South West Yorkshire Partnership NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
Barnsley Clinical Commissioning Group NHS — Putting Barnsley People First
Barnsley Healthcare Federation

The BREATHE service

Barnsley **RE**spiratory **A**ssessment & **THE**rapy

Information and guidance for primary care
July 2018

Jacqui Pollington RGN BSc MHSc on behalf of the BREATHE service June 2018
Version 2. Next revision dae December 2018

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Introduction

Barnsley CCG has embarked on an ambitious programme of respiratory service development that will significantly expand on the current services and will comprise:

- 7 day Early Supported Discharge for patients admitted with an exacerbation of COPD

- A comprehensive home oxygen assessment and review process for all adult patients requiring oxygen therapy – comprehensive domiciliary LTOT reviews.

- Specialist Respiratory MDT support for primary care an neighbourhood teams including:
    - Urgent telephone advice and guidance from respiratory nurse/respiratory consultant
    - Urgent (same day/next day) Hot clinic appointment for patients with an exacerbation of COPD who are at risk of admission (replaces HUB referral)
    - Urgent (same day/next day) respiratory nurse home visit for patients with poorly controlled COPD symptoms
    - Email advice for non urgent queries (3 day turnaround)
    - Joint primary care clinics with an option of locality based consultant/GP/practice nurse/respiratory nurse clinics
    - A dedicated time window for telephone discussion with respiratory consultant that will help the primary care clinician manage the patient without the need for onward referral
    - The design and co-delivery of a structured patient education programme for patients who decline referral to pulmonary rehabilitation
    - Co-ordination and delivery of MDT for patients with severe disease/who are approaching end of life/who are on domiciliary NIV/who have needed NIV acutely.
    - Short term intensive 'case management' of a small number of respiratory patients with complex needs e.g. patients who are repeatedly admitted to hospital with features of an exacerbation of COPD

      There will be presence of COPD nurses in ED at peak times
- Pulmonary rehabilitation
    - Dorothy Hyman –permanent venue rolling programme, classes run Mon pm & Weds pm
    - Satellite programme pilot in Dearnside Leisure Centre Tues pm & Fri pm (current), Hoyland Leisure centre November, Recovery College next year

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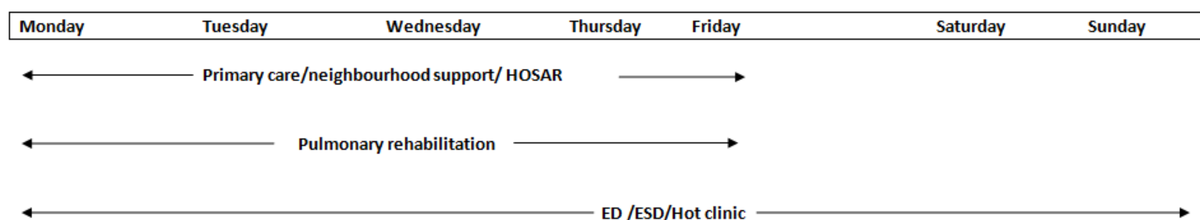
This brief document is designed to give primary care colleagues a quick view of referral criteria, referral pathways and treatments pathways for the service.

- Pathway for Early Supported Discharge (ESD) for patients presenting to the ED with an exacerbation of COPD
- Pathway for Hot clinic assessment
- Pathway for LTOT assessment
- Menu of primary care clinic support options

The nursing team will provide telephone advice to any primary care colleague and can be contacted on: 01226 431673

Services at a glance:



Staffing:

0.4 wte Band 8a Lead Respiratory nurse
1.8wte band 7 senior respiratory nurses
8.2 wte band 6 respiratory nurses
0.8 wte admin assistant

(Vacancy of 1.1 wte band 6 – still recruiting)

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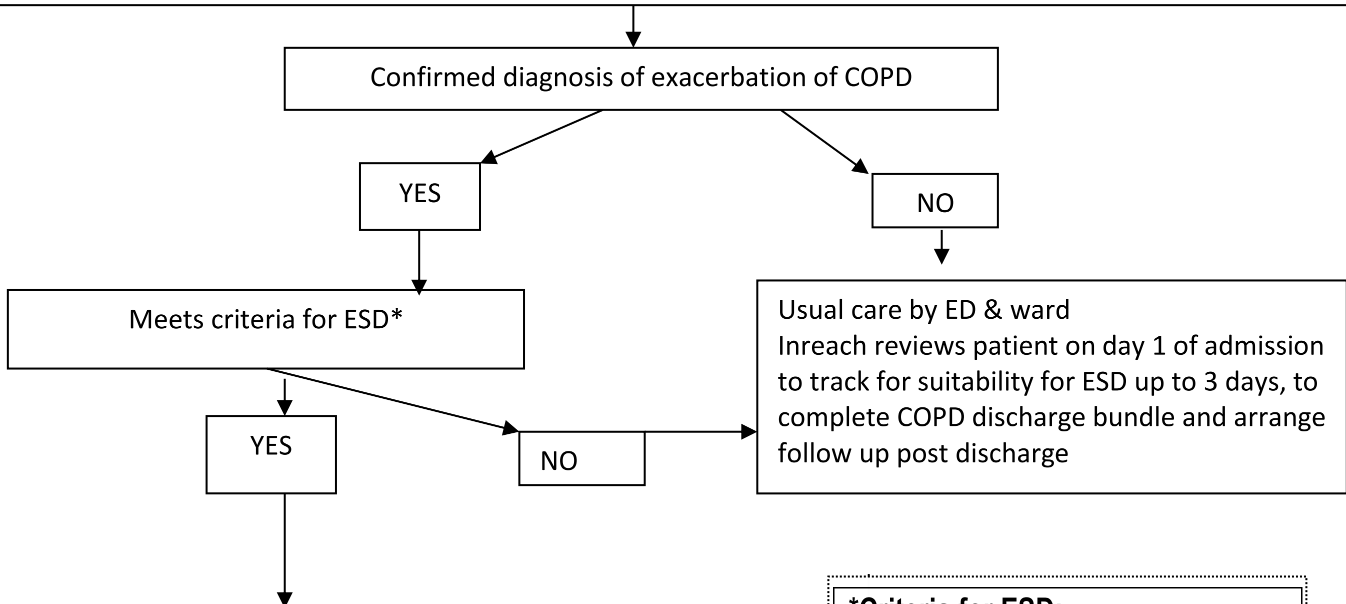
Respiratory Early Supported Discharge Care Pathway - Hospital

Patient attends ED with symptoms of exacerbation of COPD
Initial clerking, assessment and treatment by ED staff. ED staff contact BREATHE team for ESD assessment



Patients consent for home care is obtained.
Patient enrolled for home care. ESD nursing documentation is completed.
Nebuliser compressor supplied if appropriate.
Appropriate COPD exacerbation medication provided.
Patient/carer/ advised of home care arrangements.
G.P notified of enrollment onto ESD.

***Criteria for ESD:**
Requires admission for exacerbation
Acceptable social circumstances
Not confused
Telephone at home
Agrees to home care
ABG criteria (pH > 7.35, $P0_2$ > 7.3)
WBC between 4 and 20
CXR satisfactory
ECG satisfactory
Does not require IV therapy
Not out of area

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Respiratory Early Supported Discharge Care Pathway - Home

Patients will be visited the day after hospital discharge and and thereafter according to need.
Average episode of ESD home care should be 6 days

Patient is reviewed in their own home by a respiratory nurse until respiratory symptoms have improved.
Visit time – 30 mins to 1 hour
Visit consist of:

- Clinical assessment
- Chest auscultation
- Clinical observations
  e.g B.P, HR, RR, SPO2, MRC, Temp
- Discussion about symptoms management, medications e.g reduce nebuliser therapy where appropriate, sputum production
- Education, inhaler technique, symptom management.
- Completion of nursing documentation

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On final home visit:

- Full clinical assessment
- Remove nebuliser compressor if appropriate
- Ensure patient is happy for discharge

Provide rescue medications (where appropriate) and self management plan with education on appropriate use of medications.
Patient provided with emergency care plan.

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Respiratory nurse completes ESD discharge letter:

- Copy to G.P and original referrer
- Copy for hospital notes
- Refer to Community Matron if appropriate

Ensure referrals to pulmonary rehabilitation/smoking cessation if appropriate.

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Follow up is arranged depending on current care pathway.

Patients' condition is deteriorating and no longer suitable for home care. Respiratory nurse arranges hospital admission. G.P notified of outcome.

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Urgent assessment in Hot clinic – Referrals taken Mon-Fri 8 til 6
Clinic availablity flexible: currently 10.45-12.15

Respiratory Hot Clinic Care Pathway

Patient referred for Urgent respiratory assessment by G.P, community matron, practice nurse.
Referral is by telephone contact via RCB 01226 431333

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Confirmed diagnosis of COPD (spirometry required)

YES ↓

History is obtained by RCB and urgent assessment proforma completed.

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Criteria met for urgent assessment ↔ Criteria for Hot clinic assessment:

- Confirmed diagnosis of COPD
- Oxygen saturation >88%
- In exacerbation that has not responded to steroids/antibiotics

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YES

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Rightcare will advise the referrer to provide the patient with request for FBC & CXR if these tests have not been carred out during this episode, and contacts BREATHE and arranges appointment time for urgent assessment. Patient will be seen by Respiratory consultant and respiratory nurse, comprehensive clinical assessment performed, diagnosis made and treatment plan devised. Where appropriate, homecare from the BREATHE service will be offered.

NO ↓

- Patient is not accepted for urgent BREATHE assessment and RCB will advise the referrer further.

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Home oxygen assessment and Review

Patient is referred by primary care clinician for oxygen assessment because SPo2 ≤ 92%
Written/verbal referrral information must include: diagnosis, spirometry and smoking status

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home visit for SPo2 +/- ABG within 2 weeks of referral
If blood gases indicate the need for LTOT, patient is booked into outpatient oxygen assessment clinic

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LTOT assessment completed

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4 week post installation visit

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3 month LTOT reasssessment at home

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12 month (may be more frequent depending on complexity of case) LTOT reassessment at home and 12 monthly thereafter

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Menu of primary care clinic support options delivered by BREATHE team

Menu 1 Suitable for surgeries with established respiratory care (register reflects expected numbers, competent in performance and interpretation of spirometry, prescribing trends in line with agreed standards, SS, PR and respiratory admissions in expected range)

- Doctor clinic/case note review
- Nurse/nurse case note review

Menu 2 Suitable for surgeries who have identified in TNA the need for clinical support in COPD management (register over/under estimates COPD population, limited expertise in performing/interpreting spirometry, higher levels of ICS/LABA prescribing, higher admission rates)

- Doctor/doctor clinic
- Nurse/nurse clinic
- Support for spirometry clinic
- Support for spirometry interpretation

Menu 3 Suitable for surgeries with very limited/no respiratory expertise (e.g. respiratory pn left and not been replaced)

- Doctor/doctor clinic
- Nurse/nurse clinic
- Support for spirometry clinic
- Support for spirometry interpretation
- Interpretation of spirometry with treatment plan

Menu 4 Suitable for neighbourhoods where there is a high number of hospital admissions Neighbourhood-based clinic offering consultant review for patients from any surgery in that area.

- Neighbourhood based consultant & nurse clinic accessible by any patient in that neighbourhood – GP/PN can refer for consultant review

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Summary

The service has been mobilised over a relatively short space of time and recruitment has determined service delivery. **The service is now delivering supported discharge 7 days a week from 8 til 6 (4.30pm close Saturdays & Sundays). The HOS-AR service is fully operational. Dr Mark Longshaw came into post 2 months ago and is now delivering Hot clinics Monday to Friday. The next step is to embed primary care clinics into the community model.**
This guide will be updated when changes are made.

BREATHE REFERRALS AT-A-GLANCE

What is the problem?	Service you need	Contact details
Patient has confirmed diagnosis of COPD and suboptimal control despite your intervention	BREATHE urgent review (seen within a week)	Email referral to Breathe.service@nhs.net
Patient is in exacerbation of COPD, low risk for admission but may benefit from respiratory review	BREATHE urgent review (seen within 48 hours)	Email referral to Breathe.service@nhs.net
Patient is in exacerbation of COPD and high risk for admission	BREATHE Hot clinic appointment	RightCare Barnsley on: 01226 431333
Patient has oxygen saturation ≤92% in the stable state	Oxygen assessment	Email referral to Breathe.service@nhs.net
Patient has exercise limitation despite optimal inhaled therapy	Pulmonary rehab	E referral on S1/swyt-tr.pulmonaryrehab@nhs.net Or fax 01226719789 Phone 01226719789
Patient has had 4 or more exacerbations in the last 12 months requiring hospital stay	BREATHE review	Email referral to Breathe.service@nhs.net

Rightcare Barnsley is the contact for Hot clinic referrals and for all other referrals please use the BREATHE email address. For advice/guidance/discussion phone 01226 431673