Royal College of Physicians

National Respiratory Audit Programme (NRAP)

Organisational audit 2024: COPD data deep dive

Resourcing and organisation of asthma and COPD care in hospitals, and PR services in England and Wales

Publication year: 2024

In association with:

Commissioned by:

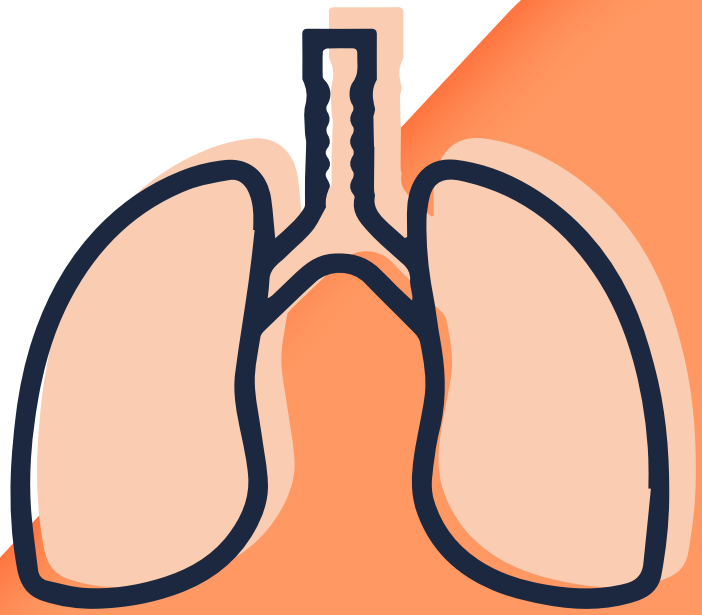
Funded by:

Summary of COPD data deep dive

Deep dive 1: access to specialist respiratory care

Deep dive 2: access to specialist tobacco dependence support

Deep dive 3: access to integrated respiratory care



Access to specialist respiratory care

COPD exacerbations make up a significant proportion (24%) of all acute respiratory admissions to hospital. However, NRAP organisational audit data show that only 23% of patients with COPD are admitted to a respiratory ward during their hospital stay (Fig 1), which has reduced from 39% in the 2021 audit.

Standards and guidelines

The GIRFT report recommends: 'Review patient flows to ensure admitted respiratory patients go to a respiratory ward, with a long-term goal of 65% of respiratory patients to be managed and followed up by chest specialists. Thereafter with full respiratory ward occupancy, review the respiratory bed base to ensure sufficient respiratory beds exist within the trust with an associated expansion of workforce where required'.[1]

What the data show

NRAP data also indicate that access to specialist-led care for patients with COPD outside the respiratory ward setting is limited, in particular at weekends and out of hours. Only 31% of services have a dedicated respiratory consultant on call, with 30% of services reporting no specialty triage of acute admissions to respiratory medicine. In services where specialty triage exists, this is available in 70% of services on weekdays, but in only 37% of services at weekends.

Services report a ward round of new COPD admissions being undertaken by a senior respiratory decision maker (ST3 or above) on non-respiratory wards as follows:

	Medical admission unit	Non-respiratory post-acute wards
Weekdays	54%	45%
Weekends	20%	13%

Multidisciplinary care by a respiratory nurse or physiotherapist available to review new COPD admissions is also limited at weekends (32.4% and 67% respectively).

These findings are likely to be related to workforce shortages, as NRAP data show that there are (median) 2.1 respiratory consultants and only 0.9 respiratory nurses in post per 300 COPD admissions nationally.

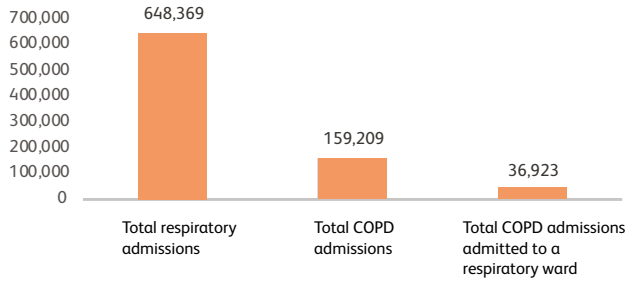


Fig 1. England and Wales breakdown of respiratory admissions (2022/23)

Why is this important?

Previous national audit data have shown that patients with COPD seen by respiratory specialists receive better evidence-based care, and that specialist respiratory care in COPD reduces length of stay as well as both inpatient and 90-day mortality.[2] Subsequent studies have confirmed this,[3] and national recommendations highlight the need to improve access to respiratory-led care.[4]

Practical steps to healthcare improvement

NRAP would encourage services and trusts to:

- review their own data and outcomes with respect to how many patients with COPD are managed on a respiratory ward.

Focus on:

- developing an agreed clinical pathway for acute COPD admissions in your trust
- implementing a robust process for highlighting new admissions with COPD exacerbations, eg an electronic alert system
- reviewing workforce gaps within the respiratory service and evaluate the impact that this has on delivering specialist respiratory care
- developing a close working relationship with emergency medicine teams, medical bed managers and acute medicine teams to prioritise patients with COPD exacerbations for specialist respiratory care.

Access to specialist tobacco dependence support

NRAP organisational audit data show that there is significant variation in access to specialist tobacco dependence services and advisers across services.

What the data show

83.1% (113/136) of services report they have a tobacco dependence service available for COPD inpatients, and 94.1% report that they have a tobacco dependence service available for patients with COPD on discharge. However, the number of tobacco dependence advisers in post in hospitals admitting patients with COPD throughout England and Wales varies significantly (median 0.8 WTE), with only 53.4% of services (73/136) reporting they have a tobacco dependence adviser in post (Fig 2).

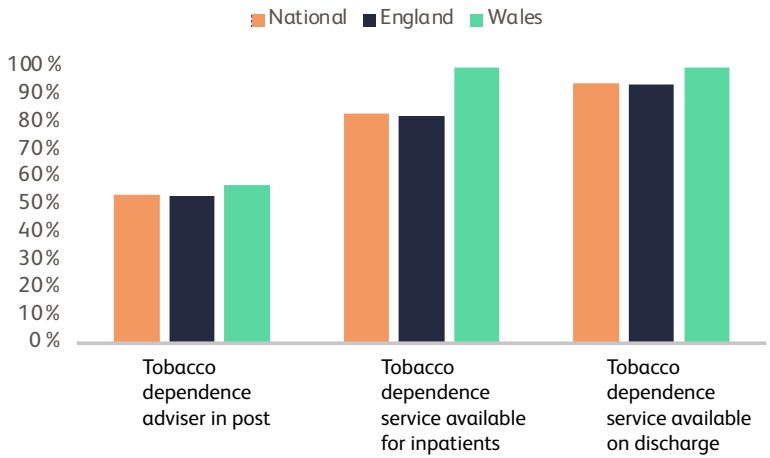


Fig 2. Tobacco dependence services for patients with COPD

Why is this important?

Smoking causes and exacerbates COPD and 80% of COPD deaths are caused by smoking. Treating tobacco dependence is one of the most effective, high-value interventions for COPD, and is a key element of the COPD Discharge Bundle.[5,6] Despite this, the smoking prevalence of patients admitted to hospital with COPD has remained static at around 35% since national audit data have been collected. The NHS Long Term Plan in England, and the Tobacco Control Delivery Plan in Wales, aim to ensure that a universal NHS-delivered opt-out smoking cessation service is available to all inpatients who smoke by 2023/24.[7,8] This requires adequate in-house provision of tobacco dependence advisers able to support and treat smokers with COPD in hospital, with follow-up in the community on discharge.

Practical steps to healthcare improvement

Identifying smokers in hospital during an acute admission and offering them evidence-based treatment is a key healthcare improvement goal for NRAP. NRAP would encourage services and trusts to:

- ensure that screening for tobacco dependence is a routine part of inpatient COPD care
- make sure that all healthcare professionals looking after patients with COPD are trained in how to provide 'very brief advice', treatment and support at every opportunity for patients with COPD to quit smoking
- consider implementing NCSCT treatment bundles for tobacco dependence and the recommendation from the BTS Clinical Statement for inpatients with COPD who smoke[9]
- work with their ICB to access NHS Long Term Plan funding for a hospital-based smoking cessation service
- identify a clinical lead for tobacco dependence treatment services with adequate protected time, and consider implementing other recommendations from the GIRFT report on tobacco dependence.

Access to integrated respiratory care

NRAP organisational audit data show there is significant variation in access to evidence-based pathways of care for patients presenting with acute COPD exacerbations.

What the data show

Between 27% and 46% of services report no access to early or supported discharge for acutely admitted patients (outreach or inreach models respectively). 21.3% of services report no availability of admission avoidance pathways. Only 38.2% of services have a regular multidisciplinary team (MDT) meeting where hospital and community teams come together to review and optimise care and pathways for patients with COPD (Fig 3): where these do exist, only 51.5% of teams meet weekly. GPs join these care planning meetings very infrequently (16.8%). Only 38.6% of teams report that the MDT has time dedicated to planning and developing local integrated respiratory services.

Why is this important?

Supported discharge and hospital at home schemes are safe and effective and are recommended by NICE as alternative ways of caring for people with exacerbations of COPD who would otherwise be admitted or stay in hospital.[5] Integrated disease management supports improvement in disease-specific quality of life, exercise capacity, hospital admissions and hospital days in COPD,[10] and closer joint working between primary and secondary care has been shown to improve guideline-concordant care and deliver substantial and sustained reductions in COPD hospitalisations and emergency department visits.[11]

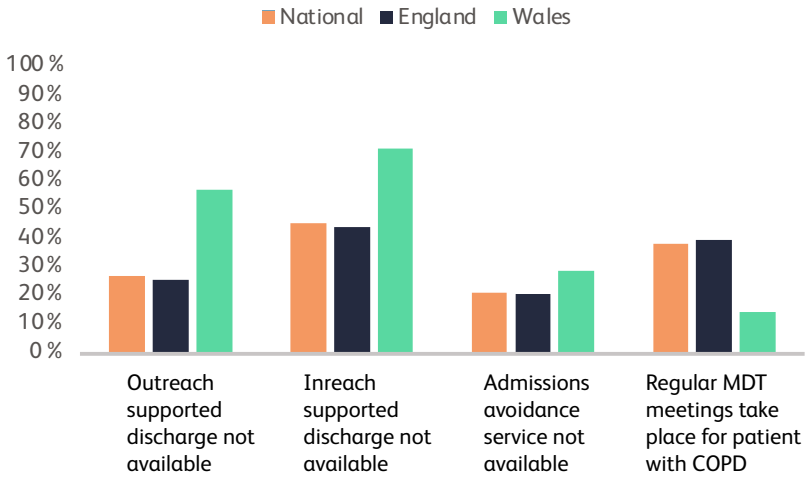


Fig 3. Integrated care service

Practical steps to healthcare improvement

NRAP would encourage services and trusts to:

- ensure protected senior clinical leadership time to deliver integrated services for COPD
- review workforce needs to ensure they are resilient and flexible to deliver fully integrated services for patients with COPD
- implement a weekly integrated care MDT meeting between the hospital and community, which is easily accessible and responsive to primary and community care teams looking after patients with COPD
- ensure that patients have access to admission avoidance and supported discharge, which could include 'hot' clinic and virtual ward models of care.

The Royal College of Physicians (RCP)

The RCP plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. The RCP provides physicians in over 30 medical specialties with education, training and support throughout their careers. As an independent charity representing 40,000 fellows and members worldwide, the RCP advises and works with the government, patients, allied healthcare professionals and the public to improve health and healthcare.

Healthcare Quality Improvement Partnership (HQIP)

The National Respiratory Audit Programme (NRAP) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges and the Royal College of Nursing. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales.

HQIP holds the contract to commission, manage and develop NCAPOP, comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies. www.hqip.org.uk/national-programmes.

National Respiratory Audit Programme (NRAP)

The National Respiratory Audit Programme (NRAP) aims to improve the quality of care, services and clinical outcomes for patients with respiratory disease across England and Wales. It does this by using data to support and train clinicians, empowering people living with respiratory disease and their carers, and informing national and local policy. NRAP has a track record of delivery and is critical in assessing progress against the NHS Long Term Plan. To find out more about NRAP, visit our website.

Acknowledgements

This report was produced by:

Dr Alexander Adamson, NRAP data analyst; research associate – medical statistician, Imperial College London
Lara Amusan, programme manager, NRAP, CQID, RCP
Tim Bunning, principal consultant, Crown Informatics
Dr Hannah Burke, COPD clinical fellow, NRAP, CQID, RCP
Teena Chowdhury, deputy director, CQID, RCP
Dr Yueqi Ge, healthcare improvement clinical fellow, NRAP, CQID, RCP
Jodie Henderson, project manager, NRAP, CQID, RCP
Ben Hitchman, programme coordinator, NRAP, CQID, RCP
Rachael Hodges, deputy programme manager, NRAP, CQID, RCP
Ruth O'Beirne, programme coordinator, NRAP, CQID, RCP
Dr Irem Patel, COPD clinical lead, NRAP, CQID, RCP
Professor Jennifer Quint, data analysis lead, Imperial College London
Professor Alice Turner, healthcare improvement clinical lead, NRAP, CQID, RCP
Peter Van Geffen, project manager, NRAP, CQID, RCP
Professor Tom Wilkinson, senior clinical lead, NRAP, CQID, RCP
NRAP COPD advisory group
NRAP board
NRAP patient panels

Citation for this document
Royal College of Physicians. *National Respiratory Audit Programme: Organisational audit 2024. Resourcing and organisation of asthma and COPD care in hospitals, and PR services in England and Wales*. Supplementary report. RCP, 2024.

References

1 Allen M, MBE. *Respiratory medicine GIRFT Programme national specialty report*, 2021. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/Respiratory-Medicine-Oct21L.pdf [Accessed 30 August 2024].

2. National Confidential Enquiry into Patient Outcome and Death. *Inspiring change: A review of the quality of care provided to patients receiving acute non-invasive ventilation*, 2017. https://www.ncepod.org.uk/2017niv.html [Accessed 10 September 2024].

3. Lane ND, Brewin K, Hartley TM *et al*. Specialist emergency care and COPD outcomes. *BMJ Open Respir Res* 2018;5:e000334. https://doi.org/10.1136/bmjresp-2018-000334 [Accessed 10 September 2024].

4. Stone RA, Holzhauer-Barrie J, Lowe D *et al*. COPD: *Who cares matters. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme: Clinical audit of COPD exacerbations admitted to acute units in England and Wales* 2014. RCP, 2015. www.rcp.ac.uk/media/temdec3v/nat_copd_audit_prog_secondary_care_clinical_audit_report_2014_executive_summary_final_print.pdf [Accessed 10 September 2024].

5. National Institute for Health and Care Excellence. Chronic obstructive pulmonary disease in over 16s: diagnosis and management. NICE guideline [NG115], updated 2019. www.nice.org.uk/guidance/ng115 [Accessed 10 September 2024].

6. National Institute for Health and Care Excellence. Chronic obstructive pulmonary disease in adults. Quality statement 8: Hospital discharge care bundle. NICE quality standard [QS10], updated 2023. www.nice.org.uk/guidance/qs10/chapter/Quality-statement-8-Hospital-discharge-care-bundle [Accessed 10 September 2024].

7. National Institute for Health and Care Excellence. Tobacco: preventing uptake, promoting quitting and treating dependence. NICE guideline [NG209], updated 2023. www.nice.org.uk/guidance/ng209 [Accessed 10 September 2024].

8. NHS Long Term Plan. Chapter 2: More NHS action on prevention and health inequalities. 2.8: Smoking. www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/smoking/ [Accessed 10 September 2024].

9. Agrawal S, Evison M, Ananth S *et al*. British Thoracic Society Clinical Statement: Medical management of inpatients with tobacco dependency. *Thorax* 2024;79 (suppl 1):3–11. https://doi.org/10.1136/thorax-2023-220607 [Accessed 10 September 2024].

10. Poot CC, Meijer E, Kruis AL, Smidt N, Chavannes NH, Honkoop PJ. Integrated disease management interventions for patients with chronic obstructive pulmonary disease. *Cochrane Database Syst Rev* 2021;9:CD009437. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009437.pub3/full [Accessed 12 August 2024].

11. Licskai C, Hussey A, Rowley V *et al*. Quantifying sustained health system benefits of primary care-based integrated disease management for COPD: a 6-year interrupted time series study. *Thorax* 2024; 79:725–34. https://thorax.bmj.com/content/79/8/725.long [Accessed 10 September 2024].

National Respiratory Audit Programme (NRAP)

Royal College of Physicians
11 St Andrews Place
Regent's Park
London NW1 4LE

The Spine
2 Paddington Village
Liverpool L7 3EA

Tel: +44 (0)20 3075 1526
Email: NRAPinbox@rcp.ac.uk

www.rcp.ac.uk/nrap
@NRAP
#NRAP

Royal College of Physicians

National Respiratory Audit Programme (NRAP)