

A breath of fresh air

Working **together** to
improve respiratory
care in the North West



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Breathing space

A breath of fresh air is something we wish everyone could take for granted, but around 715,000 people in the North West struggle with breathing difficulties caused by chronic obstructive pulmonary disease (COPD) and asthma, leading to serious discomfort, loss of earnings and even premature death.

We want to celebrate the achievements of our healthcare community working across the region. Its members combine care, knowledge and creativity, in working towards prevention and management of respiratory disease. We congratulate them for contributing towards our aims of high standards of care, positive patient experience and confident, effective, commissioning of services.

By highlighting the experience of seven of the many innovative teams in the North West, we underline some of the widespread good practice, which is already reducing unnecessary hospital admissions for respiratory conditions and is also having an impact on the quality of life of patients.

Ongoing changes in the NHS put more emphasis on the role of GPs in the commissioning of care through Clinical Commissioning Groups (CCGs). It is therefore even more important to emphasise the

need for continued investment of time and resources in respiratory care. Not only are the costs of respiratory disease high, in both financial and human terms, but also much of it is preventable.

Our biggest challenges are to identify and treat the 100,000 people in the North West not yet diagnosed as suffering from COPD, to reduce admissions for both COPD and asthma, and to improve the respiratory health of our population.

This brochure highlights seven events which we believe sum up best practice in respiratory care, illustrated with case studies from around the region.

We hope that CCGs will join us in our task of helping everyone in the region to breathe freely.

Stephen *June* *John*

Stephen Gaduzo, June Roberts, John Williams

75 percent of people
admitted to hospital for
asthma should not be there



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Respiratory disease - the basics

What do we mean by respiratory disease?

The North West Respiratory Clinical Pathway has focused on asthma and chronic obstructive pulmonary disorder (COPD). COPD is an umbrella term, which includes emphysema and chronic bronchitis.

How serious is it?

Almost 3,000 people die from **COPD** in the North West every year - it is one of the main causes of **PREVENTABLE** death and disability in the North West. It is also the **SECOND** most common reason for emergency admission to hospital **AND** the **FIFTH** most common cause of readmission.

North West England is the region with the **HIGHEST ASTHMA** emergency admission rate in the country - **76 PERCENT HIGHER** than in the East of England region.

How widespread is it?

The North West has a higher prevalence of both asthma and COPD than the England average. It is estimated that more than three million people have COPD, of whom fewer than one million are registered with their GPs as suffering from the condition. There are around 100,000 undiagnosed COPD cases in the North West. More than 460,000 people suffer from asthma in the North West.

How does it affect people?

- **One third** of COPD sufferers experience disabling breathlessness
- **Two thirds** of COPD sufferers are unable to take a holiday and **90 percent** are prevented from taking part in certain social activities
- **A quarter** of COPD sufferers are unable to work, costing employers and the UK economy around £3.8 billion
- **Asthma** accounts for **12.7 million** work days lost and costs the NHS **£889 million** each year
- Life expectancy is reduced by up to **15 years** in the North West among people with **COPD**, and by around **2.5 years** for people with **asthma**.

What causes COPD?

Smoking is a major cause of COPD. The chemicals in cigarette smoke cause inflammation and scarring in the lungs.

COPD leads to a narrowing of the airways, which obstructs the flow of air in and out of the lungs, making it difficult to breathe. Unlike asthma, where narrowing of the airways can be reversed, the narrowing in COPD is progressive and not fully reversible.

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How can COPD be treated?

It is not possible to cure COPD, but its rate of progress can be slowed. The goal is to improve patients' quality of life. Treatment aims to improve symptoms of breathlessness and to increase the amount of exercise a person can manage, as well as to reduce the risks of exacerbations, hospital admissions and complications.

The best way to do this is to stop smoking and to avoid other people's smoke.

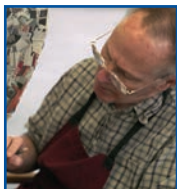
What causes asthma?

Asthma is an inflammatory disease that causes narrowing of airways in response to triggers such as pollen, dust and chemicals.

Family history, combined with environmental factors, eczema and allergies, make a person more likely to develop asthma.

How can asthma be treated?

Like COPD, asthma can not be cured, but effective medications like inhaled corticosteroids allow most people to control their symptoms. Controlled asthma leads to a better quality of life.

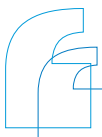


How is the North West Respiratory Clinical Pathway Team working to tackle COPD and asthma?

We have set up an integrated respiratory network across the region, which is working to achieve:

- Uniform high-quality standards of care
- Positive patient experience
- Confident commissioning of effective services.

We have taken information from national guidelines and strategy documents, looked at data on service outcomes and produced best practice top tips. Our networking days have been used to share best clinical practice, discuss common problems and to establish a community of practice. The events have also acted as a focus for encouraging local action planning and clinical leadership.



Respiratory diseases are the third highest cause of **mortality** in England after **circulatory diseases** and **cancers**



How to prevent COPD admissions – the General Practice way

The GP surgery is most people's route into the NHS. The GP's role has been greatly enhanced by their new responsibilities as commissioners of services following the reorganisation of the NHS. Given GPs' key role, we are eager to work as effectively and efficiently as possible with practices to prevent hospital admissions.

Key ways for GP to prevent admissions

- Identify patients most likely to have undiagnosed COPD in the practice
- Log those at highest risk of hospital admission (see page 14)
- Assess the impact of COPD on patients' daily lives by recording their general activity (MRC and CAT scores), frequency of exacerbation and oxygen saturation
- Optimise treatment and management by reviewing inhaler technique, referring to pulmonary rehabilitation, treating depression and anxiety and considering additional opiates and anxiolytics to alleviate breathlessness
- Work with specialist teams to educate and support patients through guided self-management education, a simple written action plan and the provision of rescue packs of antibiotics and oral corticosteroids
- Train reception staff to recognise, and fast track, people with a COPD exacerbation to a doctor or nurse
- Review all those admitted to hospital within two weeks following discharge, to reduce the risk of readmission

- Use trigger points for end of life care discussions, holistic assessment and referral to palliative and other support services



KEY POINT:

If each GP surgery in the North West were able to prevent FIVE people with COPD from being admitted to hospital every year, the North West's emergency admissions for COPD would be brought down to the England average.



Case study: Stockport algorithm

Most GPs are aware that the North West is the region with the highest rate of prescribing inhaled corticosteroids in England. At Cheadle Medical Practice, GPs decided to analyse their respiratory patient data to try to reduce this.

Their analysis not only revealed high levels of prescribed inhaled corticosteroids, but also that many patients were not on the best drug for their condition. In COPD, patients should be on long-acting bronchodilators before being prescribed inhaled corticosteroids, whereas in asthma, the opposite is true. Yet some patients with COPD were only on corticosteroids and some asthma patients were on bronchodilators alone.

GP Dr Stephen Gaduzo (also a lead in the North West Respiratory Clinical Pathway Team), devised an algorithm to review their respiratory patients, focusing on high-dose corticosteroids and suitable for all practices. The aim was to ensure that patients are both correctly identified, and also receive the optimal treatment for their condition.

The algorithm consists of a series of simple questions, delivered either by computer, or in a paper version for less technologically-advanced practices. The answers help GPs to decide, quickly and easily, what treatment each patient should be receiving. It is an excellent way to review patients in a structured manner.

The algorithm has the full support of the North West respiratory leads for its ease of use and speed of adoption. Its impact on admissions is still being evaluated, but clinical users are hopeful that it will play a significant role in reducing the number of hospital admissions, and the number of inappropriate prescriptions for high-dose inhaled corticosteroids.

In Stockport, 23 practices are now piloting the use of this algorithm.



20 percent of all people admitted to hospital with COPD have **no previous diagnosis with the condition**



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Listening to patients

Respiratory disease profoundly affects the lives of patients and their families. The physical symptoms of the disease restrict daily activities and associated psychological symptoms, such as anxiety, can lead to depression and a feeling of being trapped by the disease. Health professionals need to be aware of the patient perspective of this debilitating condition and the impact it has on their lives.

There is a growing acknowledgement of the need to build services with our patients. They are then more likely to comply with treatment that suits their needs and circumstances.

The North West Respiratory Clinical Pathway Team organised a listening event attended by patients, carers and managers from all over the North West. The aim was to find out from them how they felt about their experiences at different points of their treatment pathway. It resulted in a report and 10 key points to bear in mind when communicating with a patient and his or her family.

Key communication points according to patients are:

1. Give consistent messages
2. Know that your patient's COPD journey started long before diagnosis
3. Realise that it takes time to get a patient's diagnosis right
4. Help patients to understand and manage their own care
5. Introduce the patient and their carer to the best information about their condition
6. Ensure that when in hospital, patients are referred to see a respiratory specialist
7. Make patients aware of support groups and networks
8. Provide access to pulmonary rehabilitation
9. Show you care and involve your patients in their own care
10. Boost confidence in locally-available and relevant NHS services.



25 percent of people with **COPD** are **unable to work**, leading to a **cost nationally of £3.8bn**

Case study:
Central Lancashire Visioning Event

Service user involvement in Central Lancashire had already taken place through the introduction of Service Lines, whose purpose is to make cost-effective changes to respiratory services across the patient pathway, from early identification to end of life.

A decision was taken to try to make the commissioning process more interactive, by involving patients in decisions about provision and by identifying gaps in services. Its guiding principles would be established through a three-day visioning event attended by patients, health care workers and managers.

Pre-event focus groups with patients from Breath Easy groups in Lancaster and Preston established their service expectations and highlighted local geographical differences in provision. From this information, a table was drawn up showing patients’ points of concern in the service and suggestions for the future.

This table became an integral part of the Visioning Event. Professionals and patients referred to it during the three days of discussions and workshops, to ensure that all aspects of the patient pathway were considered in commissioning decisions.

The event has had a powerful effect in Lancashire in encouraging patients to be more vocal about expressing their opinions about services. This has also encouraged staff to integrate patients’ views into decisions about the way services are organised and commissioned. The chairs of the two local Breath Easy groups are active in the commissioning decisions of Service Line.



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Early diagnosis and smoking cessation

COPD in the UK is a major cause of illness and death, as well as being costly for the NHS. The average cost per year of treating a severely-affected patient is £6,475, as opposed to £98 for a patient with mild disease. Detecting and treating COPD as early as possible will reduce subsequent lung damage and cut costs, yet the number of diagnosed cases of COPD in the UK is less than half the expected figure.

Using early diagnosis to make progress in picking up the missing patients:

1. Maximise your chances of early identification by using several methods simultaneously:

- Systematic audit of GP patient records to identify smokers and ex-smokers over 35 years treated for chest infections
- Targeted population case finding, focusing on patients in geographical hot spots, or high risk jobs
- Opportunistic screening may be the only chance you will have to meet the patient for a few years, even though its success rate in diagnosing COPD is not high.

2. Quality-assured diagnosis

Around 15 percent of registered COPD patients have normal spirometry. Proper performance and interpretation of spirometry requires:

- Well-trained staff, whose professional standards are regularly reviewed
- Interpretation of spirometry measurements within the context of the full clinical picture (normal results should not exclude asthma).

3. Smoking cessation

Seventy percent of smokers wish to stop smoking. This is the most cost-effective therapeutic intervention in the treatment of COPD patients. The following points improve the chances of success:

- Good-quality support from smoking cessation advisors
- Evidence based treatments
- A programme combining counselling and medication is ten times more successful than willpower alone
- Remember to mention smoking and the availability of treatment at every consultation to double the chance of quitting.

4. Management of mild COPD should always focus on:

- Stopping smoking to reduce the accelerated decline in lung function
- Promotion of activity, especially prompt referral to pulmonary rehabilitation after admission (for MRC3 or more)
- Use of long acting bronchodilators only if symptoms are troublesome.

Case study: St Helens PBC Consortium

COPD is a significant problem in St Helens where admissions from the condition are 45 percent higher than the national average. Local general practices acknowledged that as many as 4,000 people in the borough were undiagnosed as suffering from the condition and that they needed some way of rapidly identifying them.

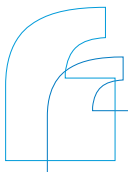
St Helens, PBC Consortium and GlaxoSmithKline collaborated on an early screening project involving 22 member GP practices in screening 'at risk' patients before they displayed symptoms. They used a mini spirometry (FEV6 meter) as a tool, to identify people requiring full assessment and spirometry.

The project had, by November 2011, screened 3,939 patients and had obtained 1,648 abnormal results, of which 718 COPD diagnoses were confirmed by spirometry (most of them mild to moderate).

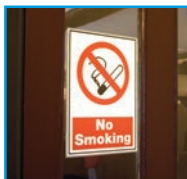
So far this has translated into:

- A nine percent reduction in hospital admissions for COPD in St Helens
- Identification of more than 700 undiagnosed COPD patients
- Improved standards of care.

Around 85 percent of patients now receive the standard of care NICE recommends (as compared with 32 percent previously). Alongside this, there have been large improvements in understanding of medication, in patient satisfaction and in nurse confidence in referring to specialists.



**Early detection
and treatment
reduces disease
progression and
cuts costs**



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Pulmonary rehabilitation

Pulmonary rehabilitation (PR) is one of the most cost-effective therapies for improving outcomes for people with COPD. It increases both exercise capacity and ability to cope with the activities of day-to-day life. Improving and maintaining physical activity preserves patient health and reduces the risk of hospital admission and death. It is vital that all patients who might benefit from PR are identified and referred.

What is pulmonary rehabilitation (PR)?

PR is a multidisciplinary programme of standardised exercise and self-management education, tailored to the individual. Patients usually attend twice a week for around six weeks, and also undertake one weekly home exercise session.

Important benefits of PR include:

- Reduced decline in physical functions
- Improved physical capacity
- Better coping and self-management skills
- Greater self confidence.

Improvement in walking distance and general health can be seen after four weeks but stamina builds up over many months, so programmes to maintain activity are important.

Who will benefit?

PR should be offered to:

- All patients who consider themselves disabled by breathlessness (usually MRC Grade 3 or above)
- Patients with symptoms and who are disabled by their condition (MRC2) but who require assessment and supervision of exercise training, rather than simple advice on lifestyle changes
- Patients with a recent exacerbation of COPD, requiring a hospital admission.

Making the most of PR

About 30 percent of people with COPD would benefit from PR. Assuming that two percent of the population have COPD, a standard Clinical Commissioning Group (CCG) with around 250,000 patients would have around 1,500 needing PR. Yet only three percent of those who would benefit are currently being referred. Of these, only around 50 percent complete the course.

To obtain the best results:

- GPs should record patients actual activity levels (MRC scores) during quality of life reviews
- Practices should be aware of local referral pathways and have sufficient patient information leaflets about the benefits of PR
- Treatment pathways should include referral to PR after hospital admission for COPD exacerbation
- Rolling programmes have similar outcomes to fixed groups and can reduce waiting times and increase availability of PR places
- Ensure that PR venues, access and times, all meet local patients' needs
- Staff should be experienced, enthusiastic, and well trained
- Services should be reviewed to ensure they meet national standards at least once a year.

Case study:

BEEP (Breathing Education and Exercise Programme) - Blackburn with Darwen

Deaths from COPD are higher in Blackburn with Darwen than anywhere else in England and Wales, partly because of the heritage of mill employment in poor working conditions and the high number of smokers. It also has a high rate of multiple hospital readmissions.

The BEEP (Breathing Education and Exercise Programme) was set up in 2008 in partnership with Blackburn With Darwen Council, by NHS Blackburn with Darwen, to try and alter these trends. It is supported by the British Lung Foundation.

COPD patients referred by a health professional, are offered free sessions at a choice of three community venues (or at home for the house bound). They are taught how to manage their illness, and control and improve their breathing through a range of activities. These include basic exercise classes delivered by specialist exercise professionals, advice on relaxation and breathing management from an occupational therapist, and even walks in local parks.

The opportunity to continue beyond the core programme is offered through the Pulmonary Health Graduate Programme. A support group for all people with respiratory conditions has also been developed.

The emphasis is on motivating service users and their carers to make positive health choices in order to overcome the physical and psychological barriers to exercise and independence.

BEEP had a total of 443 referrals in 2009/10 and assessed 361 patients, representing a take-up rate of 81 percent (compared with 67 percent recommended by NICE commissioning). Completion rates for the community and home programmes are at 63 percent (national average is 50 percent).

Patients on the scheme have demonstrated clinically-significant improvements in health-related quality of life. In particular, they have experienced a reduction in breathlessness during daily activities, improvements in functional exercise capacity and reductions in depression and anxiety.



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Reducing unscheduled admissions and readmissions

We know that patients who have been admitted three times in the past 12 months have an almost 60 percent chance of readmission during the following winter, compared with just 10 percent chance for those with one previous admission. We need to identify and target high-risk groups with the best management programmes, in order to reduce the risk of admissions. The AQUA COPD dashboard and general practice registers are useful resources.

Identify COPD patients at most risk of hospital admission:

- Previous emergency admission
- Severe disease - an FEV1 score less than 30 percent of that predicted for the patient
- More than 75 years old
- On long-term oxygen therapy
- Reduced mobility
- Presence of additional health problems such as coronary heart disease, diabetes and depression
- More than two exacerbations in the past 12 months.

Optimise treatment and management

- Support people to stop smoking
- Promote flu and pneumococcal vaccination
- Encourage physical activity and promote pulmonary rehabilitation

- Offer self-management education including an action plan and rescue medication for self treatment for exacerbations
- Review inhaler technique and compliance with therapy
- Identify and treat depression and anxiety
- Refer for home oxygen assessment if oxygen blood levels are low (92 percent or less)

Big wins

- Hospital at home schemes enable early supported discharge for up to 40 percent of patients and reduce admissions
- COPD admission and discharge bundles reduce the length of hospital stays and readmissions
- Oxygen alert cards could reduce admissions and save lives
- Community care pathways deflect admissions from hospital to more appropriate sites (see case study opposite)

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Case study:
NWAS Community Care Pathway Referral Process

In 2010, more than 18,000 COPD patients were admitted to hospitals across the North West. An estimated 11,000 of these could have been treated in the community by specialist nurse-led teams. North West Ambulance Service decided to address this, building on the existing award-winning Paramedic Pathfinder initiative.

The latter scheme - which won them the 2011 Health Service Journal Clinical Redesign award - enabled paramedics on an emergency call from a patient, to make a decision to refer them to an urgent treatment unit, rather than A&E, based on symptom recognition rather than diagnosis.

The Community Care Pathway Referral Process is an extension of this. It brings ambulance staff together with a COPD patient's community health care team to make a care plan built on individual baseline measurements. When paramedics receive a call-out from a COPD patient, they can check whether this person has gone through this process and, based on baseline levels, take them to A&E, their GP or to the community service.

Pilots to create community care pathways are taking place in a number of venues including Warrington and Blackburn with Darwin. Two-year funding has been secured to roll the scheme out to the whole North West. NWAS propose to start implementation from July 2012.

75 percent of
asthma admissions
and **two thirds** of
COPD admissions
are avoidable



Better commissioning of services

Good quality commissioning should aim to improve equality of health services for people with COPD and asthma, and for their carers. In 2012, the Department of Health is producing a toolkit focused on four specific areas:

- Acute care - management of exacerbations
 - Pulmonary rehabilitation
 - Case finding - spirometry and assessment
 - Oxygen assessment and review.
- ◆ Proactive chronic disease management with optimal prescribing and self care
 - ◆ Continuing support for smoking cessation since it has a 10 times better success rate than willpower alone

Key steps to improve commissioning outcomes:

- ◆ Earlier recognition of COPD in people with symptoms, to reduce subsequent disability and lung damage.
 - ◆ Quality-assured accurate diagnosis to ensure correct treatment
 - ◆ Comprehensive assessment of severity of the condition and other existing diseases
- ◆ Prompt self-management of worsening of symptoms, with multidisciplinary support at home when appropriate, leading to reduced hospital admissions
 - ◆ Structured hospital admission with early specialist input for every COPD patient, when needed
 - ◆ Early provision of pulmonary rehabilitation when appropriate to reduce admissions
 - ◆ Supplying of home oxygen when appropriate, supported by specialist assessment and review.



COPD
is expected
to be the
third leading
cause of death
worldwide by 2030

One person in England and Wales
dies every 20 minutes from COPD –
about **25,000 people per year**

Case study:
Logic Model of Commissioning – NHS Liverpool

Health outcomes managers working at NHS Liverpool recognised that commissioning services for conditions like COPD could be complex because of the multifaceted nature of the interventions required. They decided to clarify the process around commissioning for pulmonary rehabilitation, by adapting a model originally developed by the Kellogg Foundation for running social programmes.

The Logic Model was modified by Steve Callaghan and Gina Perigo from NHS Liverpool and tested at Aintree Universities Hospital, before being incorporated into the COPD service at Liverpool Heart and Chest Hospital for 12 months.

It requires commissioners to run through a set of questions to set clear criteria about which patients they treat, the clinical standards to which they work, the quality and quantity of the care delivered and the impact of a pulmonary rehabilitation programme on the patient.

Over the 12-month trial at Liverpool Heart and Chest Hospital, 89 percent of COPD patients achieved a 35 percent improvement in walking distance (the benchmark is 20 percent). Patient anxiety and depression was also reduced, even three months after completion of the rehabilitation course, and those treated in the community increased their understanding of their condition by 78 percent (54 percent for those treated as in patients).

The Logic Model has been widely used across NHS Liverpool and has been recognised by the Department of Health as a valuable tool for

improving clarity and focus in commissioning services for different aspects of respiratory disease. The model has also been further adapted for use in a wide range of health areas, from public health and pregnancy to acute and end of life care.



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The challenge of a new home oxygen service - **the transition**

A new provider of oxygen services for the North West, Air Liquide, takes over from July 2012, so respiratory teams need to prepare for the transition and share best practice in the delivery of Home Oxygen Services (HOS) for COPD. Nationally-approved changes to the contracts will require more input from clinical staff. North West Respiratory Clinical Pathway Team held a meeting to focus on the transition to Air Liquide from July 2012

Top tips for the transition:

- Start to prepare as soon as possible
- All patients should, wherever possible, be referred to the HOS team for oxygen prescription
- Make sure the home oxygen service database is accurate before the new provider takes over
- Check data on monthly invoices against HOS patient registers, to ensure the correct patients are on the lists, and to record how each of them receives their oxygen
- Check patient's current concordance levels on quarterly reports
- Be familiar with the new two-part, home oxygen order (HOOF) forms, to avoid potential extra costs of wrongly filling them in
- Note that all equipment will now be prescribed by the clinician/HOS team
- Monitoring performance, invoice and concordance will be a function of the HOS team.



Three million people in England have **COPD**, of whom only **890,000** are registered with their GP

Case study:
Wirral home oxygen service

Wirral home oxygen service, based at Wallasey Community hospital was chosen in 2010 as one of several national pilot sites for oxygen services for the Lung Improvement Programme. Its work includes close liaison with the local fire service.

The service’s particular interest was to determine how best to work with patients receiving home oxygen when it is no longer clinically indicated, without eroding patient trust.

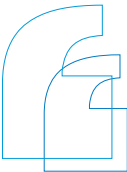
The Wirral service has been doing this through the use of primary care multidisciplinary teams and by strengthening relationships with cardiac and neurology specialists, to develop pathways for oxygen use in these specialities.

Emphasis has also been put on the time-consuming task of tracking oxygen prescriptions, costings and patient data. A comprehensive real-time database enables monitoring of the population.

Assessment of more than 300 new referrals for oxygen revealed 90 cases for which oxygen was not appropriate. Intervention with this group resulted in a potential saving of at least £40,000.

A review of more than 700 existing patients, who were already on home oxygen, has led to a further £45,000 reduction on oxygen expenditure. This has been achieved by accurate assessment, optimising treatment and oxygen prescriptions, data reconciliation and stopping clinically-unnecessary and unused oxygen.

The local primary care trust has been keen to ensure adequate quality assurance from the start and commissioned Manchester Metropolitan University to carry out a rigorous evaluation of the service. Patient feedback was excellent and very supportive. Most patients reported that the service had helped them manage their condition better.



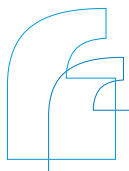
30 percent of oxygen prescriptions are either **inappropriate** or taken incorrectly



The standards we work to

These are the quality standards published by the National Institute for Health and Clinical Excellence (NICE), which guide all respiratory work.

1. People with COPD have one or more indicative symptoms recorded, and have the diagnosis confirmed by post-bronchodilator spirometry carried out on calibrated equipment by health-care professionals competent in its performance and interpretation.
2. People with COPD have a current individualised comprehensive management plan, which includes high-quality information and educational material about the condition and its management, relevant to the stage of disease.
3. People with COPD are offered inhaled and oral therapies, in accordance with NICE guidance, as part of an individualised comprehensive management plan.
4. People with COPD have a comprehensive clinical and psychosocial assessment, at least once a year or more frequently if indicated, which includes degree of breathlessness, frequency of exacerbations, validated measures of health status and prognosis, presence of hypoxaemia and comorbidities.
5. People with COPD who smoke are regularly encouraged to stop and are offered the full range of evidence-based smoking cessation support.
6. People with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme.
7. People who have had an exacerbation of COPD are provided with individualised written advice on early recognition of future exacerbations, management strategies (including appropriate provision of antibiotics and corticosteroids for self-treatment at home) and a named contact.
8. People with COPD potentially requiring long-term oxygen therapy are assessed in accordance with NICE guidance by a specialist oxygen service.
9. People with COPD receiving long-term oxygen therapy are reviewed in accordance with NICE guidance, at least annually, by a specialist oxygen service as part of the integrated clinical management of their COPD.



**25,000 people
die of COPD
each year in
England & Wales**

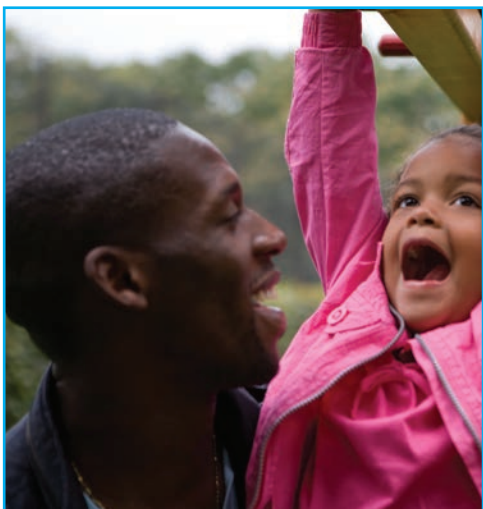


10. People admitted to hospital with an exacerbation of COPD are cared for by a respiratory team, and have access to a specialist early supported-discharge scheme with appropriate community support.
11. People admitted to hospital with an exacerbation of COPD and with persistent acidotic ventilatory failure are promptly assessed for, and receive, non-invasive ventilation delivered by appropriately trained staff in a dedicated setting.
12. People admitted to hospital with an exacerbation of COPD are reviewed within two weeks of discharge.
13. People with advanced COPD, and their carers, are identified and offered palliative care that addresses physical, social and emotional needs.

15 percent of those admitted to hospital with COPD die within three months

OUR RESPONSE:

The North West Respiratory Clinical Pathway Team is working with the Advancing Quality Alliance (AQUA) to devise and pilot an incentive scheme (Integrated Care Regional CQUIN), which ensures that all patients get equal access to quality care.



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Contact Details

For more details and background about the seven themes we have highlighted in this booklet, here are the following resource and contacts:

How to prevent admissions – the GP way

Email: Dr Stephen Gaduzo at sgaduzo@nhs.net

Listening to patients

<http://www.inspirationnw.co.uk/inspire/respiratory-listening-event>

http://www.lunguk.org/supporting-you/breathe-easy/breathesasygroupsacrosstheuk/breathe_easy_groups_in_the_north_west

Email: Preeti Sud at Preeti.sud@northwest.nhs.uk

Early diagnosis and smoking cessation

Case study contact: Andrea Gupta at Andrea.Gupta@hsthpcct.nhs.uk

Pulmonary Rehabilitation

Case study contact: Will Sullivan at Will.Sullivan@lancashirecare.nhs.uk

Reducing unscheduled admissions and readmissions

Email: June Roberts at june.roberts@nhs.net

Case study contact: Mark Newton at mark.newton@nwas.nhs.uk

Better commissioning of services

Case study contact: Steve Callaghan at seve@eqehealth.co.uk

The challenge of a new home oxygen service - the transition

Email: Dr John Williams at johnwilliams5@nhs.net

**FOR MORE INFORMATION AND
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Important websites:

Look at the North West Respiratory Clinical Pathway Team's website:

<https://knowledgehub.local.gov.uk/group/northwestrespiratoryforum>

National Lung Improvement: <http://www.improvement.nhs.uk/lung/>

Advancing Quality Alliance: <http://www.advancingqualityalliance.nhs.uk/>



One premature death will be avoided for **every 80 people** who are given brief intervention on **stopping smoking** by their GP

Working **together** to **improve respiratory** **care** in the North West



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