Service Development

How smart use of templates and coding can improve respiratory care


Fran Robinson interviews **Anne Rodman**

Making relatively simple changes to practice templates to facilitate coding of key indicators has enabled a Birmingham practice to improve outcomes for its respiratory patients.

This project is being led by Anne Rodman, independent advanced respiratory nurse specialist, Education for Health trainer and PCRS-UK Conference Committee member, at the Cape Hill Medical Centre in Birmingham. It is part of a wider Birmingham Cross City Clinical Commissioning Group ACE (Aspiring to Clinical Excellence) initiative which is working to improve care across a number of areas in the city.

Anne has been employed by the Cape Hill practice to spend a year focusing on improving outcomes for asthma and COPD. The 12,000 patient practice has a hard-to-reach population and high DNA and hospital admission rates for asthma and COPD.

At the start of the project an in-depth audit was conducted of all the information that was on the practice system about patients with asthma.

The GPs and nurses in the practice have varying degrees of confidence about managing asthma, and data from the audit has highlighted the need to create a more structured system for reviews and consultations that will help clinicians to follow guidelines and work through what needs to be done for the patient.

This has been achieved by adjusting two templates. For example, two codes have been added to the routine review template so that, rather than just ticking a box to say the technique has been checked, clinicians are now prompted to both observe patients' inhaler technique and correct it if necessary.

"I know from working on the National Review of Asthma Deaths that boxes get ticked but outcomes for patients don't necessarily improve. So these codes have been added to the template to make sure that patients are not only asked how they use their inhalers but to ensure clinicians actually watch them and show them how to use their inhalers as well. These were fairly straightforward codes to add," says Anne.

The audit highlighted that doctors were seeing and treating patients but weren't always following them up and were not coding their actions in a uniform way. They would often record their findings as freee text, making it impossible to audit their actions. So a new template has been introduced to guide doctors through a more thorough acute respiratory assessment process.

Specific codes for discussing lung health with patients have been introduced which are easy to audit. To facilitate these discussions the practice has purchased some micro spirometers. The clinician can now run a quick test and identify whether patients with asthma, current or ex-smokers and those presenting with chest infections are developing long-term lung damage and need referral for full spirometry.

"The idea is that, by discussing lung age and lung health with patients, they are more likely to attend for a full spirometry test because you are giving them a good reason to come back – i.e. you're saying, we've identified there is a possible problem with the lungs that might be causing this chest infection or the fact is you are having lots of symptoms with your asthma and we need to do a more in-depth test and work with you to protect your lung health," explains Anne.

The coding has been kept as manageable and as simple as possible. So there are boxes to prompt the clinician to ask whether this person needs a chest x-ray, spirometry or follow-up. There is also a prompt to make sure the patient's contact details are correct. The practice population is very disadvantaged with a high deprivation index and ethnically diverse population with over 30 languages interpreted. Trying to contact people and get them back in for follow-up is really difficult, so it is essential the practice can contact them

by telephone. Like all practices, there is pressure on appointments so if GPs can't easily find an appointment for a follow-up review, they can try to contact the patient for a telephone consultation.

There has also been a focus on improving inhaled steroid use in patients with asthma and COPD through talking to them about the risks and benefits of being on high doses, and there is a code for making sure they have spacers and steroid cards to highlight the importance of keeping their inhaler going on a regular basis.

"The GPs are not required to tick every box, but the information is there in front of them to help them focus on what else might be going on when patients present with an acute episode. The templates ensure that the information is recorded in a systematic way."

"We have made quite a lot of small tweaks that will not only improve care generally and make it part of routine practice but will also make patient care safer and more effective. The main changes have been made within the chronic review template and it takes just the same amount of time to go through these things in an asthma review as it did with the old template," says Anne.

In addition to improving their templates, the practice has implemented a rapid review system for people who have had exacerbations of asthma and COPD. A live register of patients who have had exacerbations has been set up and a daily search picks up the relevant code and puts those patients on a list for a follow-up appointment. A link worker then spends time encouraging patients to come in for a review. This is already starting to have an impact on reducing hospital admissions and reducing patients' use of reliever inhalers.

"This project is all about making the best use of time and resources, but it is also focusing on doing the right things when you have got the patient there. This work could very easily be reproduced in other practices. The whole practice has enthusiastically embraced the changes and the lead GP for the project is moving into a respiratory lead role and undergoing further training, so when I leave the practice at the end of the project they will have all the skills they need," says Anne.

For further information contact Anne via the PCRS-UK Members Directory (see www.pcrs-uk.org/directory) or via info@pcrs-uk.org

GP produces guidance for bronchiectasis and cough to improve referrals

Fran Robinson talks to **Dr Lesley Ashton**, North Shields

A GP has written a set of referral guidelines for bronchiectasis and cough for her CCG to help her primary care colleagues improve the quality of their referrals.

Dr Lesley Ashton of the Jubilee Park Surgery, part of the Collingwood Health Group in North Shields, needed to undertake a quality improvement activity for some training she was taking part in so she offered to write the guidelines for North Tyneside CCG. The CCG has been developing a referral management system for a number of specialities since mid-2015.

The aim of the CCG's referral management system is to standardise referrals and reduce variation in referral rates among practices. The guidelines are intended to provide clear guidance to clinicians and reduce inappropriate referrals. Referrals are now triaged in secondary care before being sent on to the relevant consultant and feedback on rejected referrals is channelled back to GPs.

Dr Ashton says she chose bronchiectasis and cough because they already had some good local guidance for COPD and asthma.

She felt bronchiectasis and cough were clinical areas from which referrers would benefit having clear and simple guidance regarding when to refer and when to manage the conditions in primary care.

She worked with respiratory consultants Dr John Steer and

Dr Sean Parker of Northumbria Healthcare NHS Foundation Trust to produce the guidelines which are based on either existing evidence or work that has been validated.

She says there is evidence that referrals have reduced and feedback from colleagues has been positive with comments that the guidelines have improved their understanding of when to refer.

"I collect the referrals which have been rejected and feed them back to my colleagues as a learning opportunity. This helps us to understand better what we can do for the patient before referring them. I have found this exercise very satisfying because I personally love clarity and simplicity," says Dr Ashton.

KEY POINTS

Bronchiectasis
The guidance includes:
- Criteria for referral for diagnosis
- Criteria for referral in established bronchiectasis
- Red flag symptoms where you might consider a 2-week referral

Cough
The guidance includes:
- Steps that should be taken in primary care prior to referral include examination, history taking, tests, potential steroid trial, eliminating certain diagnoses, red flag symptoms that might require a 2-week referral

For further information or to receive a link to download the guidance contact Lesley via info@pcrs-uk.org