National COPD Audit Programme

COPD: Time to integrate care

Resources and organisation of care in hospitals in England and Wales 2017

Findings and quality improvement

Royal College of Physicians

Setting higher standards

The audit programme partnership

Working in strategic partnership:

Imperial College
London

Supported by:

Commissioned by:

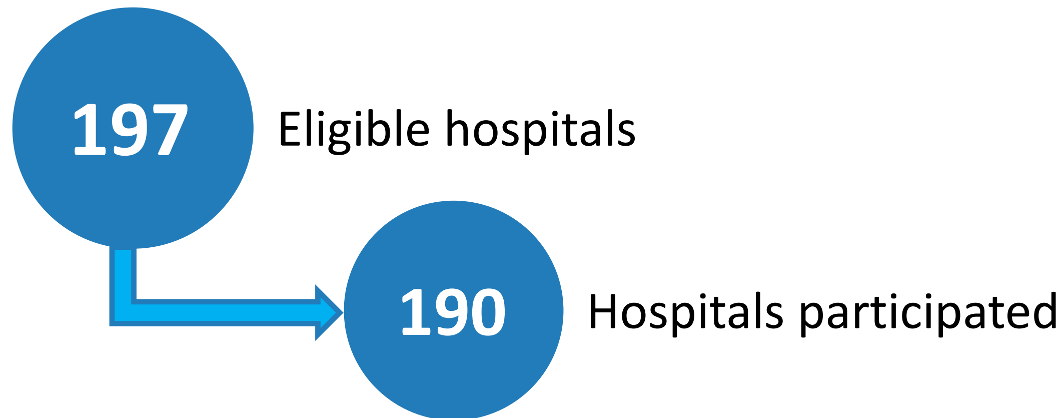
Key findings and recommendations

Recruitment

Audit participation

All secondary care hospitals that admit patients with acute exacerbations of COPD (AECOPD) were invited to participate.

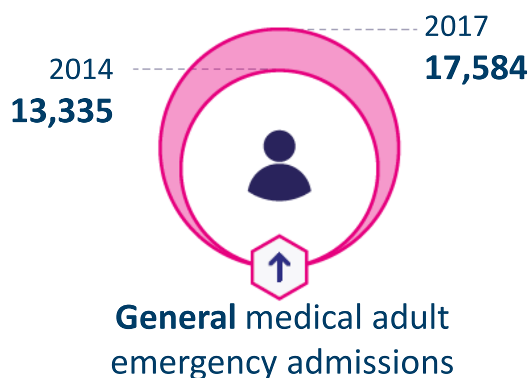
Data collection began on 3 April, and closed on 30 June 2017.



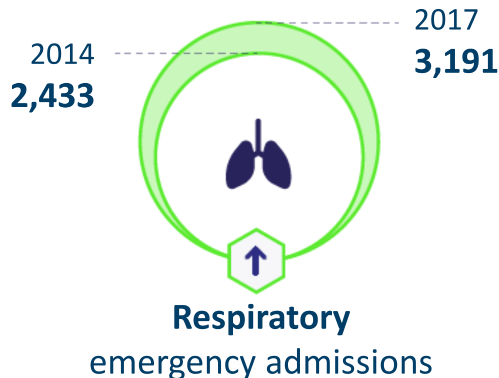
Staff shortages were cited as the main reason for non participation.

Admissions, staffing levels, general organisation of care

Admissions



General medical adult emergency admissions



Respiratory emergency admissions

COPD admissions

Staffing and general organisation of care

Respiratory team staffing unchanged since 2014

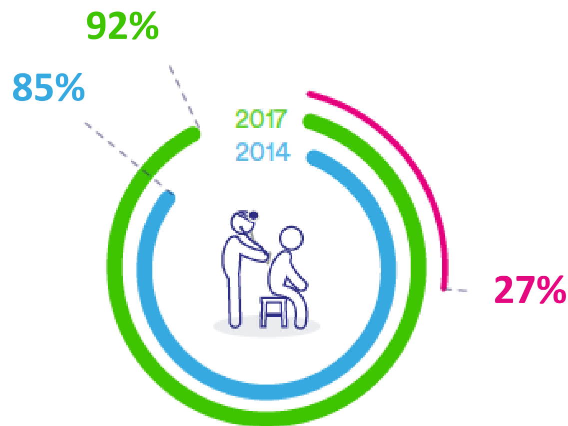
Hospital provided **Smoking cessation services**

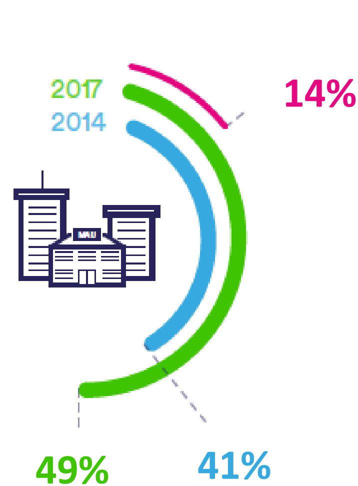
On-site provision of **palliative care services**

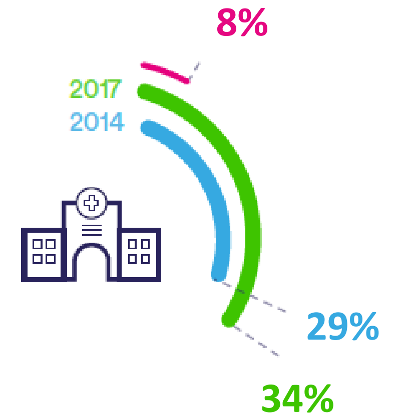
Organisation of acute respiratory care

Respiratory review

The provision of new-patient **ward rounds by senior decision makers** (ST3 or above) **from the respiratory team** has **improved**, but remains suboptimal outside of respiratory wards:







On respiratory wards:
increased to **92% in 2017** from **85% in 2014**. Only **27% operate 7 days per week**.

On medical admission units:
increased to **49% in 2017** from **41% in 2014**. Only **14% operate 7 days per week**.

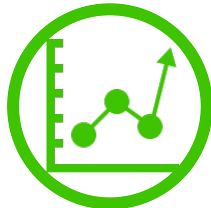
On other wards:
increased to **34% in 2017** from **29% in 2014**. Only **8% operate 7 days per week**.

Managing respiratory failure

Non invasive ventilation (NIV)

NIV training programmes (95%) are in near-universal use.

This has improved from 90% reported in the 2014 audit.

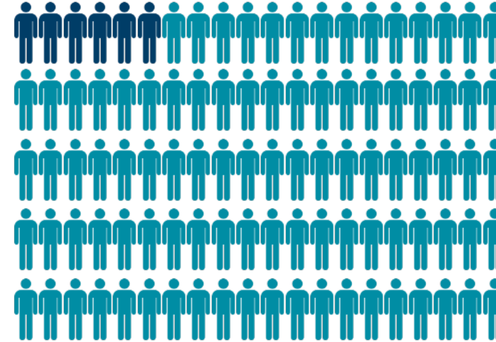


NIV monitoring charts (90%) are used widely. *

88% of hospitals have a **named clinical lead for NIV service**, in line with NCEPOD recommendations.

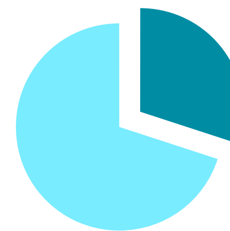
This remains the same since the 2014 audit.

Emergency oxygen therapy



94% of hospitals have an **oxygen policy** in place.

This has reduced from 95% reported in the 2014 audit.



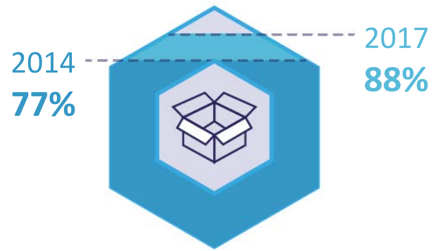
30% still have **no training programme** in place.

This has improved from 32% reported in the 2014 audit.

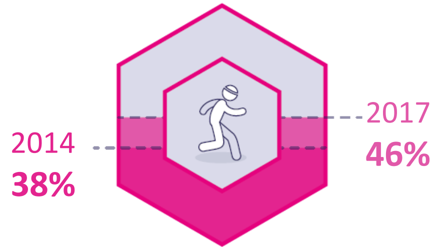
*This was not in the dataset for the 2014 audit hence no comparative data available.

Integrating care across primary and secondary sectors

Integrated care

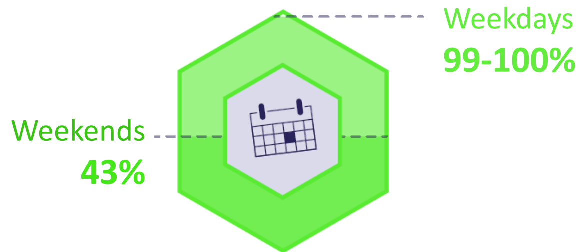


Use of COPD **discharge care bundles** has increased to **88% in 2017** from **77% in 2014.**



The availability of **PR within 4 weeks of discharge** has increased to **46% in 2017** from **38% in 2014.**

Access to **early/assisted COPD discharge teams** has increased to **88% in 2017** from **82% in 2014.**



There is a contrast between **access to integrated services** from **99-100% on weekdays** compared to **43% at weekends.**

The facility for hospitals to provide **home NIV** has increased to **50% in 2017** from **43% in 2014.**

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Setting higher standards

Quality improvement (QI)

2014 audit recommended 9 key actions for teams to improve the quality of their care*

8% of hospitals achieved key action 1: All patients with COPD exacerbation who remain in hospital should be **managed on a respiratory ward**.

32% of hospitals achieved key action 2: All patients **with COPD exacerbation** who remain in hospital should receive a **specialist respiratory opinion within 24 hours**.

57% of hospitals achieved key action 3: Respiratory wards should be staffed to run **at least 1 Level 2 bed where NIV can be administered**, commensurate on demand and the size of hospital.

64% of hospitals achieved key action 4: ICU outreach services should be available **24 hours, 7 days a week**.

32% of hospitals achieved key action 5: All hospitals should have a **fully funded and resourced smoking cessation programme** delivered by **dedicated smoking cessation practitioners**.

*The figures on this slide report how teams have met the recommendations set in 2014.

Quality improvement (QI)

2014 audit recommended 9 key actions for teams to improve the quality of their care*

47% of hospitals achieved key action 6: All hospitals should make **spirometry results accessible from every computer desktop** via their IT department's browser system/intranet.

21% of hospitals achieved key action 7: There should be a **data sharing agreement** between hospital and primary care IT ensuring **general practice spirometry data are universally available**.

42% of hospitals achieved key action 8: Each acute hospital or trust should nominate a **respiratory clinical lead for discharge care and integrating services**.

32% of hospitals achieved key action 9: Hospitals should develop an **improvement plan** based upon recommendations within the national and their site-specific report.

*The figures on this slide report how teams have met the recommendations set in 2014.

Key recommendations

For providers across the sectors

- Develop **achievable QI projects** that aim to **improve patient access to services**, thereby possibly **reducing** the risk of **avoidable admission**. *E.g. Improving on the proportion of current smokers receiving smoking cessation pharmacotherapy*
- Review **respiratory bed allocation**, in light of the audit showing that most COPD patients are not being cared for by respiratory teams.
- Work to develop a **7-day, cross sector COPD service**. Look at the **existing resource** and consider developing a **business case** to increase the team.

For commissioners / STPs

- Ensure there is an **agreed COPD pathway** that links **discharge processes** to **admission avoidance** strategies, as well as to **evolving community-based frailty** and **social care** services.
- Ensure that within this pathway, **pulmonary rehabilitation** is available to all **appropriate patients**, including **early post-discharge**.

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Setting higher standards

Quality improvement (QI)

Using quality improvement methodology to plan a change (SMART)

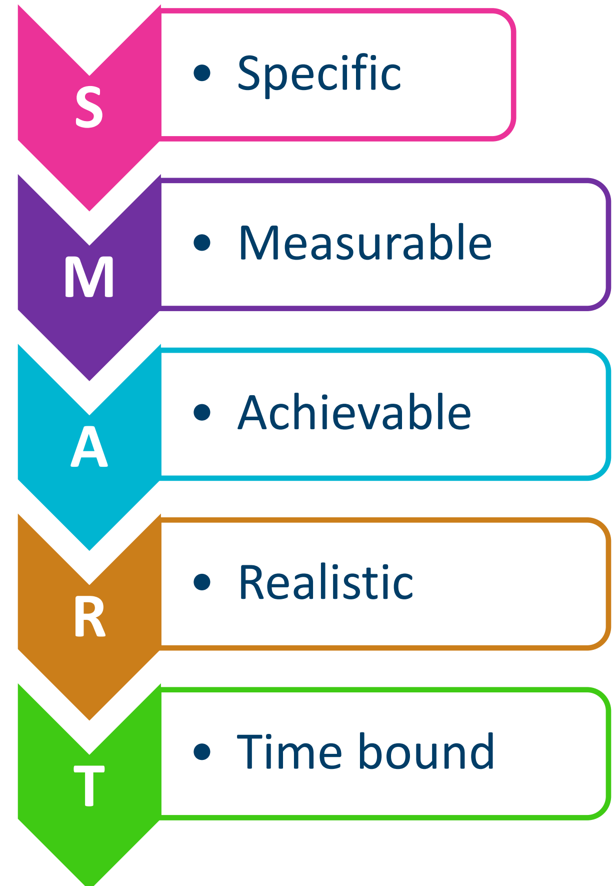
Look for areas where you can **realistically** make improvements.

Decide on an **aim**, this should be **SMART**.

Build a **team** and understand your **stakeholders**.

Meet with your team regularly to **performance manage** yourselves, and have **clear responsibilities**.

Plan how you will **achieve** your aim.

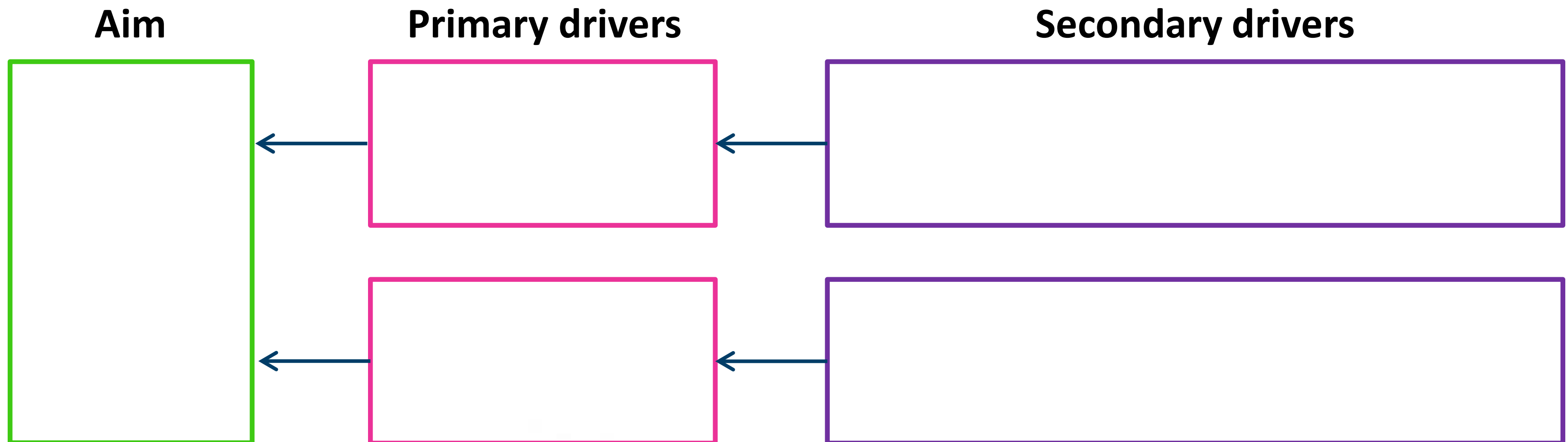


Quality improvement (QI)

Defining your overall aim (driver diagrams)

To decide what to start on for your overall improvement aim, you may find it helpful to use a driver diagram.

The Institute for Healthcare Improvement has a helpful guide on how to use them
http://www.ihi.org/resources/Pages/Tools/Driver-Diagram.aspx



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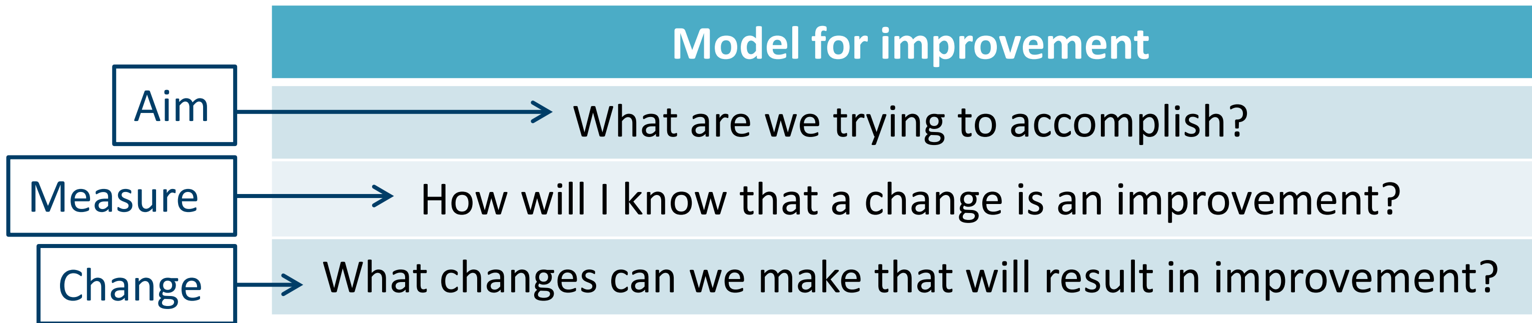
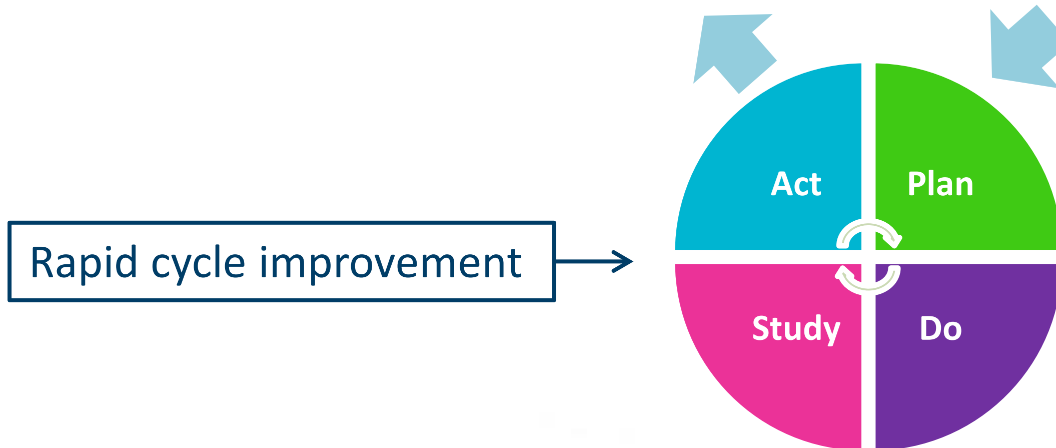
Quality improvement (QI)

A model for improvement

To plan your change, it is important to regularly measure and study your activity using:





Quality improvement (QI)

The PDSA cycle

Act
- What changes are to be made?
- Next cycle?

Plan
- Objective
- Questions and predictions (why)
- Plan to carry out the cycle (who, what, where, when)

Do
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data

Study
- Complete the analysis of the data
- Compare data to predictions
- Summarise what was learned

Quality improvement (QI)

The PDSA cycle example: COPD patients to be treated on respiratory wards

ACT: Identify what still needs to change to improve further and plan what you will do next. Use your audit run-charts provided on the web-tool* to help identify these. (Next PDSA cycle)

Act

Plan

PLAN: Use your audit run-charts provided on the web-tool* to identify all COPD patients admitted that haven't been seen by a respiratory physician.

STUDY: Analyse data to see if the rate has improved. Compare results to your audit run-charts on the web-tool* and your results reported in the last audit. Plot change over time and summarise what you have learned.

Study

Do

DO: Instigate 2 ward rounds of A&E per day to identify COPD patients.

*www.nacap.org.uk

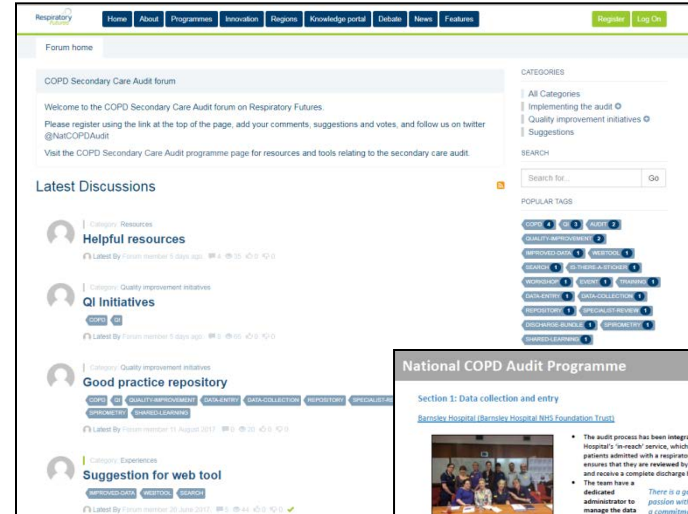
Quality improvement (QI)

Resources

Respiratory futures forum

Login to share and learning and express your thoughts and ideas.

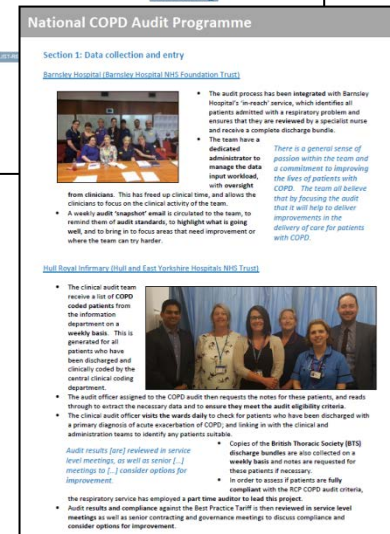
www.respiratoryfutures.org.uk/copdsecondarycareauditforum



Good practice repository

View our secondary care repository sharing stories from teams across the country about their challenges and achievements in the provision of quality COPD care.

www.rcplondon.ac.uk/nacap-copd-resources



National COPD Audit Programme

Section 1: Data collection and entry

Barnsley Hospital (Barnsley Hospital NHS Foundation Trust)

- The audit process has been **integrated** with Barnsley Hospital's 'in-reach' service, which identifies all patients admitted with a respiratory problem and ensures that they are **reviewed** by a specialist nurse and receive a complete discharge bundle.
- The team have a **dedicated administrator to manage the data input workload, with oversight from clinicians**. This has freed up clinical time, and allows the clinicians to focus on the clinical activity of the team.
- A weekly **audit 'snapshot' email** is circulated to the team, to remind them of **audit standards**, to **highlight what is going well**, and to bring in to focus areas that need improvement or where the team can try harder.

There is a general sense of passion within the team and a commitment to improving the lives of patients with COPD. The team all believe that by focusing the audit that it will help to deliver improvements in the delivery of care for patients with COPD.

Hull Royal Infirmary (Hull and East Yorkshire Hospitals NHS Trust)

- The clinical audit team receive a list of **COPD coded patients** from the information department on a **weekly basis**. This is generated for all patients who have been discharged and clinically coded by the central clinical coding department.
- The audit officer assigned to the COPD audit then requests the notes for these patients, and reads through to extract the necessary data and to **ensure they meet the audit eligibility criteria**.
- The clinical audit officer **visits the wards daily** to check for patients who have been discharged with a primary diagnosis of acute exacerbation of COPD; and linking in with the clinical and administration teams to identify any patients suitable.
- Copies of the **British Thoracic Society (BTS) discharge bundles** are also collected on a **weekly basis** and notes are requested for these patients if necessary.
- In order to assess if patients are **fully compliant** with the RCP COPD audit criteria, the respiratory service has employed **a part time auditor to lead this project**.
- **Audit results and compliance** against the Best Practice Tariff is then **reviewed in service level meetings** as well as senior contracting and governance meetings to discuss compliance and **consider options for improvement**.

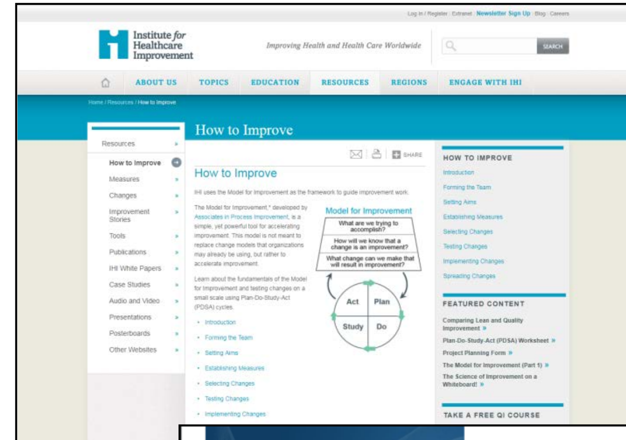
Audit results [are] reviewed in service level meetings, as well as senior [...] meetings to [...] consider options for improvement.

Quality improvement (QI)

Resources

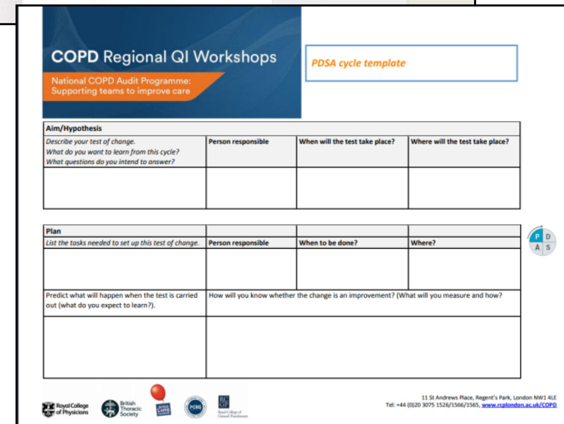
Institute for Healthcare Improvement

IHI uses the Model for Improvement as the framework to guide improvement work.
http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx



COPD QI workshop resources

During 2017 the COPD team ran a series of QI workshops. A selection of QI resources from the events have been published online.
https://www.rcplondon.ac.uk/projects/outputs/copd-audit-regional-qi-workshops



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