Royal College of Physicians | NACAP

National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP)

Adult asthma and COPD 2021 organisational audit

Resourcing and organisation of care in hospitals in England and Wales

Summary report

Published 16 June 2022

In association with:

ARNS · Asthma + Lung UK · British Thoracic Society · Imperial College London · PCRS · Royal College of General Practitioners · RCPCH Royal College of Paediatrics and Child Health · HQIP Healthcare Quality Improvement Partnership

Commissioned by:

Asthma and Chronic Obstructive Pulmonary Disease (COPD) are two of the most common respiratory diseases in the UK. These and other lung diseases affect one in five people in the UK and their prevalence is growing.[1] There is a link between the resourcing and structure of services and the quality of care they can provide,[2] and hospital respiratory services must be equipped to deal with the increasing demand they face.This report presents information on the structure and resourcing of 159 out of 198 (80.3%) of the hospital services that provide asthma and COPD care to adults in England and Wales. Data were gathered between 6 September and 8 October 2021 and measured against the key performance indicators (KPIs) recommended by NACAP to support good practice in the delivery of acute asthma and COPD secondary care.

Four of the KPIs have been identified as improvement priorities* which, if delivered, can drive marked improvements to care. We have provided guidance and recommendations to enable these improvement priorities to be achieved more widely.

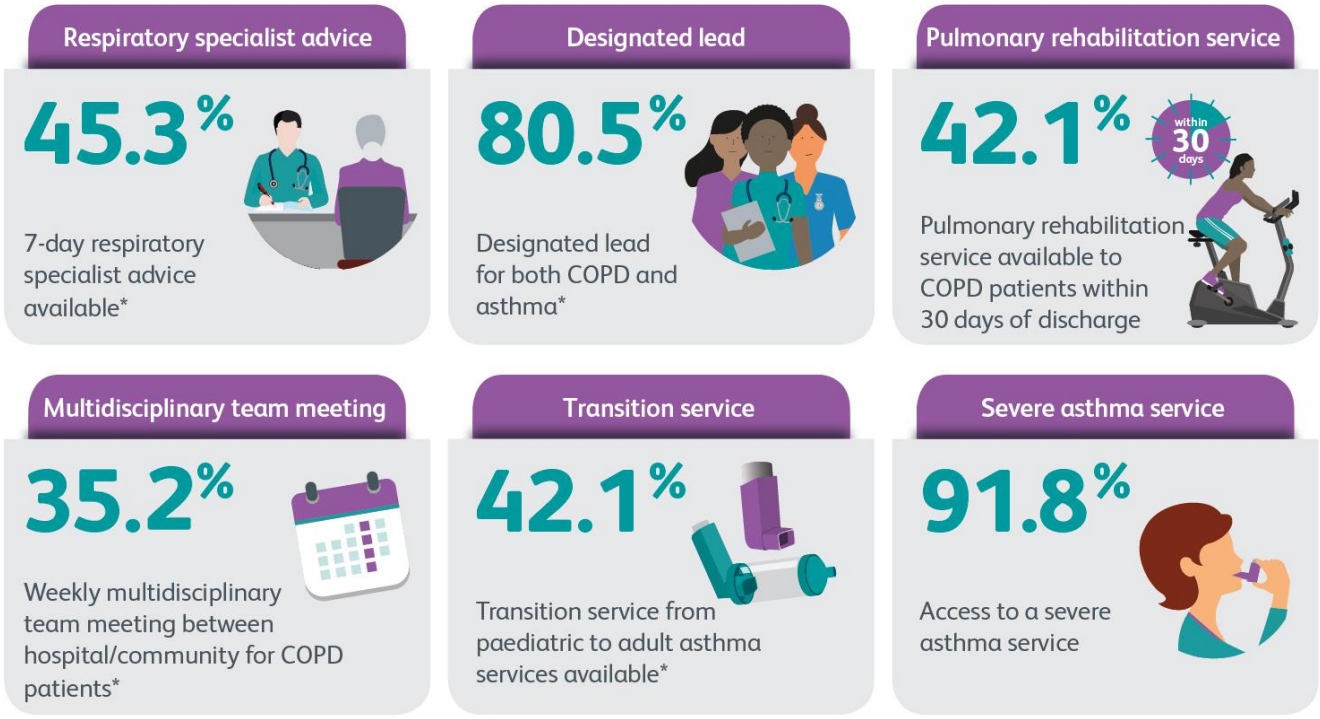
This report is intended for the use of service providers, commissioners and clinical teams to:

- review and recognise the gaps in services across England and Wales assessed against national standards of care
- understand how services are performing against national averages and KPIs using the full data file and benchmarked key indicators report, to identify where changes are needed or where successes offer opportunities for shared learning
- review guidance on improving performance in the areas that NACAP has identified as improvement priorities, and
- influence for change, and work together to ensure services are sufficiently resourced to facilitate high-quality care for all patients with asthma and COPD.

'The audit is a great way to find out what best practice should be, and whether a…hospital is trying to achieve it. It's also a good way to encourage health professionals to work toward best practice, which will then improve the lives of all of us with lung conditions.'
Member of NACAP patient panel

**In NACAP reports and publications released before 2022, improvement priorities are referred to as quality improvement (QI) priorities.*

Summary of performance against KPIs



*improvement priority

The infographic summarises the national position of services against audit key performance indicators (KPIs) and demonstrates variation in service provision across England and Wales. Since NACAP's first organisational audit of adult asthma and COPD services[3] in 2019:

- the provision of specialist respiratory review 7 days a week continues to vary
- a higher percentage of services have a designated clinical lead in place for asthma and COPD
- a higher percentage of services have at least one formal transition arrangement in place for young people with asthma (**41.1%** compared to **30%**)
- a higher percentage provide access to severe asthma services
- one-third of services (**35.2%**) hold a weekly MDT meeting, compared to **48.6%** in 2019
- less than half of services (**42.1%**) offer access to pulmonary rehabilitation (PR) services within 30 days of discharge for patients with COPD, compared to **45%** in 2019.

Six services met all six KPIs, demonstrating that they are achievable. These services should share the factors that enabled their success. In order to meet KPIs, all services should use the guidance available to them in this report and further support on the NACAP website, including good practice repositories with case studies from services delivering adult asthma and COPD care.The challenge of managing the COVID-19 pandemic has been considerable for respiratory and other services, and is likely to have impacted improvements in care and contributed to the variation in resources and organisation demonstrated in this report. COVID continues to affect services and it is key that teams have the capacity and adequate contingencies to continue to deliver high quality care in this phase of the pandemic, in line with national standards and NACAP KPIs.

Recommendation 1: National recommendation

This recommendation is for commissioners, service providers and clinical teams

To drive improvement in care, NACAP urges commissioners, service provides and clinicians to review the way in which they provide care and work together to effect service-level change by implementing the individual recommendations in this report.

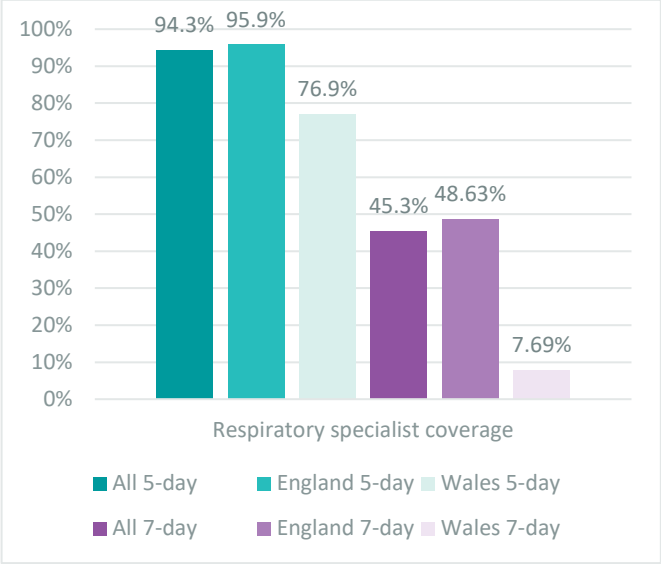
KPI: Make 7-day respiratory specialist advice available to all patients admitted with an asthma/COPD exacerbation

NACAP's asthma audit[4] shows that patients reviewed by a respiratory specialist are more likely to receive key elements of care and have a reduced risk of dying. Similarly, NACAP's COPD audit[5] demonstrates a link between specialist review and better care.

Patients admitted because of asthma and/or COPD should have access to specialist advice 24/7. However, although **94.3%** of services reported that specialist advice was available 5 days a week, only **45.3%** reported access 7 days a week (**fig 1**).

Patients should also be reviewed by a member of the specialist respiratory team within 24 hours of admission to quickly establish a correct diagnosis and to ensure early commencement of evidence-based care.

Fig 1: Availability of respiratory specialist advice



Patient priority

Respiratory specialist review within 24 hours was chosen by NACAP's patient panel as a KPI that is especially important to patients.
See more on how NACAP works with patients.

Improvement priority

Recommendation 2: Respiratory specialist advice

Make 7-day respiratory specialist advice available to all patients admitted with an asthma/COPD exacerbation
This recommendation is for service providers and clinical teams

Rationale

- NICE 2011 QS10[6]
- NICE 2013 QS25 [QS9][7]
- People admitted to hospital with an asthma/COPD exacerbation are more likely to receive all necessary high value interventions if they are seen by a specialist within 24 hours

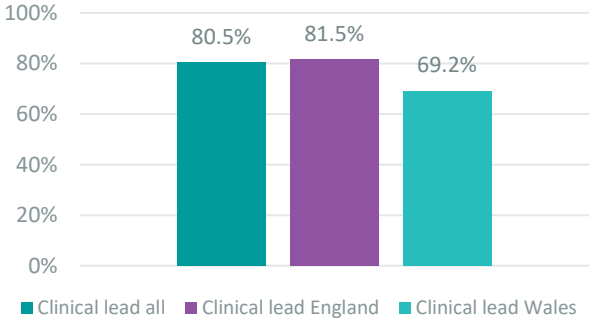
Practical steps which may help to achieve this priority

- Identify which members of the respiratory team (doctors, nurses and allied health professionals (AHPs) can provide specialist advice to asthma and COPD patients
- Sign up to the NACAP Quality Improvement programme to share learning with other services and receive education and specialist advice from a designated coach in your region
- Get practical ideas from NACAP adult asthma and COPD good practice repository case studies from services which have achieved this KPI
- Use the full data file and benchmarked key indicators report to identify hospitals that have achieved this KPI and identify lessons that have enabled this.

KPI: Have designated clinical leads in place for both asthma and COPD

Good clinical leadership is required to ensure service improvement and to address gaps in services. While leadership can come from any member of the respiratory team, it is important that services have a designated clinical lead for both COPD and asthma. **Fig 2** shows that **80.5%** of services meet this KPI. Performance in this area has improved since 2019; **88.7%** of services now have a designated clinical lead for COPD and **85.5%** for asthma, compared with **84%** and **81%** respectively in 2019.[3] As services reorganise to meet the challenges of COVID-19, there is an opportunity to identify and support lead roles for these asthma and COPD services.

Fig 2: Percentage of services with designated clinical lead for both asthma and COPD

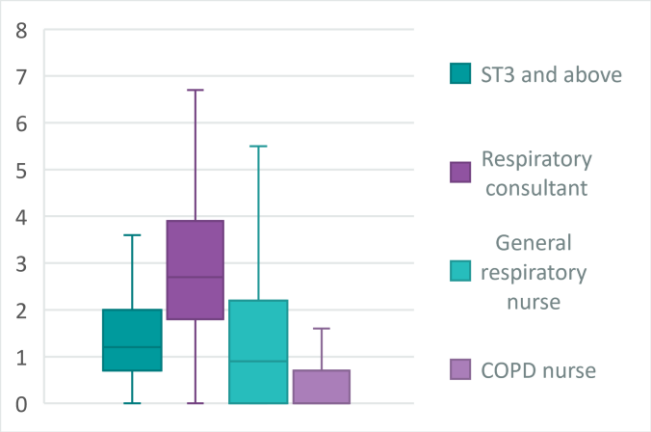


Staffing levels

Fig 3 shows considerable variation in staffing levels and grades. There is a median of 2.7 whole-time equivalent (WTE) respiratory consultants per 1,000 adult respiratory admissions (interquartile range (IQR) 1.8–3.9). Furthermore, there is a median of 1.3 WTE (IQR 0.7–2.0) ST3 and above doctors per 1,000 adult admissions in England, and 1 WTE (IQR 0.5–2.3) in Wales. The median number of respiratory nurse specialists is less than 1.0 WTE per 1,000 adult respiratory admissions (0.9 (IQR 0–2.2)), despite their essential role in delivering care.

Getting it Right First Time (GIRFT) recommends respiratory departments are staffed with 'the appropriate numbers and skill mix of doctors, specialist nurses, physiologists and allied health professionals'[8] to meet the needs of the local population. While there is limited guidance on the number of staff that should be made available within teams, the British Thoracic Society (BTS) has produced guidance on the development of respiratory support units (RSUs),[9] including workforce planning.

Fig 3: Staff WTE per 1,000 adult emergency respiratory admissions (median and IQR)



NB: For ease of interpretation, a small number of data outliers have been excluded from Fig. 3. For these, and full data on filled and unfilled staff posts, see the full data file.

Improvement priority

Recommendation 3: Clinical leadership

Have designated clinical leads in place for both asthma and COPD
This recommendation is for service providers

Rationale

- NICE 2011 QS10 [6]
- NICE 2013 QS25 [7]
- NRAD 2014 [Rec 1][10]
- National COPD Audit Programme 2014 [National Organisational Audit Report][11]
- GIRFT 2020 [Rec 14a][12]

Practical steps which may help to achieve this priority

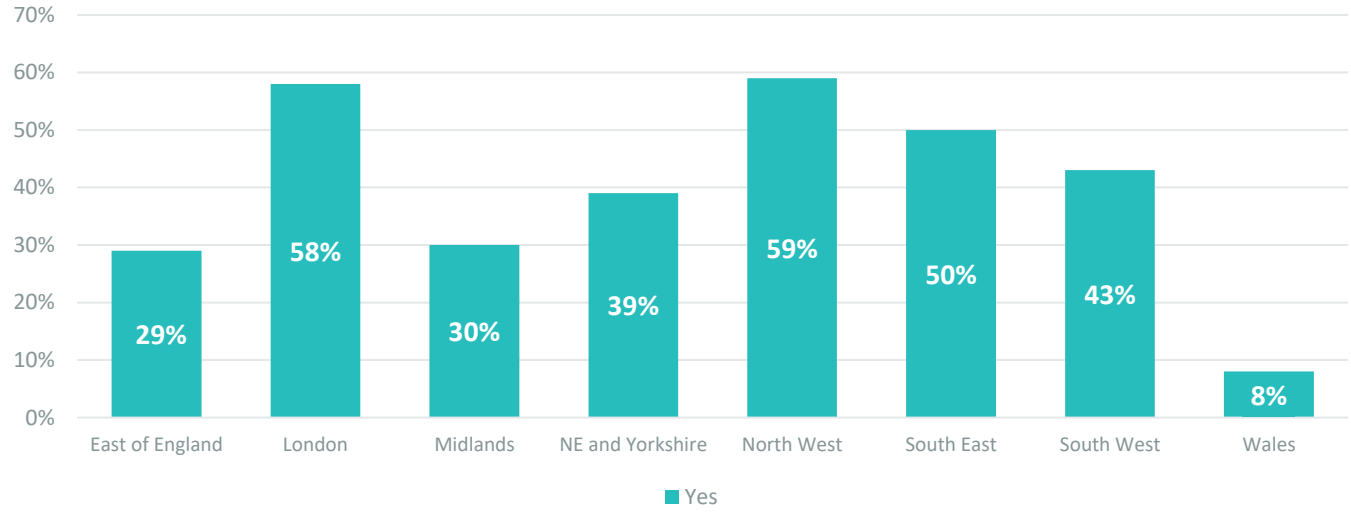
- Review your workforce and identify which members of the respiratory team (doctor, nurse or AHP) have the necessary experience and expertise for this role
- Ensure that clinical leads have allocated time within their job plan for leadership activity
- Use the full data file and benchmarked key indicators report to identify hospitals of a similar capacity to yours that are achieving this KPI, and what factors may have contributed to this

KPI: Ensure pulmonary rehabilitation (PR) services are available to COPD patients within 30 days of discharge

NICE recommends that pulmonary rehabilitation is made available to eligible people with COPD, with referral within 30 days of a hospital admission for COPD exacerbation.[13,14,15] Overall, provision of access to PR services was good at 96.2% with the majority provided by community-based teams which may offer patients local access and reduce travel burden.

However, data show that **42.1%** of services offered PR within 30 days of discharge. There is inequity of access to evidence-based care regionally, with this KPI achieved in **59%** of services in the north west and **8%** in Wales. There is a clear need to improve access to PR for patients with COPD, so that timely access is available to all eligible patients.

Fig 4: Access to PR via referral pathway within 30-days of discharge



NB: Please refer to the benchmarked key indicator report and full data file for the number of participating services per region.

Recommendation 4: Access to PR

This recommendation is for commissioners and service providers

Commissioners and service provides should work together to use data to identify areas where access to pulmonary rehabilitation is limited or where waiting times exceed the recommended 30 days, and consider commissioning local post-exacerbation pulmonary rehabilitation services to respond to demand.

KPI: Hold a weekly multidisciplinary team (MDT) meeting between hospital and community for COPD patients

NICE recommends[14] an MDT approach to address the complex challenges of COPD. Close communication between primary, secondary and community services is key to successful delivery of care. Similarly, integration with local social services is vital to support patients to best manage their condition at home.

In order to offer optimal multidisciplinary care, MDTs should include expertise from each discipline involved in COPD care. While **95.1%** of MDT meetings were attended by a consultant, only **10.9%** were attended by a GP, **14.9%** by psychologists and **10.9%** by occupational therapists.

Overall, **63.5%** of services reported regular MDT meetings for COPD care, an improvement from **58.0%** in 2019. Teams should prioritise the re-establishment of regular MDT meetings as a core function of their services. Weekly MDT meetings are suggested as a way to enable timely assessment, planning and management of care, and more efficient use of resources. However, only **35.2%** of services hold weekly MDT meetings across England and Wales (down from **48.6%** in 2019).

The MDT meeting is also an ideal platform to explore service development and improvement, but just **32.1%** of services in England and **7.7%** in Wales offer time during MDT meetings to develop integrated models of care.

All services must develop multidisciplinary approaches to COPD care, with regular MDT meetings including a broad base of clinical expertise and designated time for service development.

Improvement priority

Recommendation 5: MDT meetings

Hold a weekly MDT meeting between hospital and community teams for COPD patients
This recommendation is for service providers and clinical teams

Rationale

> NICE NG115 [1.2.96, 97][14]

Practical steps which may help to achieve this priority

> Review MDT meeting attendance to ensure all relevant staff disciplines are represented. Ensure MDT meetings are included in job plans to facilitate attendance
> If weekly MDT meetings are not possible, eg due to time/travel constraints, service providers should look at their service model and consider alternative approaches to ensuring effective communication across professional and organisational divides
> Refer to NICE NG115[14] [1.2.97] for key elements to include in MDT meetings and structure accordingly

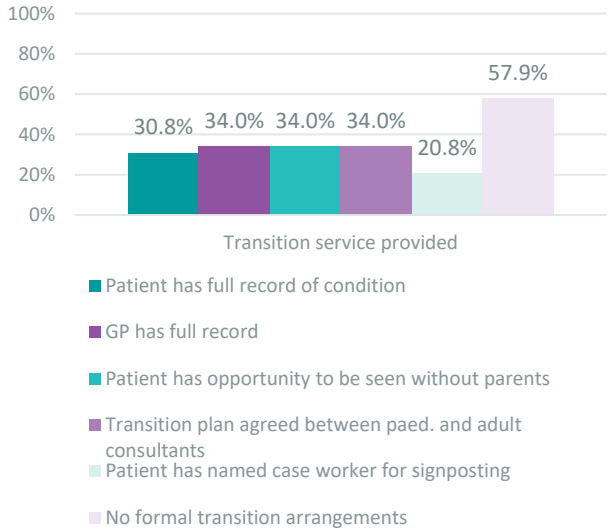
KPI: Have a transition service in place for children and young people moving to adult asthma services

There is a wide variation in the provision of transition services. The move from paediatric to adult care can be a difficult period for patients and families. Transition services aim to enable young people to move to being succesful self-managers of their condition. NACAP's improvement priority transition in 2020/2021 was for all asthma services to have at least one element of transition services in place. While performance against this KPI has improved to **42.1%** from **30%** in 2019,[3] **57.9%** of adult asthma services have no transition arrangements in place. **Fig 5** shows that among the **42.1%** of services meeting this KPI, provision of key components of transition care services is variable:

- **20.8%** of services have a named case worker to assist with signposting during transition
- **34%** of services are set up to allow a transition plan to be agreed between paediatric and adult teams
- **30.8%** of services reported young people had a full record of their condition
- **34%** reported GPs had access to that full record.

Asthma services can learn from disease areas where transition is more developed, such as cystic fibrosis and transplant services. Effective transition has been shown to lead to higher patient satisfaction, better outcomes of care and fewer emergency admissions.[16]

Fig 5: Elements of transition service provided by services in England and Wales



NB: Services could select multiple elements or *'No formal transition arrangements in place.'*

'It is imperative…to have a key named worker who is able to support us to access and negotiate the terrain of adolescent and adult services…we need someone to help us navigate this minefield.'
Patient quote, Royal College of Paediatrics and Child Health (RCPCH)[18]

Improvement priority

Recommendation 6: Transition services

All centres which accept transfers of care from paediatric services should put in place all five components of a transition service.
This recommendation is for commissioners, service providers and clinical teams

Rationale

- NICE NG43[16]
- BTS/SIGN 2019 [11.11.4][17]

Practical steps which may help to achieve this priority

- Ensure clinicians have time within job plans to engage in service development with paediatric colleagues and deliver additional clinical activity where required
- Ensure services have adequate asthma nurse specialist* time
- Use the full data file to identify services delivering all elements of transition services, and use to benchmark local staffing arrangements
- Ensure NICE recommendations on transition planning[16] are implemented in your service. Where this is not the case, place this on your risk register
- Refer to RCPCH resources on delivering effective transition services[18]

*Dedicated nurse with specialist training in the treatment and management of asthma[19]

KPI: Provide access to a severe asthma service

Access to severe asthma services is not universal, with **91.8%** of services reporting that patients have access to a specialist service either onsite or via a defined referral pathway. Asthma and Lung UK has recently reported that only **22%** of eligible patients have access to asthma biologics, despite evidence that these therapies can transform quality of life.[20] Asthma biologics can only be prescribed by services linked to a severe asthma centre or MDT, so ensuring that *all* services have access to severe asthma networks is a priority.[6]

Recommendation 7: Severe asthma services

This recommendation is for commissioners, service providers and respiratory networks

All services reviewing patients with severe asthma, and commissioners of these services, who are not already members of a regional network must develop referral pathways to a commissioned severe asthma service to ensure that all patients have access to a severe asthma MDT. Leadership for this should come from regional respiratory networks in England. In addition, the NHS Accelerated Access Collaborative consensus pathway in England is working to define clinical standards for pathways of care that span primary, secondary and tertiary care for patients with suspected severe asthma, as well as improving access to diagnostics for patients with suspected asthma.

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Healthcare Quality Improvement Partnership

The National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices. Its aim is to promote quality improvement, 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 the National Clinical Audit and Patient Outcomes Programme (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.**

NACAP

NACAP is a programme of work that aims to improve the quality of care, services and clinical outcomes for patients with asthma and COPD in England and Wales. Spanning the entire patient care pathway, NACAP includes strong collaboration with asthma and COPD patients, as well as healthcare professionals, and aspires to set out a vision for a service which puts patient needs first. To find out more about NACAP visit: **www.rcp.ac.uk/nacap.**

Adult asthma and COPD 2021 organisational audit report

This report was prepared by the following people, on behalf of the NACAP adult asthma and COPD advisory group. The full list of members can be found on the NACAP resources page: **www.rcp.ac.uk/nacap**

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