

Innovation in the delivery of care closer to the patient

Winner COPD Services, Nottinghamshire County Teaching PCT and Sherwood Forest Hospitals NHS Trust

COPD services in the Community

Who we are

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Service developed

Community based specialist COPD service incorporating consultant clinics, pulmonary rehabilitation and domiciliary oxygen assessment.

Why the service was developed?

In 2004 we commissioned a Public Health report which showed that the COPD death rate locally was 28% above the national average, and there were more than 1000 emergency admissions p.a. due to COPD exacerbations, each with an average in-patient stay of 9 days. Additionally a focus group study, undertaken locally, indicated that patients experienced a fragmented service, with individuals from primary and secondary care not dealing with patients' needs in their own communities. There was lack of a coherent approach to patient education at diagnosis or continued support. Patients most feared COPD exacerbations and loss of independence.

These two reports emphasised the need to improve COPD services and to provide a co-ordinated and consistent de-centralised approach that focussed delivery closer to the patients' homes.

How did you develop the service?

We formed a service implementation group with representation from the local PCTs, public health, primary and secondary care, to provide a vision for the future delivery of COPD services.

The purpose of the group was to develop and implement a plan in which specialist care could be delivered more directly and closer to patients' homes. A hub and spoke model was devised utilising the local community hospitals at Kirkby-in-Ashfield, Mansfield and Newark. The three community hospitals would provide consultant-led specialist COPD clinics, respiratory nurse specialist services, pulmonary rehabilitation and home oxygen assessment services. Management arrangements for this service were not straightforward, the PCT appointed specialist nurses and physiotherapists to work in the centres, whilst the head of pulmonary rehabilitation and specialist physician run the service from secondary care, but are based at one of the community hospitals. Activity is counted as PCT activity. The PCTs and secondary care provided capital for equipment.

Following this vision the group produced local guidelines and the care pathway for patients with COPD from diagnosis to end of life care. These have been launched within each of the communities with many local meetings involving general practitioners and nurses.

Another piece of work demonstrated the economic and clinical good sense of implementing an early supported discharge scheme for patients with COPD. This was agreed by the hospital and PCT. In addition the nurse involved proved to be a focal point for the integration of care in the community. She hands over patients to chronic disease management teams and refers patients into the specialist and pulmonary rehabilitation clinics.

In order to deliver the updated domiciliary oxygen assessment and monitoring processes we undertook a radical re-design of how we provided services. The secondary care arrangements were fragmented, cumbersome and lengthy. We developed clinical physiologist/specialist nurse led oxygen assessment clinics, based in the community hospitals. These combine the full range of activities that were previously disparate and that delayed oxygen implementation. Patients are assessed and oxygen orders placed within the same clinic creating a one-stop service. The PCTs invested in bench top and portable blood gas machines and supported the costs of a secondary care based Senior Clinical Physiologist. Patients have a robust point of contact for problems and readily access the aftercare service without having to visit GP or secondary care.

How do you know that what you have done has improved the situation?

Referrals have increased whilst waiting times for the COPD specialist clinics have reduced dramatically to 3 weeks. Patients are asking to be referred to pulmonary rehabilitation (PR) where waiting times have reduced from 9 months to 3 weeks and throughput has increased by 70%. Re-referrals for PR 'Booster programmes' have increased by 80%. Referrals to the Respiratory nurse clinics, which act as step down clinics from consultant care, have increased with the majority of patients electing to continue follow-ups at the community hospitals. There is good information flow between the COPD services and GPs – achieved by a structured PR reporting system and same day oxygen and respiratory nurse reporting service. GPs are fully informed of patient follow-up arrangements and aftercare options are either arranged by the service or communicated to GPs.

The COPD clinics and PR provide a comprehensive assessment for all patients. The new service streamlined the delivery of care recommended by NICE and delivers it near to the patient's home. We carry out a rolling audit programme assessing exercise capacity and quality of life before and after the intervention. This has demonstrated the programmes consistently achieve good improvements in the key outcomes. Patient throughput is monitored and access to PR has increased to 28% (based on NICE estimated need for area).

The early discharge scheme has shortened the length of stay on average to 5 days, and reduced readmission rates.

How could it be applied elsewhere?

This is a hub and spoke model with the hub providing the leadership, management and training for services. We have designed it so that specialists and generalists are working together in primary care. We have been asked to add more spokes to the hub and are in the process of doing so.

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