Royal College of Physicians | National respiratory audit programme (NRAP)

National Respiratory Audit Programme (NRAP)

Healthcare improvement (HI) strategy 2024-2026

Version 1.2: April 2024

Introduction

This strategy outlines a sustainable framework for how the National Respiratory Audit Programme (NRAP) will support healthcare improvement within respiratory settings in England and Wales between April 2024 and May 2026.

NRAP aims to improve the quality of care, services and clinical outcomes for people with respiratory conditions, and healthcare improvement is central to the programme. Our approach involves providing meaningful real-time data to participating services, engaging with local, regional and national stakeholders, supporting a comprehensive improvement programme, and using data insights from the data collected to inform national policy to support population-level change.

The aim of this healthcare improvement (HI) strategy is to:

- Outline the 5 healthcare improvement goals which NRAP will support clinical services to achieve by May 2026
- Outline a framework of HI activity which enables and supports stakeholders to use audit data to facilitate improvements in the quality of care and outcomes for people living with respiratory conditions
- Outline how progress will be tracked and reported on.

Improvement goals

Our 5 HI goals cover the breadth of the patient pathway, and have been informed by wide stakeholder engagement, including involvement from our adult, children and young people patient groups. The achievement levels for each goal were decided in collaboration with a dedicated task and finish group. They represent ambitious yet achievable goals in NRAP priority areas of prevention, early and accurate diagnosis, self-management and treatment, and are underpinned by evidence-based guidelines for high quality care.

Respiratory care is increasingly delivered in an integrated way across primary, community and secondary settings. Whilst we do not expect every goal will be achieved across each setting individually, we will work to support improvement across the whole pathway. When delivering improvement activities in support of these goals, services should ensure they are working towards equity of care to address unwarranted variation in achievement.

These improvement goals will be supplemented by national recommendations identified yearly in our annual State of the Nation reports.

Prevention strategies

Identifying tobacco dependency and ensuring all patients have access to evidence-based behavioural support and treatment in line with the NHS Long Term Plan commitment remains a priority for the health system.

In 2021-22, 69.1% and 57% of current smokers with asthma and COPD respectively were referred for smoking cessation following an admission, and 37% of parents/carers who were current smokers of children and young people with asthma had tobacco dependency addressed. In 2021, 2.6% and 5.1% of current smokers with asthma and COPD respectively received a referral from primary care (Wales only).

***HI Goal 1:* 100% of patients with COPD and asthma who smoke, and parents of children and young people who smoke, have been offered a referral to treat tobacco dependency and/or prescribed treatment by May 2026.**

Delivering earlier, accurate diagnosis

Guaranteeing an early and accurate diagnosis of respiratory conditions ensures people can access the right treatments and care they need.

In 2021-22, 43% of people with COPD admitted for an exacerbation had a spirometry result available. In 2021, 1.9% of people on the COPD register in primary care had a spirometry result meeting the diagnosis requirement, and 43.9% of adults and 34% of children diagnosed with asthma in the past two years had a record of any objective measurement.

***HI Goal 2:* 70% of patients with COPD have a quality assured post-bronchodilator spirometry which confirms obstruction, and 70% of people diagnosed with asthma in the past two years have a (ever recorded) record of any objective measurement, in line with national guidelines, by May 2026.**

Supporting self-management

Personalised action or self-management plans for people with respiratory conditions support patients and their families with self-management, providing the information they need to manage their symptoms and prioritise what matters to them.

In 2021-22, 54.5%, 57.7% and 38% of people with adult asthma, COPD and children and young people's asthma respectively received a personalised action plan as part of their discharge bundle. In 2021, 25% and 22.9% of adults and children and young people with asthma respectively had a personalised action plan in primary care (Wales only).

***HI Goal 3:* 75% of patients with asthma and COPD who are discharged from hospital after an acute event, as well as patients in primary care with a recorded diagnosis, have a current self-management plan by May 2026.**

Ensuring timely access to optimal care

Everyone living with respiratory conditions should receive timely access to the best interventions and care which help prevent hospital admissions, including pulmonary rehabilitation and inhaler technique checks.

In 2021-22, 40% of people with COPD started PR within 90 days of referral, and 20% of people with an acute exacerbation of COPD (AECOPD) started PR within 30 days of referral.

***HI Goal 4:* 70% of patients start a PR programme within 90 days of referral, and 70% of patients with AECOPD start within 30 days of referral, by May 2026.**

In 2021-22, 68.2%, 66.9% and 65.2% of adults with asthma, COPD, and children and young people with asthma respectively received an inhaler technique check following a hospital admission.
In 2021, 25.1%, 28.2% and 24.9% of adults with asthma, COPD and children and young people with asthma respectively received a check in the last year in primary care (Wales only).
***HI Goal 5:* 80% of all people with asthma and COPD have their inhaler technique checked after admission and annually within primary care by May 2026.**

Tailored improvement approaches

National

At a national level, we will provide high-quality data and insights to support improvement initiatives in England and Wales. We will continue to engage with national bodies to ensure our insights contribute to the understanding of relevant policy areas, including through DHSC's upcoming Major Conditions Strategy, and will provide national high-level reporting (both clinical and organisational) annually to support policy makers. We'll promote improvement through engagement with key stakeholders including the British Thoracic Society, Asthma + Lung UK and Primary Care Respiratory Society. We'll also support financial incentives by reporting on Best Practice Tariffs (BPT), to ensure providers can drive healthcare improvement in line with the NRAP HI goals.

Regional

At a regional level, we will encourage and support whole system engagement in healthcare improvement. The regional respiratory clinical networks in England are continuing to become more established and we will work with colleagues in each clinical network and region to provide a tailored package of improvement support based on need. This will involve:

- Making regional and ICB-level benchmarking data publicly available for all key metrics
- Building relationships with all key stakeholders in each region, including regional NHS England teams, respiratory clinical networks, Local Health Boards and Health Innovation Networks (formerly Academic Health Science Networks)
- Attending regional meetings across England and Wales on a rolling basis to present on progress with the HI strategy and provide an offer of support
- Promoting and signposting to relevant improvement resources (videos, webinars/support sessions, resource packs, ICST respiratory toolkit)

Local

We continue to provide accessible, publicly available, meaningful data and insights which can be tailored by services. NRAP holds good practice repositories where local clinical teams can share their challenges and achievements in the provision of respiratory care with one another. We will promote these to services so they can draw on good practice to support change through peer-to-peer learning. By reporting on BPT achievement we'll enable local teams to identify financial incentives which can be reinvested locally to drive improvement. We will also provide:

- Live run charts, so services can track HI using monthly data
- Online tutorials and accessible, downloadable resources, highlighting the impact of healthcare improvement from using service data

- Local templates covering driver diagrams, PDSA cycles and SMART aims to support local improvement projects using NRAP data and evidence-based methods to enhance the chances of delivering successful projects.

Our local offer also includes a bespoke Improvement programme, which will be delivered in collaboration with the RCP education faculty. Building on our first round in 2022, this will allow clinical teams and improvement coaches to collaborate an improvement project related to these goals using NRAP data to measure change.

Enablers

NRAP team:

We are expanding our NRAP clinical team to ensure we have the capacity and expertise to achieve these goals. We are recruiting a clinical lead with specific expertise in healthcare improvement to lead the implementation of this strategy. We will also appoint clinical fellows to provide targeted HI support across each audit workstream.

Improved service-level participation and case ascertainment

To accurately identify areas of need and measure improvement, we need comprehensive audit data across England and Wales. We have developed a trust engagement strategy which outlines how we will increase engagement which the aim of achieving participation from every eligible service in England and Wales. Our case ascertainment strategy outlines strategies and next steps to increase the level of records entered into the audit by services. Participation and case ascertainment will continue to remain a central priority within our improvement work.

Patient and public involvement

Our patient panels have supported the development and shaping of this strategy. The HI goals are informed by their feedback describing what was important to them about their respiratory care. We will review annual progress on our HI goals with our patient panels and incorporate feedback from quarterly insight-gathering sessions.

Communications

The NRAP communication strategy will raise the profile of the audit programme. We will use a variety of channels, including newsletters, best practice webinars and attending conferences to raise awareness of the HI goals with audit participants. We will be proactive in having a presence in forums where our audit participants are already engaging (N-QI-CAN and FutureNHS platforms) to seek opportunities to amplify communications, be responsive to queries and feedback and signpost our resources.

Evaluation and next steps

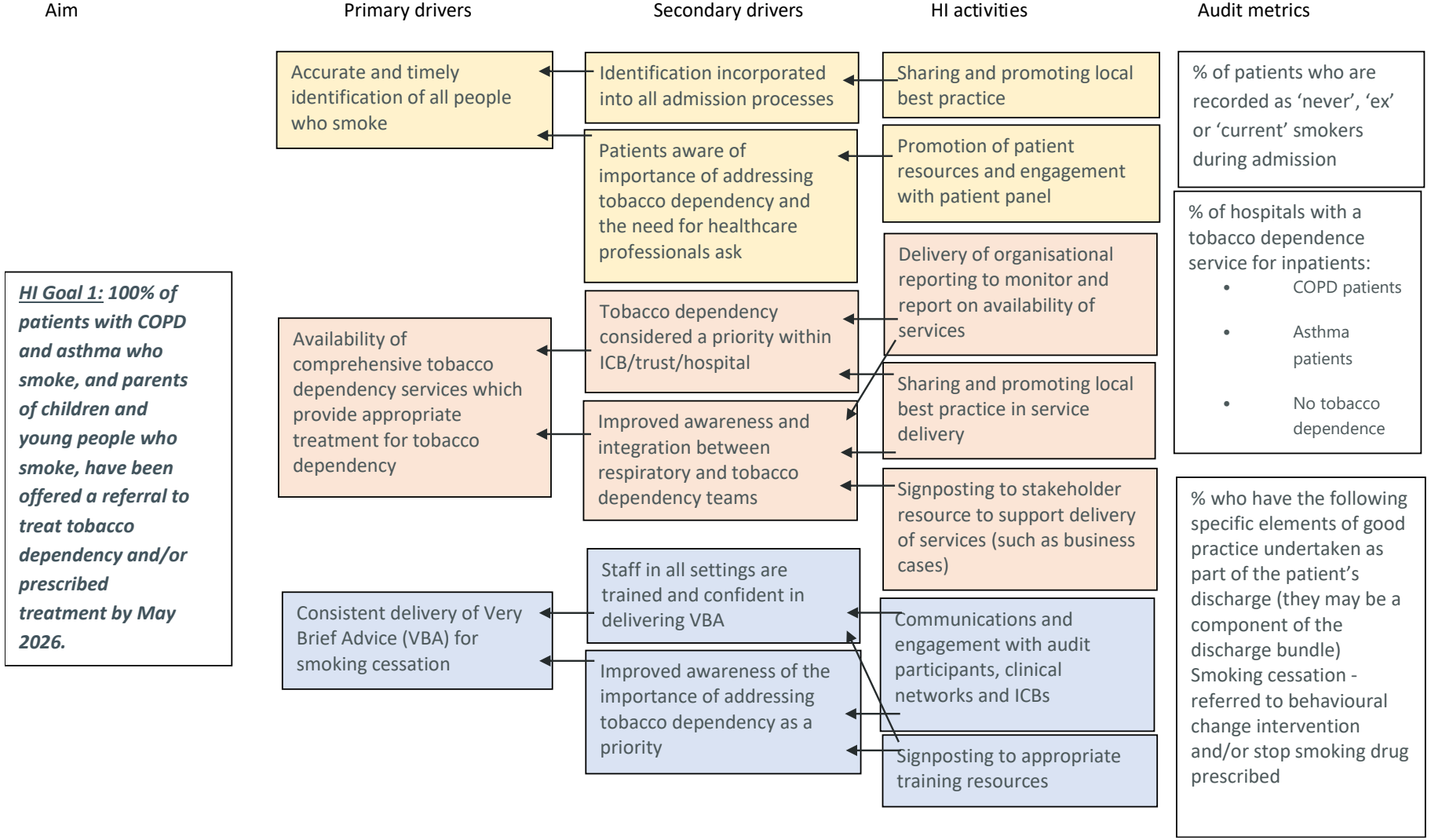
The NRAP team will review progress, assess national year-on-year achievement against our improvement goals and will report this to the NRAP Board. Where appropriate we may identify incremental percentages for our improvement goals following publication. Changes to the goals

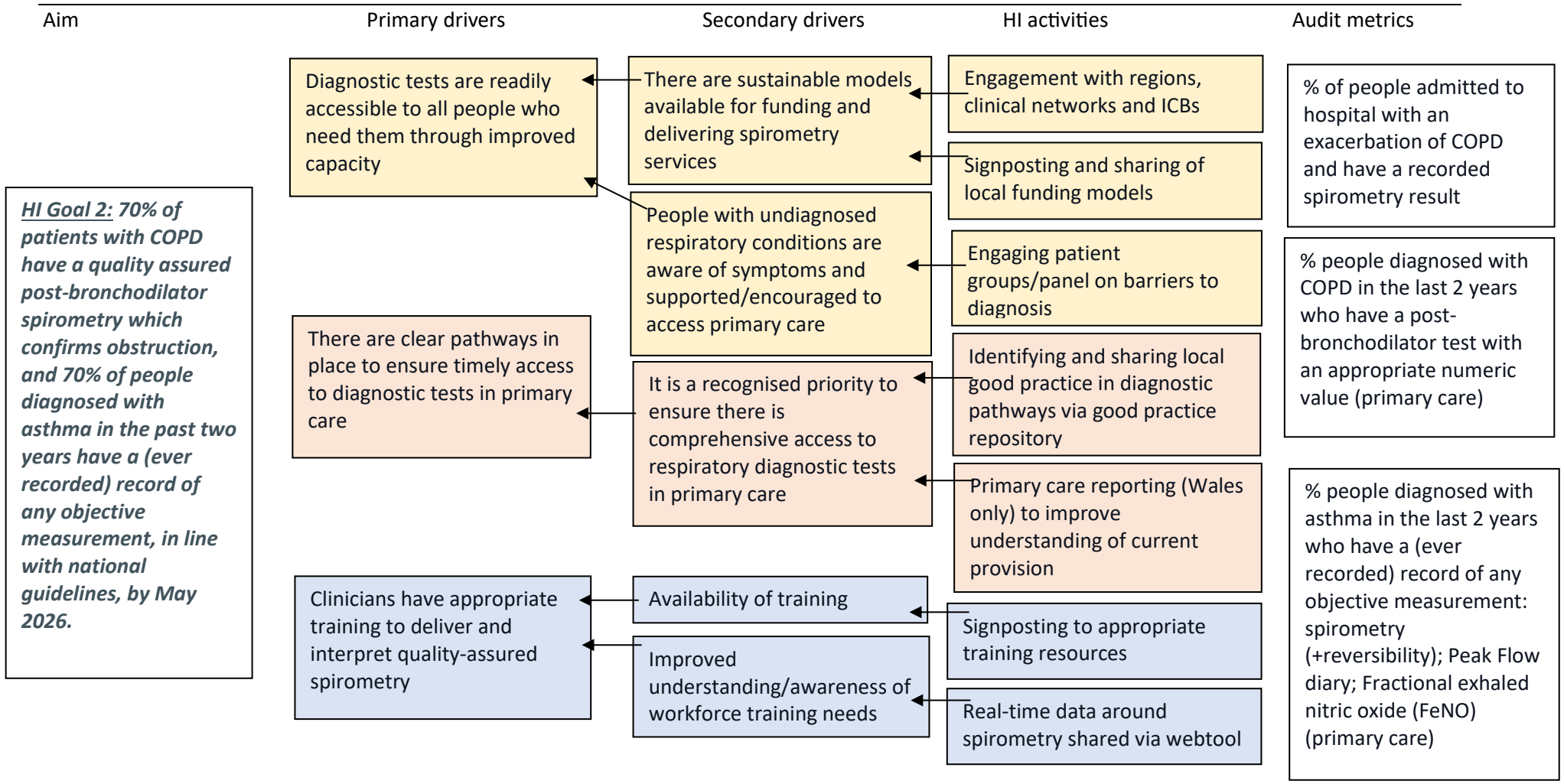
or strategy in response to internal or external factors will be suggested at operational level ratified by the Board and then incorporated by the audit team. The strategy will be fully evaluated in 2026.

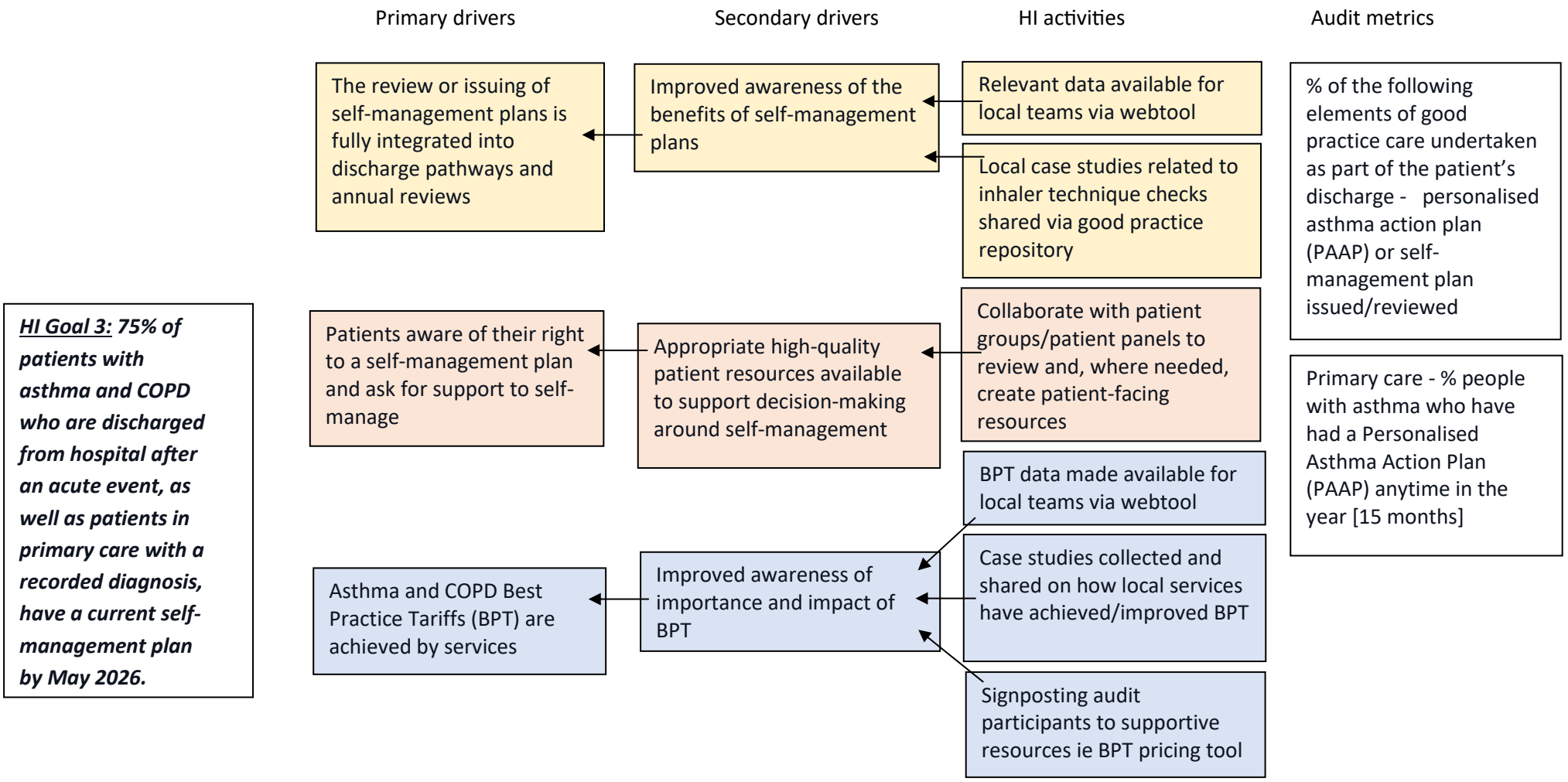
Timeline

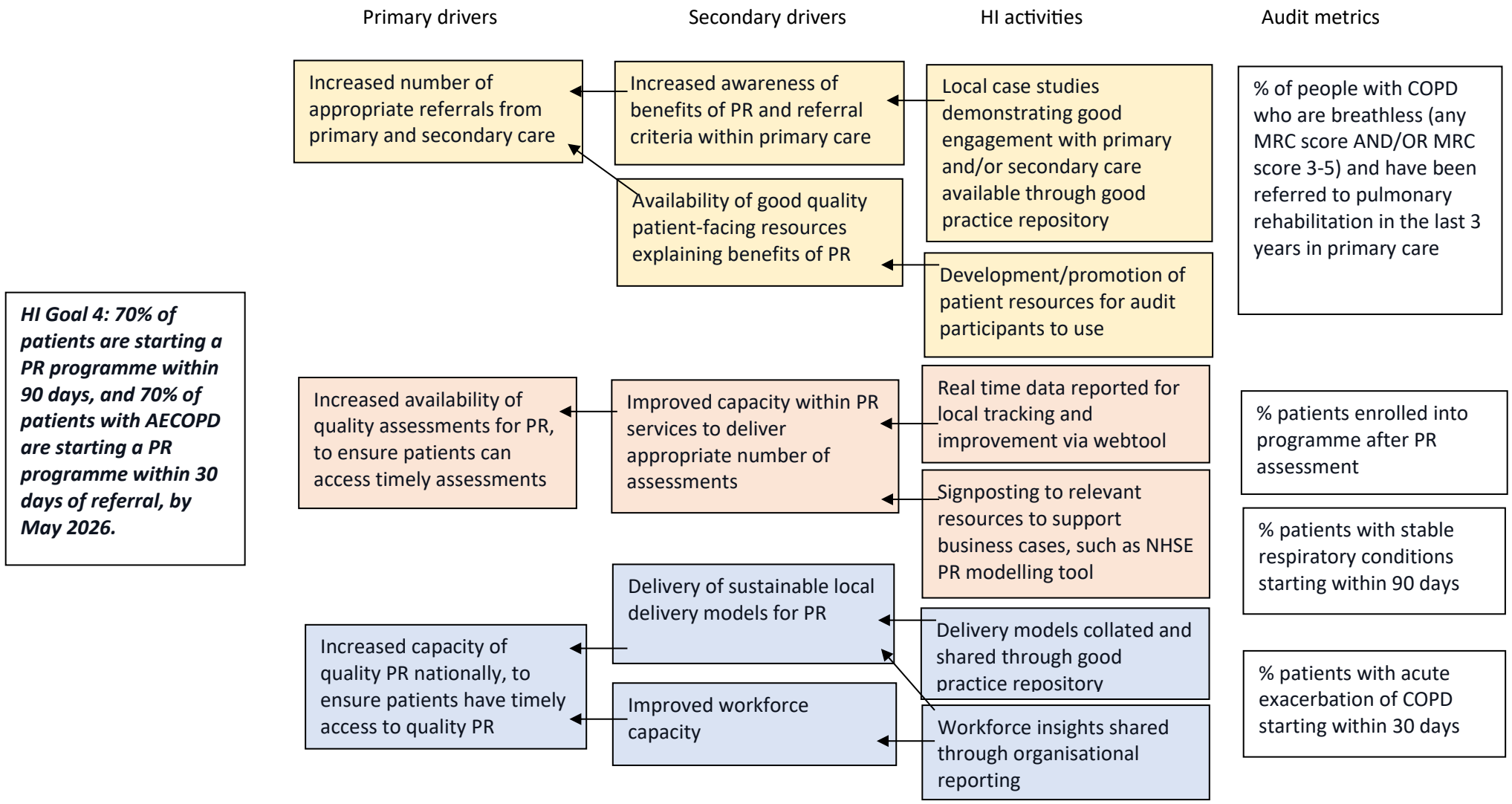
Date	Activity
By 31 Dec 2024	Recruited 4x clinical fellows
	Recruited dedicated HI clinical lead
	Met with all regional respiratory clinical networks
	Provided an offer of support to all ICBs via regional engagement
	Launched round 2 of the NRAP Improvement programme
	Plans in place for next Improvement support offer to services beyond 2024
	Published good practice repository
	Mapped existing regional HI work (through clinical networks, HINs and ICBs) to understand how we can build on this work
By June 2025	Shared evaluation of round 2 of Improvement programme
By 30 May 2026	Mapped our respiratory HI goals in ICB and LHB HI strategies
	Embedded respiratory HI projects in commissioning decisions
	Evaluation of this strategy

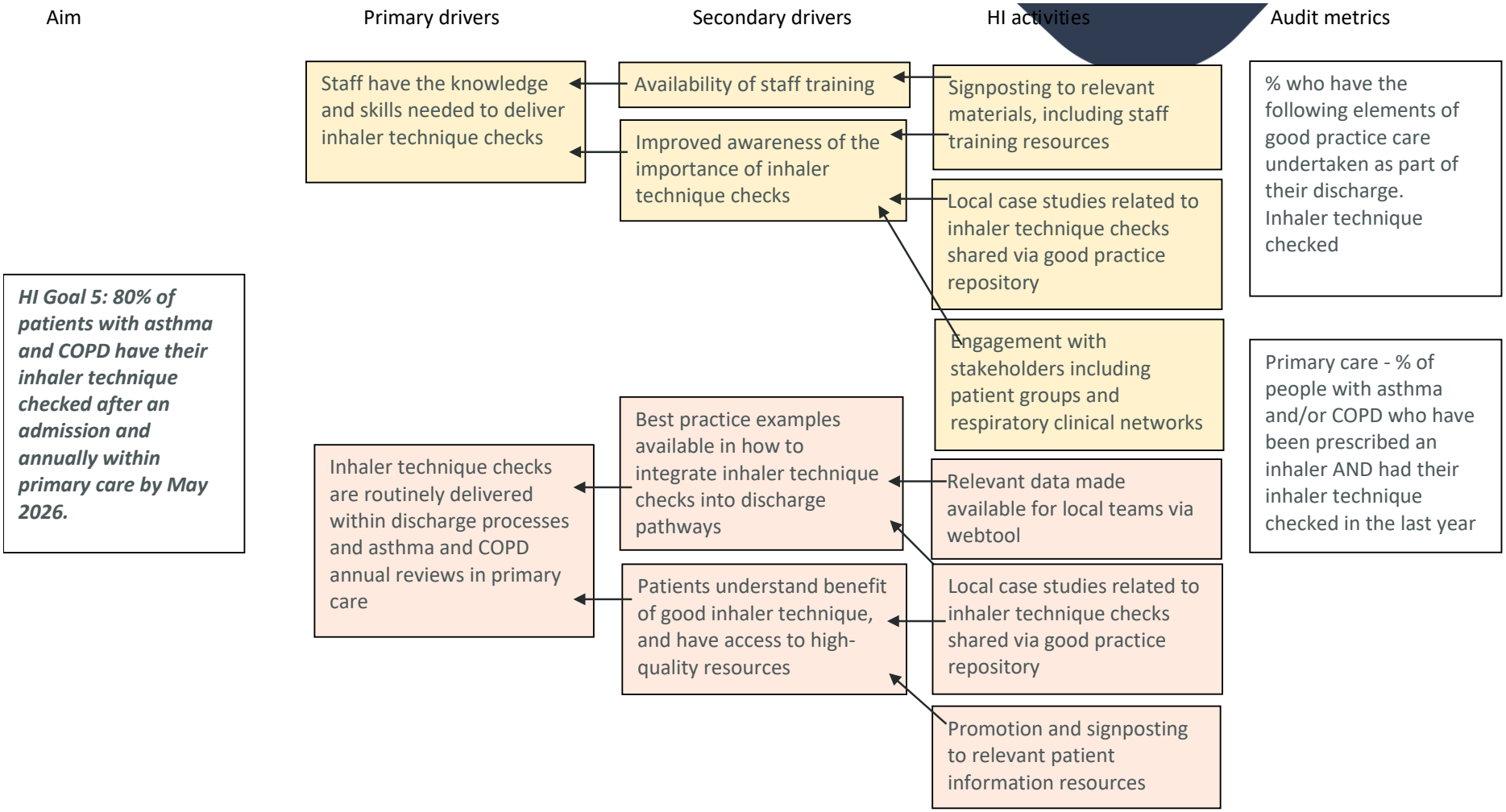
Appendix One: *Healthcare Improvement goals - driver diagrams*




Aim
Primary drivers
Secondary drivers
HI activities
Audit metrics
HI Goal 2: 70% of patients with COPD have a quality assured post-bronchodilator spirometry which confirms obstruction, and 70% of people diagnosed with asthma in the past two years have a (ever recorded) record of any objective measurement, in line with national guidelines, by May 2026.
Diagnostic tests are readily accessible to all people who need them through improved capacity
There are clear pathways in place to ensure timely access to diagnostic tests in primary care
Clinicians have appropriate training to deliver and interpret quality-assured spirometry
There are sustainable models available for funding and delivering spirometry services
People with undiagnosed respiratory conditions are aware of symptoms and supported/encouraged to access primary care
It is a recognised priority to ensure there is comprehensive access to respiratory diagnostic tests in primary care
Availability of training
Improved understanding/awareness of workforce training needs
Engagement with regions, clinical networks and ICBs
Signposting and sharing of local funding models
Engaging patient groups/panel on barriers to diagnosis
Identifying and sharing local good practice in diagnostic pathways via good practice repository
Primary care reporting (Wales only) to improve understanding of current provision
Signposting to appropriate training resources
Real-time data around spirometry shared via webtool
% of people admitted to hospital with an exacerbation of COPD and have a recorded spirometry result
% people diagnosed with COPD in the last 2 years who have a post-bronchodilator test with an appropriate numeric value (primary care)
% people diagnosed with asthma in the last 2 years who have a (ever recorded) record of any objective measurement: spirometry (+reversibility); Peak Flow diary; Fractional exhaled nitric oxide (FeNO) (primary care)


Primary drivers
Secondary drivers
HI activities
Audit metrics
HI Goal 3: 75% of patients with asthma and COPD who are discharged from hospital after an acute event, as well as patients in primary care with a recorded diagnosis, have a current self-management plan by May 2026.
The review or issuing of self-management plans is fully integrated into discharge pathways and annual reviews
Improved awareness of the benefits of self-management plans
Relevant data available for local teams via webtool
Local case studies related to inhaler technique checks shared via good practice repository
% of the following elements of good practice care undertaken as part of the patient's discharge - personalised asthma action plan (PAAP) or self-management plan issued/reviewed
Patients aware of their right to a self-management plan and ask for support to self-manage
Appropriate high-quality patient resources available to support decision-making around self-management
Collaborate with patient groups/patient panels to review and, where needed, create patient-facing resources
Primary care - % people with asthma who have had a Personalised Asthma Action Plan (PAAP) anytime in the year [15 months]
BPT data made available for local teams via webtool
Asthma and COPD Best Practice Tariffs (BPT) are achieved by services
Improved awareness of importance and impact of BPT
Case studies collected and shared on how local services have achieved/improved BPT
Signposting audit participants to supportive resources ie BPT pricing tool


Primary drivers
Secondary drivers
HI activities
Audit metrics
HI Goal 4: 70% of patients are starting a PR programme within 90 days, and 70% of patients with AECOPD are starting a PR programme within 30 days of referral, by May 2026.
Increased number of appropriate referrals from primary and secondary care
Increased awareness of benefits of PR and referral criteria within primary care
Availability of good quality patient-facing resources explaining benefits of PR
Local case studies demonstrating good engagement with primary and/or secondary care available through good practice repository
Development/promotion of patient resources for audit participants to use
% of people with COPD who are breathless (any MRC score AND/OR MRC score 3-5) and have been referred to pulmonary rehabilitation in the last 3 years in primary care
Increased availability of quality assessments for PR, to ensure patients can access timely assessments
Improved capacity within PR services to deliver appropriate number of assessments
Real time data reported for local tracking and improvement via webtool
Signposting to relevant resources to support business cases, such as NHSE PR modelling tool
% patients enrolled into programme after PR assessment
% patients with stable respiratory conditions starting within 90 days
Increased capacity of quality PR nationally, to ensure patients have timely access to quality PR
Delivery of sustainable local delivery models for PR
Improved workforce capacity
Delivery models collated and shared through good practice repository
Workforce insights shared through organisational reporting
% patients with acute exacerbation of COPD starting within 30 days


Aim
Primary drivers
Secondary drivers
HI activities
Audit metrics
HI Goal 5: 80% of patients with asthma and COPD have their inhaler technique checked after an admission and annually within primary care by May 2026.
Staff have the knowledge and skills needed to deliver inhaler technique checks
Inhaler technique checks are routinely delivered within discharge processes and asthma and COPD annual reviews in primary care
Availability of staff training
Improved awareness of the importance of inhaler technique checks
Best practice examples available in how to integrate inhaler technique checks into discharge pathways
Patients understand benefit of good inhaler technique, and have access to high-quality resources
Signposting to relevant materials, including staff training resources
Local case studies related to inhaler technique checks shared via good practice repository
Engagement with stakeholders including patient groups and respiratory clinical networks
Relevant data made available for local teams via webtool
Local case studies related to inhaler technique checks shared via good practice repository
Promotion and signposting to relevant patient information resources
% who have the following elements of good practice care undertaken as part of their discharge. Inhaler technique checked
Primary care - % of people with asthma and/or COPD who have been prescribed an inhaler AND had their inhaler technique checked in the last year