Integrated respiratory action network for patients with COPD

In this Future Hospital Programme case study Dr Helen Ward describes how a team from The Royal Wolverhampton NHS Trust established a respiratory action network for patients with chronic obstructive pulmonary disease (COPD).

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Integrated care

Key recommendations

- Develop good communication between physicians and GPs through emails, education sessions and newsletters.

- Good working relationships (eg specialists working alongside GPs) and regular meetings with the CCG can enable the service to continue to move forward.

- Establish close working relationships and partnerships between acute trust and GP practices. This should also extend to the CCG and respiratory action group.

- Respiratory HOT clinics for admission avoidance can help to stem the growth of admissions.

Local context

New Cross Hospital, Wolverhampton, is one of the largest acute providers in the West Midlands with more than 800 beds and serving a population of around 250,000. The hospital received 996 admissions due to an exacerbation of chronic obstructive pulmonary disease (COPD) in 2014/2015. Wolverhampton city is a deprived area with a higher long-term unemployment and smoking prevalence than the England average. The mean length of stay for patients with COPD and the mortality from chronic bronchitis and emphysema were above that of the average in England in 2011/2012.mental health patients managed in isolation from physical health, even though these patients have significantly worse physical health outcomes.

The challenge

1. Reducing hospital admissions, readmissions and length of stay in COPD patients.
2. No joint working across primary or secondary care and, as a consequence, no opportunities for shared learning.

The main barriers to setting up the services have been mainly financial and communication-based. From a financial perspective there are no 'payment by results' tariffs currently available to incentivise management of patients with an exacerbation of COPD at home. Barriers due to communication include differing agendas between the CCG and acute trust, and changing roles and managers within the CCG, which leads to a lack of consistency in supporting local projects and service redesign.

Our solution

We created a Respiratory Action Network for the Benefit of Wolverhampton (RAINBOW) group that oversees the integration of community, acute trust and palliative care services for patients with COPD.

The RAINBOW group has four main ambitions.

1. Improving timely and accurate diagnosis of COPD.
2. Improving the integration of the existing respiratory services.
3. Improving the end of life experience and management of patients with COPD.
4. Improving communication across the different healthcare sectors in order to adopt best practice rapidly and develop innovative solutions.

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The services we offer include;

- a chronic respiratory multidisciplinary team (MDT) meeting
- respiratory HOT clinics (a clinic which is acute and used for admission avoidance)
- respiratory in-reach into the acute medical unit (AMU)
- community clinics (further details below).

Patients benefit from better communication and coordination of the COPD services and healthcare professionals (HCPs). We now have an embedded structure for monitoring and improving performance of integrated respiratory services.

Outcomes

Since setting up the services, the length of stay for patients admitted with exacerbation of COPD has reduced from a mean of 7.7 days in 2011 to 6.2 days in 2014.

The average activity of the HOT clinics increased (from 30% usage in 2012 to average 65% in the first 5 months of 2014) through good communication with GPs through emails, education sessions and newsletters. HOT clinic appointments are standalone slots. They are supported by the respiratory physician of the week and can be booked at short notice. Referrals come from GPs, ED and AMU and, as such, we are always raising the profile of the HOT clinic.

A total of 359 patients were seen in the HOT clinic from July 2014 until the end of June 2015. The admission rate for patients seen in the clinic is 5-9% within the same financial year; whereas admission rates for 'scientifically similar' respiratory patients (assessed both prior to and after HOT clinic admission) not seen in the HOT clinic is around 19%. Therefore, the HOT clinic appears to be helping to stem the growth of admissions.

> *'73% of patients agreed they were 'almost always' satisfied with the amount of information they received.'*
>
> Dr Helen Ward, The Royal Wolverhampton NHS Trust

Staffing

The core RAINBOW group members include consultant respiratory physician, group manager from the acute trust, CCG manager, lung function manager, home oxygen service lead, physiotherapist, pharmacy lead, nursing manager from acute trust and community services and a GP with specialist interest in respiratory.

Methods

Regular meetings with the CCG and good personal relationships have enabled the service to continue to move forward. RAINBOW bi-yearly newsletters are also sent and GP educational events have been staged.

Chronic respiratory MDT – Meetings occur fortnightly to discuss patients with chronic respiratory conditions.

Respiratory HOT clinics – Two daily appointments are available for these admission avoidance clinics. Based on feedback from GPs, there is now a single point of access for patients with any respiratory problem who the HCP is concerned may need to be admitted to hospital.

Respiratory in-reach into the AMU – A respiratory consultant reviews respiratory patients on the AMU seven days a week from 09:00 until 11:45, providing a specialist opinion for patients with acute respiratory problems and facilitating discharge/evidence-based management. The consultant is

supported by a specialist respiratory nurse who completes the discharge bundles for patients with COPD and asthma and coordinates the early supportive discharge for respiratory patients.

The challenges for setting up the respiratory in-reach service were mainly around organising consultant time and resource. The Care Quality Commission alerted that pneumonia was a mortality outlier at Royal Wolverhampton NHS Trust in 2009 and so the trust, amongst other measures, supported the move for respiratory in-reach to ensure that all patients admitted with pneumonia had an accurate diagnosis and were treated as per the NICE guidelines. The pneumonia alert was subsequently cleared by the CQC.

Community clinics – Held once a month at different GP practices across Wolverhampton with the aim of building relationships between specialists, GPs and practice nurses. There was an education session available for the practice nurses and GPs to include spirometry or case-based discussions. The success of these clinics is currently being evaluated.

Healthy Lungs days – Hosted over 2 days in September 2014, jointly with the CCG, with the aim of increasing public awareness of respiratory symptoms and management. The event was a huge success with nearly 700 attendees.

Additionally, we are working to support HCPs increase their confidence identifying and awareness of anxiety of depression in respiratory patients. We are working with the psychology team to upskill the HCPs who are in close contact with patients with COPD within the hospital environment, including physiotherapists and respiratory nurses.

Patient feedback

Data show high patient satisfaction. Patients (n=130) asked for feedback about their experience following their review in HOT clinic felt able to manage their own health, to make decisions about their care and supported by health and social care to manage their health.

After the consultation each patient was given a questionnaire consisting of six questions. 130 patients out of 144 (88%) completed the questionnaire which explored how they felt about the care they had received. For the following questions, the percentage refers to how many patients agreed ‘almost always’ to the statement:

1. Did you discuss what is most important for you in managing your own health? 75%
2. Were you involved in your care plan? 62%
3. Were you satisfied with the amount of information you received? 73%
4. Did you receive enough support from social care and community services? 75%
5. Were these services ‘joined up’? 77%
6. Do you feel confident in managing your health? 55% almost always, 30% most of the time.

What’s next?

We are now working with the CCG and leads for primary, secondary and palliative care, medicines management and the community team to have a single COPD pathway, starting from public awareness/promotion through to accurate diagnosis, management of stable disease, exacerbations, hospital admissions with exacerbations and end of life care.

Barriers are likely to be the local health economy and national NHS savings and efficiencies. Through experience, I know that on-going good communication across all sectors will help to overcome many of the barriers, and the RAINBOW group is an embedded vehicle for this.

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The RAINBOW group

- Dean Gritton, group manager for medicine
- Claire Morrissey, solutions and development manager for Wolverhampton CCG
- Lisa Hickman, respiratory physiotherapy specialist
- Rosemary Steel, specialist respiratory physiologist and oxygen lead
- Pete Moxon, lead respiratory physiologist and service manager
- Rachael Berks, specialist lead nurse practitioner for the community matrons, Homes Inreach Team and Hospital at Home
- John Burrell, GP with specialist interest in respiratory
- Linda Forrester, lead prescribing advisor for Wolverhampton CCG
- Kay Lal, respiratory nurse specialist at Royal Wolverhampton NHS Trust

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