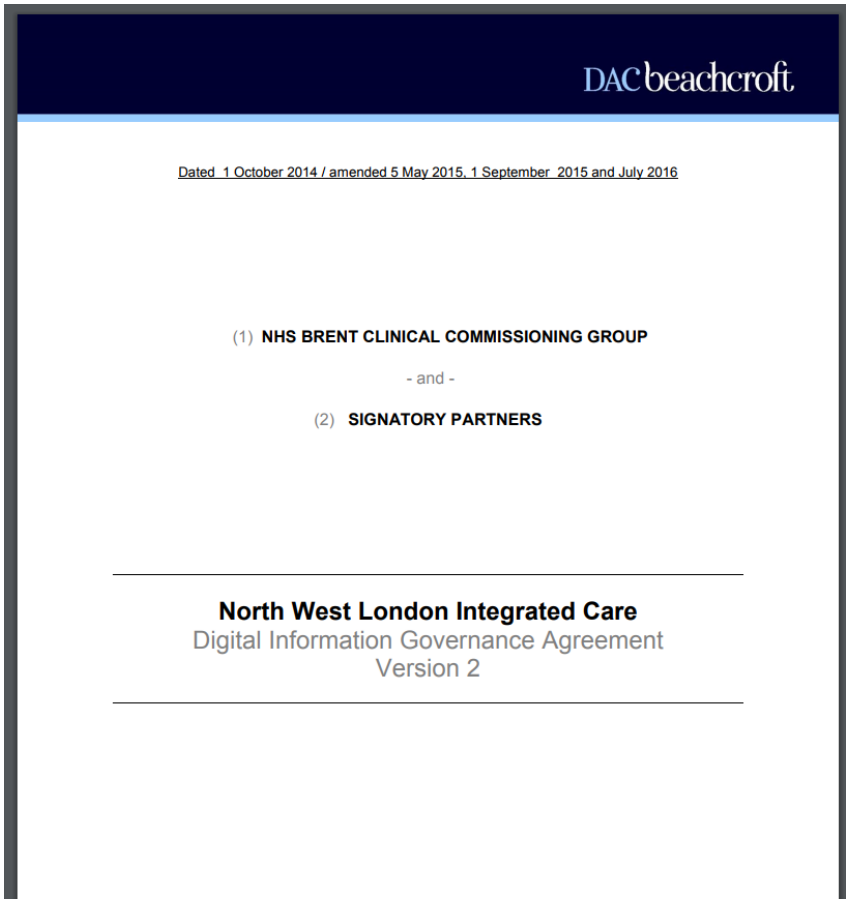
GPs

North West London Whole Systems Integrated Care

Data Sharing in NWL and the Information Sharing Agreement

The purposes of the information sharing are to enable:

- **Care Planning Purpose -** any Provider Partner providing Direct Care to a patient who has consented to access that patient's Individual Integrated Care Record electronically for the purpose of providing Direct Care.
- **Case Finding Purpose** - Provider Partners to access information from the Whole Systems Integrated Care Record about their own patients, to support their identification of patients suitable for targeted care.
- **De-identification Purpose** - the Host of the arrangement to de-identify shared information so that it may be used for the commissioning purposes of CCG Partners.
- **Patient Access Purpose** - the development of Patient Access Services to enable patients and their carers to access their records.
- **Maintenance Purpose** - the Host of the arrangement to maintain the Whole Systems Integrated Care Record, including by human intervention where required to ensure data integrity.


DACbeachcroft

Dated 1 October 2014 / amended 5 May 2015, 1 September 2015 and July 2016

(1) **NHS BRENT CLINICAL COMMISSIONING GROUP**

- and -

(2) **SIGNATORY PARTNERS**

North West London Integrated Care
Digital Information Governance Agreement
Version 2

Patients CAN OPT OUT of data sharing

ISA being re-written in 2019

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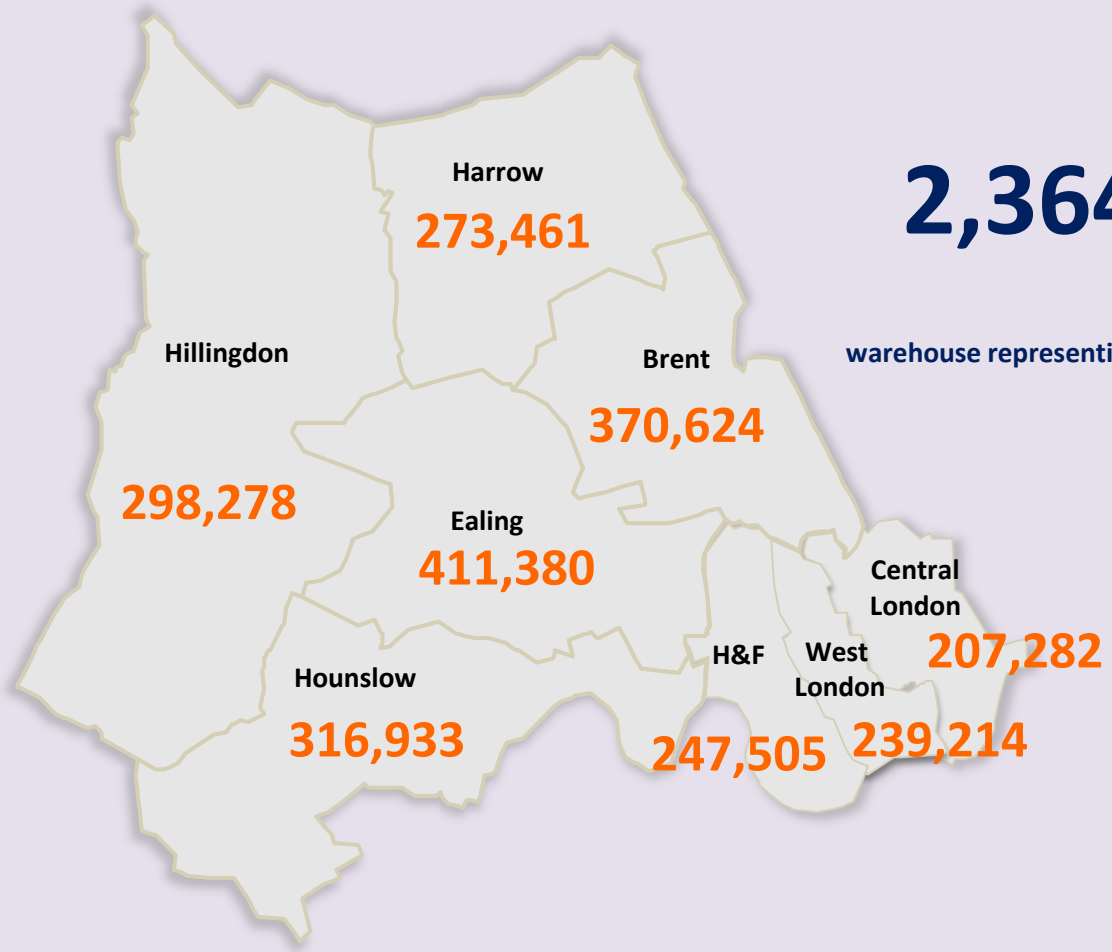
WSIC Data Warehouse Population



2,364,677 patients in the WSIC data warehouse representing **94.8**% of the patient population in NWL*

*2,493,521 patients registered at a GP practice in NWL (1/01/19)

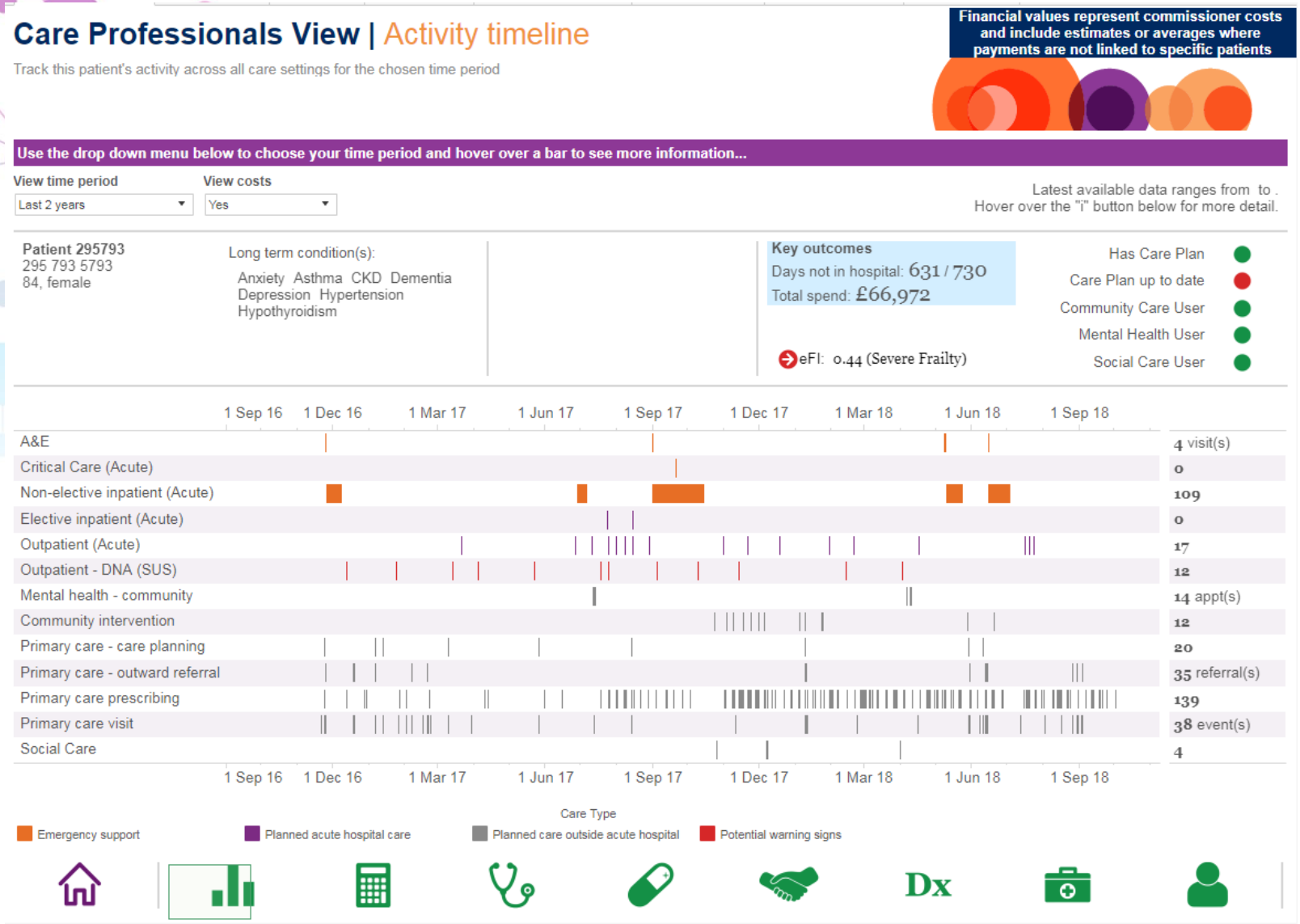
https://app.powerbi.com/view?r=eyJrIjoiNjQxMTI5NTEtYzlkNi00MzljLWE0OGItNGVjM2QwNjAzZGQ0IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

Direct Care

"Care professionals will be at the centre of organising and coordinating peoples care so that care is accessible and in the most appropriate settings".

Whole systems integrated care toolkit

Integrated Patient summary – Activity Timeline



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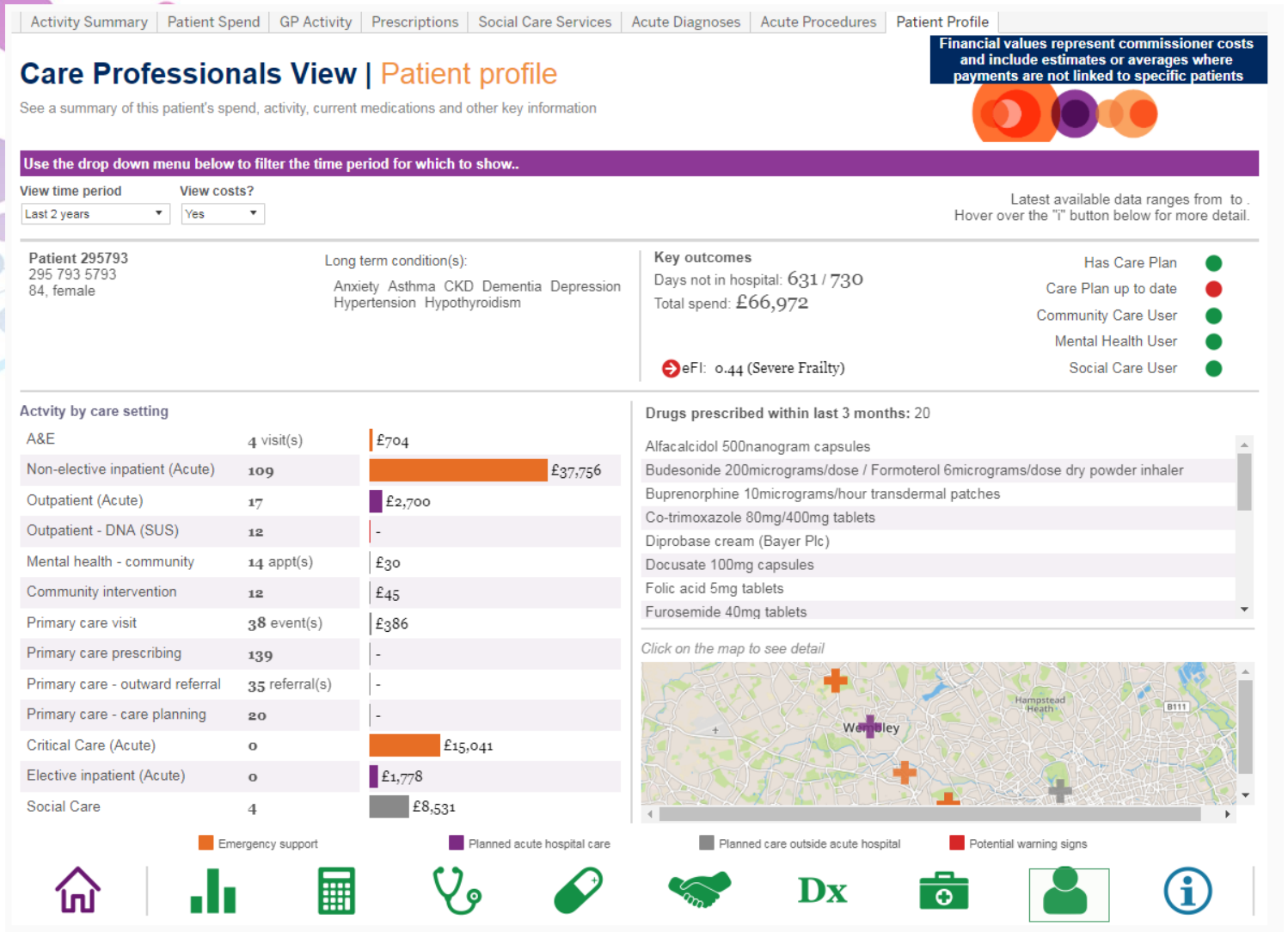
Integrated Patient summary – Patient profile



Asthma: Introduction

The UK National Review of all asthma deaths in the UK concluded that
Over 60% of the deaths had major preventable risk factors.
Risks were not recognised by the clinicians – and included :

- Patients were prescribed excess reliever medication – more than 4 puffs of a reliever in a week is an indication of poor asthma control (this equates to more than 1 ½ blue inhalers a year.
- Insufficient preventer inhalers were prescribed for most of those who died.
- 10% had been discharged from hospital after treatment for an asthma attack without follow up, in the four weeks before they died; and
- About a fifth had been treated in A&E in the year before they died.

An asthma attack means that something serious has gone wrong with the management of a patient. This may be related to drug treatment, inability to use inhalers, lack of education of patients about the disease, their medication, to recognize danger and take action, and when to call for help.

Risk factors for asthma attacks and deaths are well known and have been published in Table 11 of the BTS/ SIGN British Asthma Guidelines and table 2-2 of the Global Asthma Strategy (GINA).

Traditionally, mainly driven by QoF, asthma reviews are only done once a year in the UK. As asthma is an on-going, chronic disease, this isn't really logical. As asthma attacks and exacerbations signify that something serious has gone wrong, it is important to do a post attack review before the patient runs out of oral corticosteroids. After an attack, patients need to be assessed to determine whether the attack is over, and to act appropriately if not; and to establish what went wrong and take action to optimize the treatment. Furthermore, the presence of any risk factors should result in action by a clinician.

As there are a number of risk factors for asthma attacks, it is difficult for clinicians to check for each one during consultations. The Asthma Radar has been designed to classify risks into 'Red Flag' status, to help clinicians easily identify those patients at risk, whose care needs optimising. Patients with any of the risk factors identified should have a review by a doctor, or a nurse with training in asthma care.

Asthma Radar

Whole Systems Integrated Care | Asthma Radar

Identify patients with asthma who may be at high risk and/or in need of review

Click on a traffic light to view details of the selected patient

GP Practice	Patient Segment	RCP Review Filter	Sort by...
(All)	(All)	No filter selected	Number of Red Flags

70,596 patients on list

Patient Name	Age	Number of Risk Factors	Number of A&E/UCC Attendances (past 12 months)	Number of Exacerbations	Number of Prescriptions (past 12 months)		Asthma Care				Lung Function	
				Exacerbations	Short-Acting β-Agonists	Inhaled Corticosteroids	Asthma Review	Inhaler technique	Symptom Control Test	Personal asthma plan	Peak Flow	FEV1
	76	5.2	1	9	9	2						
	47	4.2	1	3	11	1						
	36	3.1	0	2	12	0						
	5	2.1	1	2	7	3						
	3	1	2	2	18	2						
	3	0	1	2	7	1						
	75	6.1	1	2	8	2						
	37	4.2	0	3	9	2						
	57	2.1	1	2	8	0						
	71	6.2	7	5	7	0						
	69	6.2	1	6	12	11						
	55	6.2	2	7	28	0						

Click to highlight traffic lights of that colour

Green Flag Amber Red Flag Neutral/Unknown

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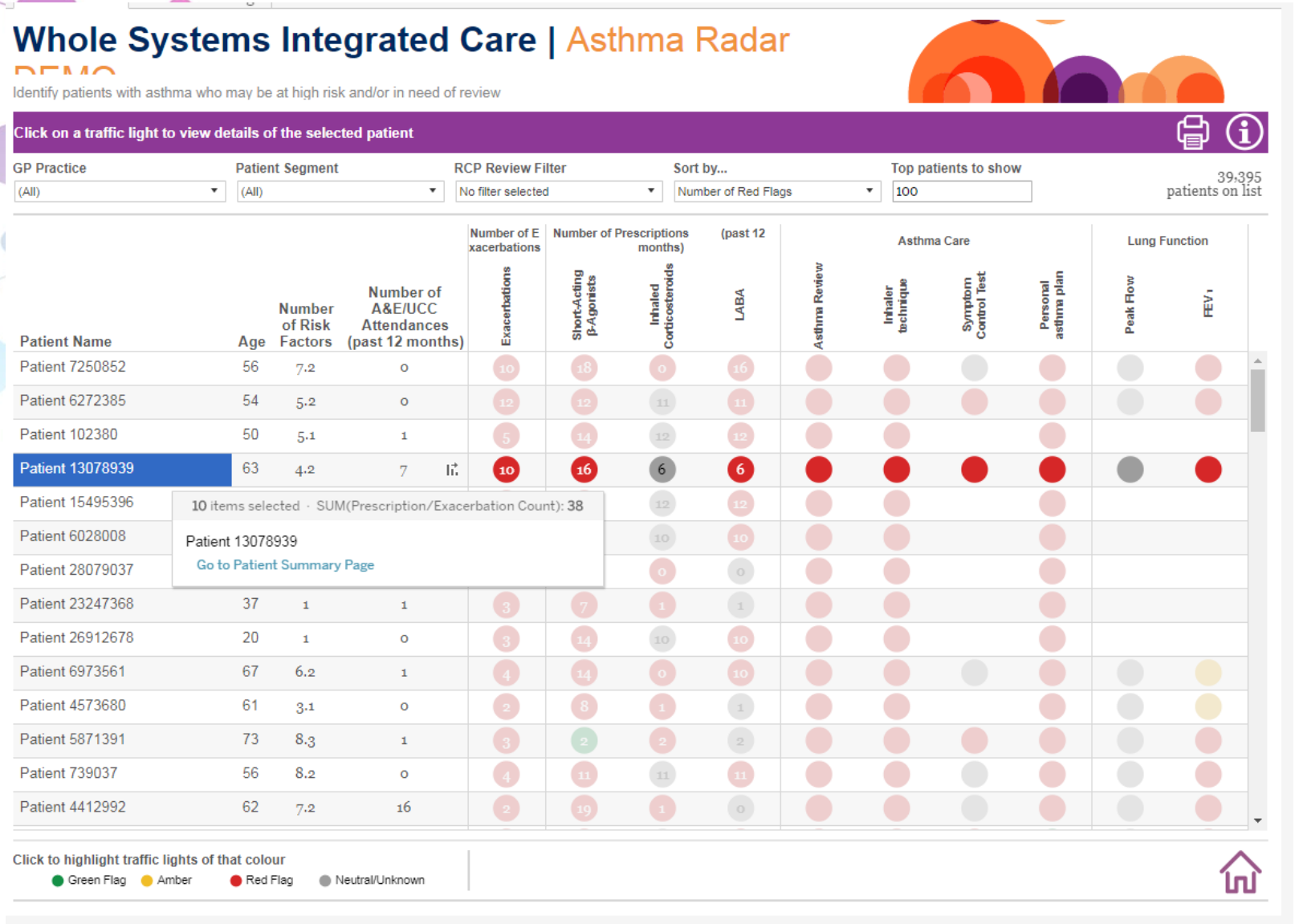
Click and hover over a patient to view links to their **Integrated Patient Summary**



- Select a patient to reveal more information below about that individual
- A missing traffic light indicates that no data is available for the indicator
- Hover over traffic lights to see when an item was last recorded and the most recent result

Whole Systems Integrated Care | Asthma Radar

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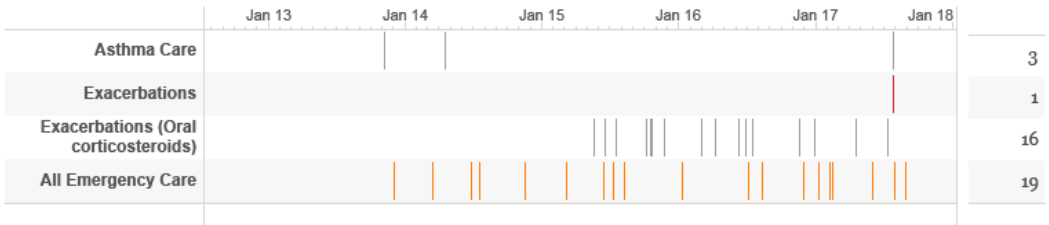
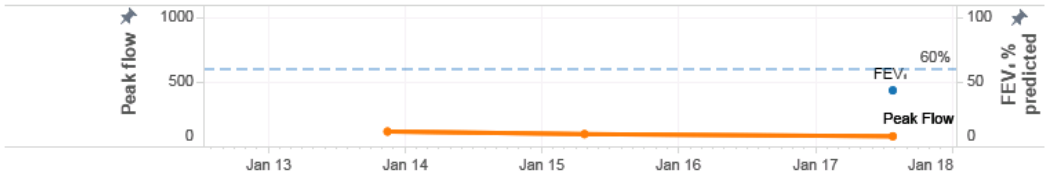
Patient Name	Age	Number of Risk Factors	Number of A&E/UCC Attendances (past 12 months)	Number of Exacerbations: Exacerbations	Number of Prescriptions (past 12 months): Short-Acting β-Agonists	Number of Prescriptions (past 12 months): Inhaled Corticosteroids	Asthma Care: Asthma Review	Asthma Care: Inhaler technique	Asthma Care: Symptom Control Test	Asthma Care: Personal asthma plan	Lung Function: Peak Flow	Lung Function: FEV1
	76	5.2	1	9	9	2						
	47	4.2	1	3	11	1						
	36	3.1	0	2	12	0						
	5	2.1	1	2	7	3						
	3	1	2	2	18	2						
	3	0	1									

Patient Name , 71
NHS #:

Risk Factors

COPD Inhaler technique poor Obesity Smoker
FEV1 < 60% predicted Multiple courses of oral corticosteroids





Click to highlight traffic lights of that colour

Green Flag Amber Red Flag Neutral/Unknown

Asthma Radar – Patient Summary

- Patient level radar showing patients diagnosed with Asthma, prescriptions, number of asthma admissions and date of last Asthma review
- Use to identify asthma patients who are having exacerbations and require a review of care and prescriptions

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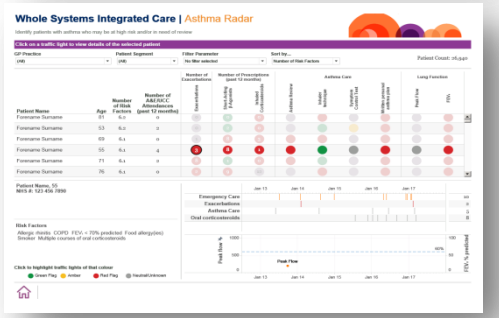
Using WSIC Dashboard to aid complex patient care
CC4C Hub MDTs - Asthma

Case Hunting

- Foundation doctor used the Dashboard Asthma Radar to pro-actively identify 'at risk' paediatric asthma patients within the CC4C hub population to discuss in their MDT meeting.
- The most 'at risk' patients were identified and ranked according to number of red flags and number of exacerbations.
- Further information was gathered from their Asthma Radar profile, hospital notes and clinic letters.
- These were summarised and sent to the Paediatric consultant facilitating the MDT meeting who finalised case selection.

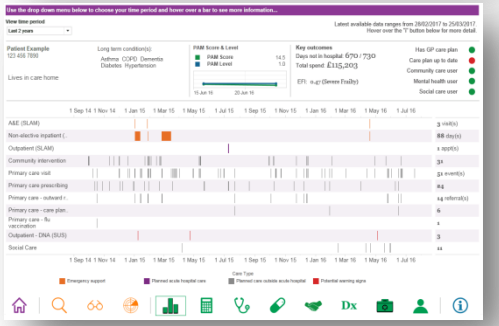
The Patient

- An 11-year-old girl was selected due to having 5 asthma exacerbations in the last 12 months, 2nd highest in the CC4C hub population. Her symptoms interfered with her daily activities and sports. She had multiple GP attendances and up to 30 courses of oral steroids, which was associated with an increase in appetite and difficulty losing weight.
- She was known to CAMHS for ADHD and attachment disorder and previously on the Children Protection Register for neglect. Her mother had depression and was a full-time carer for her uncle. She was recently bereaved of her father and grandmother.



MDT

- The patient was discussed at the specialist Paediatric and GP MDT. Updates were shared on her current clinical status and shared details of her extensive management, including practice nurse counselling and inhaler technique sessions.
- Due to her complex social situation, the practice manager arranged to follow-up the patient.
- The GP team had referred her to the General Paediatricians at St Mary's Hospital. The paediatric consultant offered to instead see her in the outreach CC4C GP hub clinic which would provide the same service in a more convenient and familiar location.



Outcome

- As a result of being identified using the Dashboard as an 'at risk' asthma patient, they were discussed by a MDT consisting of specialist paediatricians, asthma clinical nurse specialists and GPs.
- This allowed for clarity of the patient's current clinical status and complex social issues, achieving shared understanding of the wider patient picture and their management, and therefore improved continuity of care.
- The patient would be followed up by the GP practice and receive specialist paediatric service in the comfort and convenience of their local CC4C GP hub.

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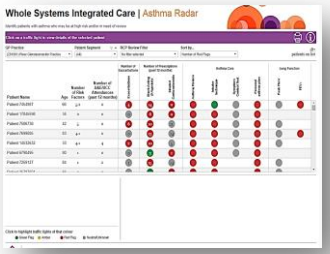
Using WSIC Dashboard to aid GP practices

Case Hunting

- WSIC dashboard was used to identify patients with poorly controlled Asthma based at a GP practice. This was based on 'red flags' pointed out by WSIC such as frequency of ED attendances



The Patient

- This identified 12 most 'at risk patients'. Further factors such as compliance to Inhaler therapies and regularity of annual asthma reviews was explored for these patients on System-1

Intervention

- Discussion with nurses & GPs at the practice led to the recommendation of initiating group consultations at the practice. This was seen as a better choice for patients as opposed to the conventional asthma review clinic and an opportunity for patients and children alike to meet with families going through similar issues

Outcome

- A framework for the group consultation model was created and the practice is now in the process of recruiting patients to attend. We will also be using the Practice Champions (patient volunteers) and Integrated Care fellows from the local hospital, for assistance in non-clinical facilitation of the consultations.

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Asthma: CYP Key indicator outcomes for YTD 17/18 and 18/19

Under 18 YTD 17/18

Numbers of patients who have an asthma management plan- **1,385**
Numbers of patients who have been shown how to use inhaler effectively – **1,680**
Numbers of patients of have had an Annual review – **2,665**
Number of patients prescribed >= 4 ICS Prescriptions – **5,184**
Number of patients prescribed <=6 SABA Prescriptions – **9,759**
Number of patient who have not had an asthma review since their last exacerbation **1,126**
How many have had an symptom control test completed – **3,374**

ACT = 642
ACQ = 2
RCP = 2,730

Under 18 YTD 18/19

Numbers of patients who have an asthma management plan- **5,247**
Numbers of patients who have been shown how to use inhaler effectively – **4,179**
Numbers of patients of have had an Annual review – **8,454**
Number of patients prescribed >= 4 ICS Prescriptions – **3,869**
Number of patients prescribed <=6 SABA Prescriptions – **12,059**
Number of patient who have not had an asthma review since their last exacerbation - **636**
How many have had an symptom control test completed – **9,604**

ACT = 1208
ACQ = 0
RCP = 8,396

Asthma: (Adults) Key indicator outcomes for YTD 17/18 and 18/19

18 and over YTD 17/18

Numbers of patients who have an asthma management plan- **6,906**
Numbers of patients who have been shown how to use inhaler effectively – **9,379**
Numbers of patients of have had an Annual review – **13,330**
Number of patients prescribed >= 4 ICS Prescriptions – **35,495**
Number of patients prescribed <=6 SABA Prescriptions – **40,854**
Number of patient who have not had an asthma review since their last exacerbation **5,967**
How many have had an symptom control test completed – **16,691**

ACT = 3,304
ACQ = 26
RCP = 13,361

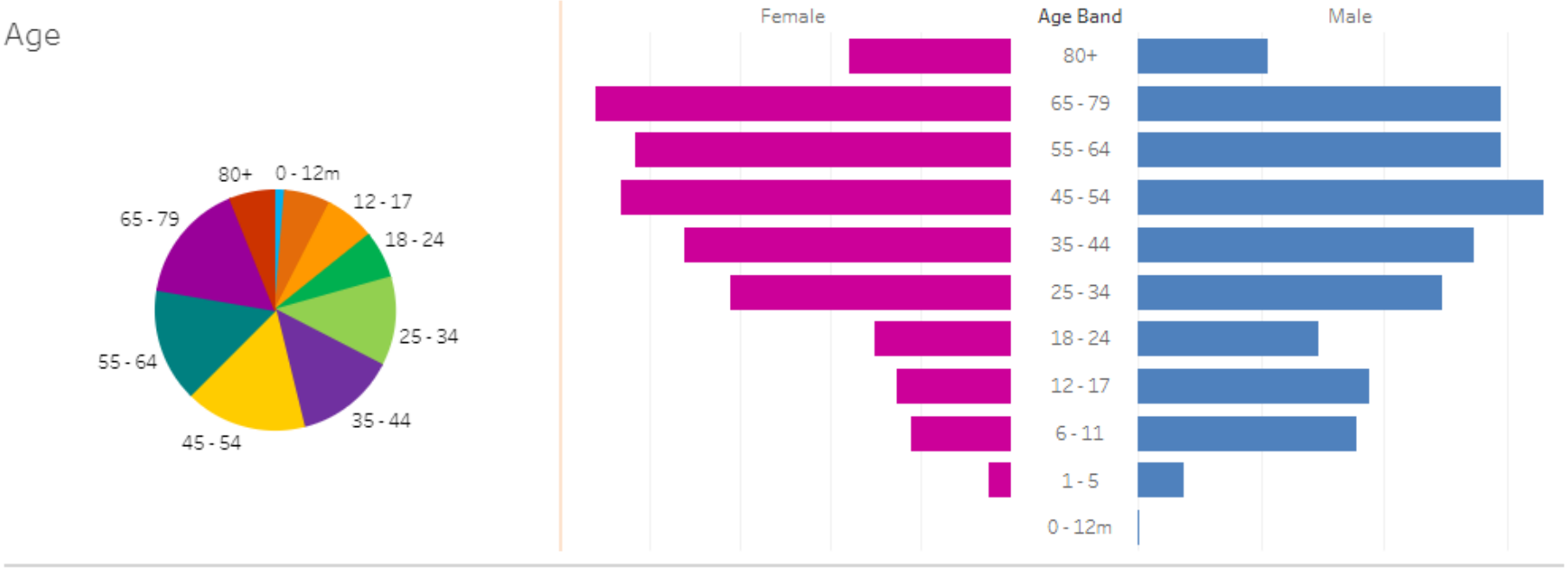
18 and over YTD 18/19

Numbers of patients who have an asthma management plan- **26,695**
Numbers of patients who have been shown how to use inhaler effectively – **21,450**
Numbers of patients of have had an Annual review – **46,133**
Number of patients prescribed >= 4 ICS Prescriptions – **28,977**
Number of patients prescribed <=6 SABA Prescriptions – **52,743**
Number of patient who have not had an asthma review since their last exacerbation – **3,408**
How many have had an symptom control test completed – **59,887**

ACT = 13,704
ACQ = 11
RCP = 46,172

Asthma: NWL WSIC population

CCG Name	0 - 12m	1 - 5	6 - 11	12 - 17	18 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 79	80+	Grand Tot..
BRENT CCG		8	14	30	724	1,530	1,871	2,351	2,354	2,546	1,034	12,462
CENTRAL LONDON CCG		60	293	377	463	814	847	998	933	981	379	6,145
EALING CCG		330	1,494	1,514	1,108	1,904	2,502	2,896	2,631	2,765	1,000	18,144
HAMMERSMITH AND FULHAM ..	1	67	458	514	618	1,717	1,228	1,391	1,181	1,161	436	8,772
HARROW CCG	5	199	912	1,065	762	1,199	1,367	1,787	1,922	2,229	911	12,358
HILLINGDON CCG		197	1,116	1,238	1,019	1,460	1,923	2,252	2,030	2,041	779	14,055
HOUNSLOW CCG		291	1,115	1,056	801	1,475	1,859	2,137	1,870	1,977	656	13,237
WEST LONDON CCG		74	365	491	448	1,038	1,069	1,402	1,264	1,366	502	8,019
Grand Total	6	1,226	5,767	6,285	5,943	11,137	12,666	15,214	14,185	15,066	5,697	93,192



*Brent Children's data currently being loaded into WSIC