Prevention of Admission for COPD

Start and end dates of work covered by case study

Sept 2009 - May 2014

Headline quote
Prevention of Admissions COPD exacerbations - PACE

Lead AHSN and joint partners
NWC AHSN – Spread of evidenced based innovative practice

Independent Nurse Practitioner, Lead GP, Pathfinder CCG, PCT, Pharmaceutical Industry

Key points at a glance
Chronic Obstructive Pulmonary Disease (COPD) is a debilitating disease for patients. Julie Morris, Independent Respiratory Nurse, explains how by systematically applying the latest best practice and clinical evidence to help patients better manage their condition through a nurse-led enhanced respiratory COPD programme, improvements in patients’ quality of life and condition can be achieved and a reduction in COPD hospital admissions

Background Summary
When patients have to attend hospital due to acute COPD exacerbations, it often results in them having to stay there for a period of time that could potentially have been avoidable. The cost to the NHS can be between £1,900 and £5,000 per patient each time. By helping patients better control their COPD and reduce the severity and number of exacerbations, the NHS can avoid unnecessary costs and more importantly, help patients avoid the distress and disruption of an emergency hospital admission.

In 2009, Dr. James Kingsland, GP and Chairman of a newly formed consortium Wallasey Health Alliance, recognised the need to better manage COPD patients in order to prevent admissions. By working with Julie Morris, an Independent Respiratory Nurse, a pilot was set up with financial support from the pharmaceutical industry and Primary Care Trust.

The pilot was a dedicated, nurse-led service for patients diagnosed with COPD. The aim was to identify COPD patients in the GP practice with a low quality of life due to frequent severe exacerbations and who were attending the GP practice for emergency acute intervention or out-of-hours that would eventually lead to a hospital admission. This group of patients required a high level of management support and dedicated time.

The annual investment for PACE was £37,800, additional costs for pulmonary rehabilitation and psychological support was £35,000. As a third sector provider, Healthbox is paid by Public Health England on payment by results. The annual cost in COPD admissions for Wirral Health Alliance consortium patient population since the implementation of PACE has seen a decline. A strong partnership between
commissioner, the two consortia Wallasey Health Alliance and Wirral Alliance, as well as provider was achieved along with the following outcomes.

**Reduced number of emergency hospital admissions for patients with COPD:**

In the 228 patients involved in PACE for the two years prior to the start of PACE there were 213 admissions. During April 2012 to March 2014 this particular group of 228 reduced to 80 admissions. On average the cost of an A&E visit or admission of greater than 12 hours equates to £1,690 – this amounts to a minimum cost saving of £224,770

**Reduced number of exacerbations in patients:**

Exacerbations in this group of 228 two years prior to PACE was 939 and went down to 552 two years later, showing a 41% reduction.

**GP emergency appointments for COPD in this group:**

Two years prior to PACE 1,758 COPD related GP appointments. Two years during PACE this reduced to 905. This improved GP capacity with a 48% reduction in COPD GP appointments

**Improved quality of life for patients with COPD:**

Patients perceive the service has improved the quality of their care, which has resulted in them feeling more confident and healthier:

**Improved patient/health professional relationship:**

PACE has helped to improve the dynamic in the patient/health professionals relationship:

**Increased number of patients attending pulmonary rehabilitation:**

Over 70% of the PACE patients attended the pulmonary rehabilitation programme and continued in the patient-led group that followed on from the physiotherapy rehabilitation. Patients have formed new friendships and social networks with their peers whom they had met at pulmonary rehabilitation.

**Increase psychological support:**

68% of the PACE patients attended the COPD support group or the patient-led group. The support group is a significant practice community asset and resource that any CCG programme can harness to help develop its COPD plan in the holistic and clinical care and management and potentially share across other long-term conditions.

**Increased quit smoking support:**

There was a 50% smoking quit rate. The most effective advocates for lifestyle change and improved self-care are service users; and many could be supported to mentor, advice and support their peers: “I feel the need to tell other patients with COPD like me to pack in smoking! If I hadn’t, I don’t think I’d be here now! I’m amazed I have done it.”

Patient journey [https://youtu.be/8LhRUAGJs6M](https://youtu.be/8LhRUAGJs6M)

*Plans for the future*

Future plans

So what could be done to improve the service to ensure even more positive outcomes?

1. A telephone COPD helpline- patients can access a respiratory nurse advice and input
2. Pharmacy involvement in monitoring issuing rescue packs of Antibiotics/Oral Pred

3. In-house, practice-based pulmonary rehab courses

4. Patient flag immediate rapid follow up post-exacerbation and post-hospital admission

Contact for further information

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AHSN Core Objectives
Innovation in Medicines Optimisation is the NWC AHSN strategic approach. This initiative is a outcome focused intervention that has a strong health economic proposition that can be delivered that has the potential to be scaled across other health economies

Clinical priority or enabling theme/s
Medicines Optimisation
Management of long term conditions
New models of care

*Optional sections to include if relevant for this case study.