Royal College of Physicians

National Respiratory Audit Programme (NRAP)

NRAP Good Practice Repository – COPD

King’s College Hospital
King’s College Hospitals NHS Foundation Trust

Overall performance in the COPD audit.

King’s College Hospital achieved:

KPI1 – 50%*

KPI4 – 84.9%*

KPI6 - 79.6%*

***In the 2022-23 cohort**

We are delighted that King’s College Hospital (KCH) has been highlighted for good practice in COPD care by the NRAP program, in particular for consistent high-quality delivery of the COPD discharge bundle for patients admitted acutely to hospital. We aim to provide excellent patient centred care through consistent 7-day specialist review for all patients admitted acutely with an exacerbation of COPD, focusing on high value COPD care, appropriate self-management support, education and the COPD discharge care bundle.

Our processes to achieve good practice in the COPD audit:

The King's College Hospital/Lambeth and Southwark Integrated Respiratory Team (IRT) is a 7-day multi-professional "team without walls" working across a large inner city teaching hospital to serve the needs of a diverse urban population in south east London.

The team works with primary, secondary and community care colleagues to deliver excellent patient centred care for local people many of whom are subject to high levels of health inequality due to deprivation, poor housing and air quality, and tobacco dependence, all of which add to the burden of respiratory disease.

The IRT ensures timely access to specialist care in hospital for patients acutely unwell with COPD, asthma exacerbations and respiratory failure and has consistently performed extremely well in key performance indicators of good practice in the previous national COPD audit and now the National Respiratory Audit Programme. In supporting patients with complex breathlessness and multi-morbidity in the community, the team focuses on long-term conditions management and collaborative care planning. Through focusing on outcomes that matter to the patient, joining up key components of care and bringing specialist care closer to home, the IRT strives to ensure that individual COPD patients receive excellent care.

The service started in 2013 and has grown since that time. Initially it was funded as a pilot from 2013-2016, and has been substantively funded from 2016 onwards, after achieving required KPIs, delivering reductions in COPD admissions readmissions and length of stay and improving quality of care. We were finalists in the Royal College of Physicians Excellence in Patient Care awards in 2016 and featured as a case study in the RCP Future Hospital Program and Journal. We have won several local awards (King's Stars Best Patient Facing team 2018 and King's Health Partners Award for Outstanding Collaboration in Integrated Care in 2023).

Staffing

The team now consists of:

- 4 airways disease consultants including one with specialist interest in integrated respiratory care.
- Band 8a specialist respiratory nurse team lead.
- 3 WTE Band 7 and 2 WTE Band 6 respiratory nurse specialists for inpatient and community care.

- Home Oxygen Service delivered by 1.7 WTE Band 7 specialist respiratory physiotherapists and 0.5 Band 3 admin.
- Pulmonary Rehabilitation Service delivered by 1WTE specialist respiratory physiotherapist with 2 WTE Band 6 and 2 WTE Band 4 physiotherapists/assistants and 1 WTE Band 3 admin.
- Tobacco Dependence Service delivered by 1WTE Band 7 and 3 WTE Band 6 tobacco dependence advisors and 1WTE Band 4 admin.
- Integrated psychosocial team consisting of a consultant psychiatrist, psychologist, and social worker (this part of our service was an HSJ Awards Finalist in 2018, commended in Positive Practice in Mental Health in 2019).
- Community spirometry service led by senior physiologist and 2 WTE Band 4 respiratory physiologists, ensuring all local patients can access quality assured diagnosis close to home (GP referral via eRS).

Key enablers of success include:

- The inception and initial set up of the service which was done in close collaboration with local primary care, particularly 2 GP respiratory leads, so that all pathways were integrated, and patient centred.
- A 7-day team.
- A 7-day telephone advice and support line for patients.
- Lots of learning from taking part in initial CQUIN for COPD discharge bundle (2016/17 onwards).
- A regular weekly MDT where patients are discussed, drawing from the expertise across the team, and taking a mind and body approach to develop collaborative care plans.
- Electronic patient records which span primary and secondary care (to access spirometry results).
- Electronic alerts to the team when a patient with COPD or asthma is admitted.
- Daily review of the Medical Take list to find new patients.
- In-reach into all medical wards on a daily basis.
- Standardised structured electronic patient assessment proforma, covering key elements of good practice including COPD discharge bundle.
- Standardised IRT discharge summary, additional to medical discharge summary, which summarises all aspects of high value care for the patient and GP, including written personalised action plan.
- All patients receive a 72-hour post discharge welfare telephone call to highlight any issues and ensure follow up in place.
- Close working with the Hospital at Home team to support admission avoidance and early supported discharge.
- Close working with ED, acute medicine, respiratory, palliative care, and other colleagues across the hospital such that all are aware of the team, correct clinical pathways and what we offer.
- Unified SEL wide COPD and Asthma guidelines for primary and secondary care to ensure consistent sustainable inhaler practice.
- Regular respiratory teaching and updates for colleagues across the hospital.

Discharge letter template:

Integrated Respiratory Team
Dr Pete Cho (Respiratory Consultant)
Dr Jo Kavanagh (Respiratory Consultant)
Dr Irem Patel (Respiratory Consultant)
Dr Laura-Jane Smith (Respiratory Consultant)
Dr Cristiano Van-Zeller (Respiratory Consultant)
Michelle Johnson (Team Lead)

Respiratory Support line: 020 3299 6531
(Mon-Fri 9am-5pm / Sat & Sun 9am-12pm)
kch-tr.IntegratedRespiratoryTeam@nhs.net

Dear @GPLASTNAME@,
@GPP@

RE: **@NAME@** Hospital No.: **@MRN@,** NHS: **@NHS@,** DOB **@DOB@**
Address **@ADD@**

For your information the above patient has been:

- Discharged from X ward at Kings College Hospital following an admission for an exacerbation of their COPD (H3122) on [date].
- Additionally seen in the community following the above admission.
- Reviewed in the community following referral by X.
- Seen in the Emergency Department and discharged with the following care plan.

Diagnosis

- COPD (H3z-1)
- Asthma (H33)
- Mixed airways disease

GP recommendations

- Please prescribe an emergency pack of oral antibiotics and prednisolone for this patient to keep at home in the management of future exacerbations. We would usually suggest Doxycycline 200mg for 5 days and prednisolone 30mg for 5 days.

Spirometry	Date:...............	Read Codes
FEV1		339O
FEV1 % pred		339S
VC (FVC)		3386 (3396)
FEV1/VC or FVC		339R
Disease severity		-
MRC Dyspnoea		173H-L
Location of Spirometry:	(Lab or ward)	

COPD Bundle Interventions:

Current smoking status and intervention

- Current smoker with x pack year history (137R)
- Ex-smoker with x pack year history (137S)
- Brief stop smoking intervention given (8CAL)
- Patient declined onward referral to smoking cessation services
- Referred to local smoking cessation services
- Initiated on NRT (type and dose)

Medication optimisation

- Inhaler technique checked and therapeutic with devices.
- Changes to medications made/suggested:

Respiratory Medications

Drug eg Salbutamol	*Dose eg 100mcg 1 puff PRN*	*Device eg pMDI plu aerochamber*

Pulmonary rehabilitation status

- Not indicated/appropriate due to ....
- Referred to local service.
- Declined referral, please revisit this in the future.

Action plan (attached to letter)

- Agreed and issued (66Y1) Please review this at the patient's next visit.
- To be agreed.

Rescue pack

- Assessed but not suitable for rescue pack.

- Assessed but not suitable for rescue pack currently, please could this be reassessed in the future.
- Assessed and suitable for rescue pack.

Follow-up arrangements

- Home visit follow-up by the Integrated Respiratory Team.
- Review in COPD disease management clinic.
- Review in outpatient Consultant-led clinic.
- Telephone support by the Integrated Respiratory Team.
- Discharged from Integrated Respiratory Team review.
- Formal Spirometry

Additional Information:

Oxygen Prescription

- Mr./s. X has a pO2 of XXXX on room air and therefore is not a candidate for Long Term Oxygen Therapy. Please refer the patient to the Home Oxygen Assessment and Review service via the Single point Referral.
- Long Term Oxygen Therapy has been initiated and will be reviewed in six weeks.
- The following changes have been made to their oxygen prescription………
- Long Term Oxygen Therapy has been discontinued as the Mr./s is no longer hypoxaemic with a pO2<7.3 on room air.
- No changes have been made to their current prescription.

Onward referrals made

- Community matron service
- At Home referral.
- Psychological therapies.

Other specialities involved in patient care

- Psychology team,
- Community Palliative Care Team.
- Other.

Advanced care planning discussions

- Patient Specific Protocol discussed and completed
- Details of patients wishes.

Patient health improvement goals

	Goal	Achieved by	Reviewed by:
1	Engage with Southwark Stop Smoking service with developed quit plan	(two weeks)	IRT home vis
2	Quit smoking for >4 weeks	1 month	GP review appointment
3			

Yours sincerely

@ME@
Respiratory Nurse
Integrated Respiratory Team