Improving COPD care in Midlothian

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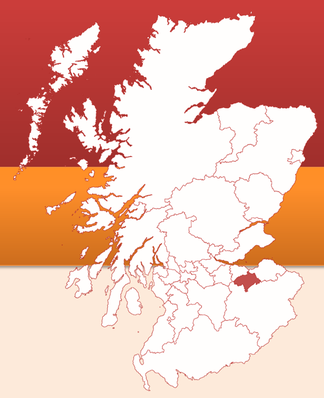


What are we trying to accomplish?

Introduction:

Midlothian is an ex-mining population with high prevalence of Chronic Obstructive Pulmonary Disease (COPD), increasing from 1.9 to 2.6 per 100 patients over the last 8 years[1], the highest prevalence rate among the Lothian H&SCPs, and second highest rate for COPD admissions and bed days among the Lothian H&SCPs. In 2016/17 216 Midlothian residents accounted for 257 admissions and 1,481 bed days, with 12% patients admitted two or more times. 81% of patients presented via their GP, NHS24 or SAS.[2] There is clearly an opportunity for improving person-centred care for patients with COPD, from diagnosis to early supported self-management, through to specialist treatment of exacerbations to reduce to burden of hospital admission.

Midlothian H&SCP has a single GP cluster consisting of 12 practices serving a population of 90,000 people, and improving COPD care forms part of the Midlothian Strategic Plan for 2019-2022.

Aims/Objectives:

This project supports the Scottish Government's 2020 Vision, that by 2020 everyone in Midlothian with COPD will be able to live longer healthier lives at home, or in a homely setting, with a focus on:

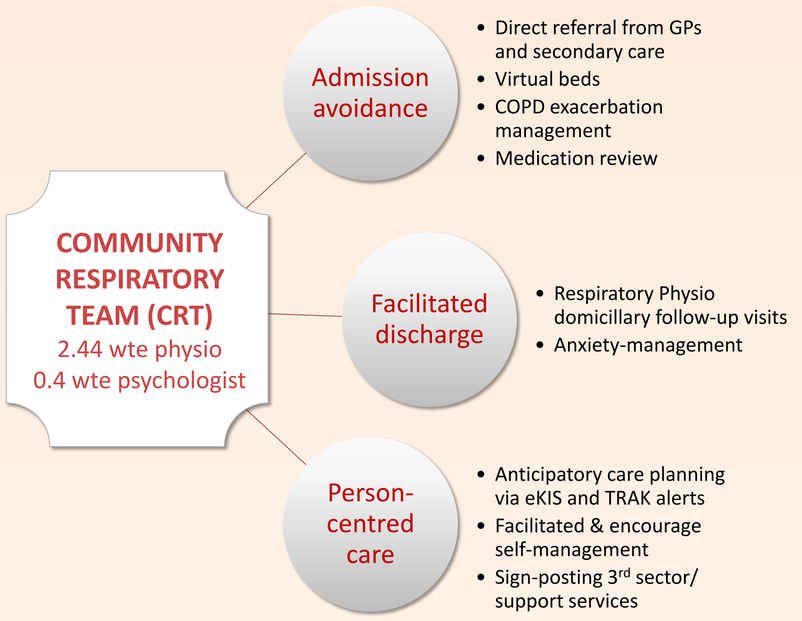
- prevention, anticipation and supported self-management
- care provided to the highest standards of quality and safety, with person-centred decision making
- ensuring that people are treated in their home or community environment , with minimal risk of admission: **40% reduction in COPD admissions by 2019,** and an ambitious 60% reduction by 2020

What changes can we make that will result in an improvement?

A public health whole-disease approach was used to consider how COPD morbidity and health resource burden could be reduced across the spectrum of the condition, and improve care for patients & their families. A stakeholder engagement event, involving health, social care, third sector and unscheduled care partners, was used to develop a process map of current COPD care and identify opportunities for improvement and intervention.

Initial priority was given to two main projects focussing on the most symptomatic patients with the most severe disease, which have been tested using improvement methodology with two GP practices over the last year:

- **development of a community respiratory team (CRT) hub for management of recurrent exacerbators in the community to prevent admission and support early discharge from hospital**
- **multidisciplinary improvement of anticipatory care plans[3] via the electronic key information summary (eKIS) written and uploaded from primary care, which are visible to and inform unscheduled care decisions**



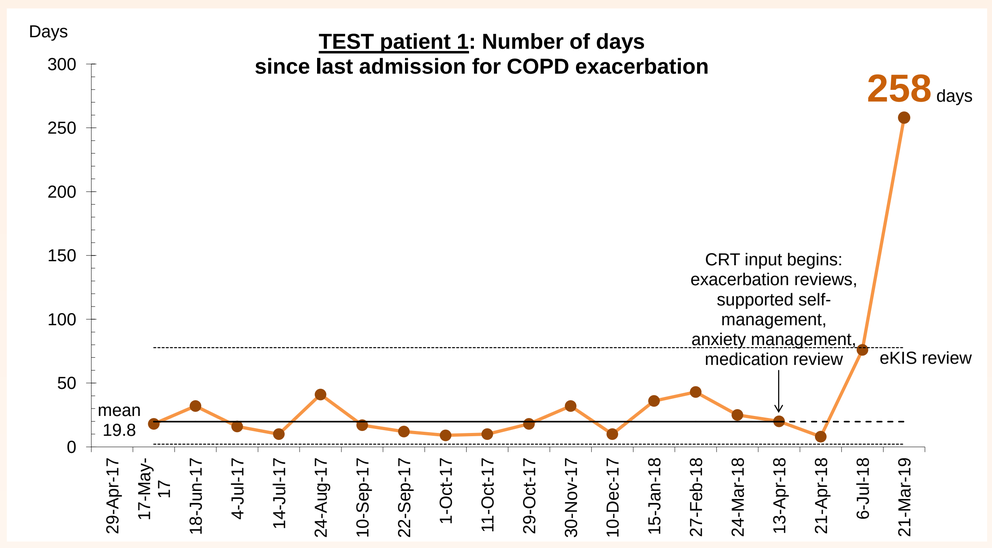
Scottish Government USC 6EA
COPD Best Practice Guide

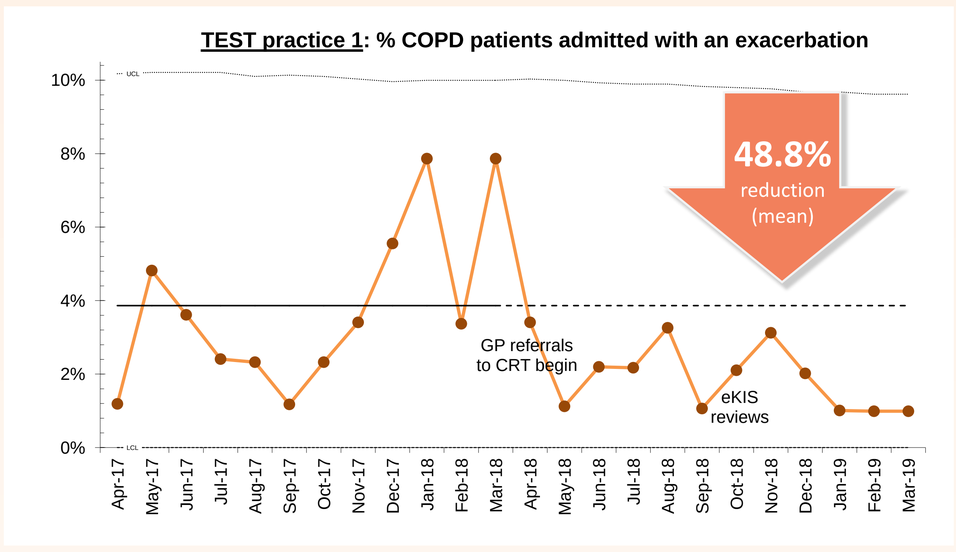
Documentation of an ACP in the eKIS which clearly outlines the patient's:

- **physical, psychological and social needs**
- **what is normal for this patient**
- **resuscitation status**
- **level of escalation during an acute exacerbation**

6 ESSENTIAL ACTIONS Unscheduled Care

How do we know if our changes are leading to an improvement?





"GPs appear satisfied with our (CRT) input and feedback during acute exacerbations, and happy with our care plans for patients, complimenting the coordination, input & improvement in care pathway..."

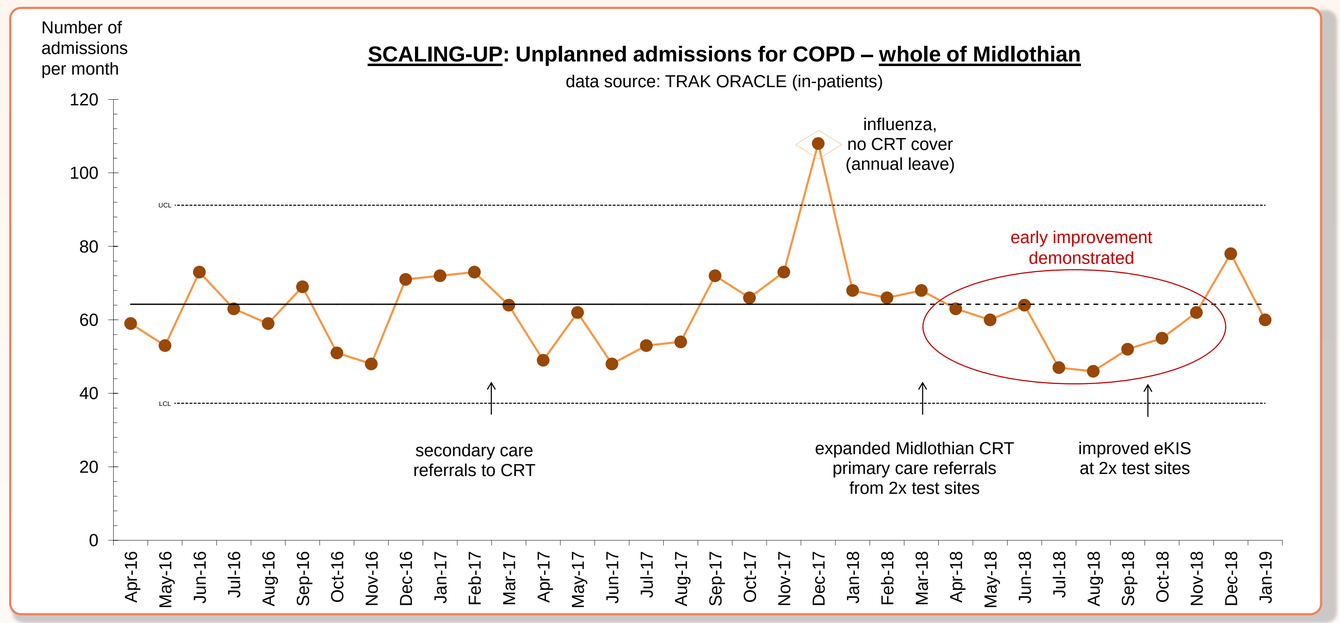
66%
111/999 calls resulted in transfer to hospital
April 2017 - July 2018
n = 35

eKIS review
all 5 COPD best practice criteria
August 2018

11%
111/999 calls now result in transfer to hospital
March 2019
n = 9

"Nobody likes being in the hospital do they?... It works really well... Everyone knows what I need and I get to stay at home"

"... I have learned to deal with the panic, I no longer phone the ambulance straight away; I take my nebuliser first and try and do my breathing exercises"



Next steps:

- Expansion of the Midlothian Community Respiratory Team (CRT) with further Band 6 physiotherapy to increase capacity & capability, and enable electronic referrals via SCI-Gateway to allow spread of primary care referrals to CRT from all 12 practices in Midlothian from May 2019
- Scale-up anticipatory care plan (eKIS) improvement work across Midlothian practices, and test collection of consent and information by nursing and allied professional colleagues
- Test (and scale-up via GP cluster) case-finding/earlier diagnosis by screening smokers over 50 yrs, and promoting smoking cessation & pulmonary rehabilitation
- Test (and scale-up via locality prescribing group) inhaler optimisation as per new GOLD guidelines[4]
- Work with local "Breathe Easy" group to provide a information/education event for people affected by COPD and provide them with practical information, as well as signposting to local services, and peer support
- Ongoing collaboration with multidisciplinary partners to provide high quality holistic care across the COPD disease spectrum.

References:
1. Quality & Outcomes Framework (QOF) and Primary Care (PCI) Dashboard
2. Scottish Morbidity Record 01 (SMR01)
3. 6 Essential Actions for Unscheduled Care COPD Best Practice Guideline, Scottish Government (2017)
4. Global Initiative for Chronic Obstructive Lung Disease (GOLD). Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease. 2018 [internet publication].

LothianQuality BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Midlothian Health & Social Care Partnership