

The challenges of delivering respiratory care to a rural, coastal, deprived population

Improving primary and community care respiratory services in deprived rural areas comes with its own unique challenges. This is the experience of PCRS-UK East of England lead and GP, Dr Daryl Freeman, who is Associate Clinical Director of Norfolk Community Health and Care NHS Trust. She is currently working with local CCGs to improve out-of-hospital care in a largely rural environment and, in another role as Chair of Norfolk and Waveney Sustainability and Transformation Partnership (STP) Respiratory Working Group, she is working on a plan for a new community respiratory service that would support general practice.

The challenges

The impact of rural poverty and deprivation on respiratory patients

More than half the population of Norfolk is designated as living in a rural area and a high proportion of residents live in the 20 most deprived areas. These are the more sparsely populated and coastal areas, where there is poor access to public transport and services such as broadband and mobile telephony. In addition, there are low educational achievement and wage levels and high rates of unemployment. The county's population is much older than the rest of the country and projected to increase at a greater rate than the rest of England.

These factors impact on respiratory health. People living in these areas often have chaotic lives, struggle to keep appointments or to come in for regular check-ups and generally don't engage with health services. Daryl says: "Educational attainment in our rural deprived areas is often very poor so there is an ongoing cycle of lack of aspiration and a negative outlook towards health. If you can't see a way out of your low status you are not going to have the will or ability to access stop smoking support or to improve your diet."

A lack of public transport services in rural areas can make accessing hospital for specialised diagnostic services or secondary care expensive and difficult for some patients.

On a brighter note, access to pulmonary rehabilitation (PR) is relatively easy to deliver to a rural population because it can be provided in any large local public room. Daryl says: "Norfolk has shown it can be done with no patient further than 20 minutes away from a PR class. This has been achieved by using gyms, local halls and, as the PR lead states, 'anywhere that will have us'."

Solutions

A new community respiratory service

The STP is keen to keep people out of hospital and for primary and community care to be delivered locally in an integrated way and for care to be standardised across Norfolk & Waveney.

But Daryl says it is difficult to design a 'one size fits all' respiratory service. "What might work in Norwich, which is relatively affluent, isn't going to work in somewhere like Great Yarmouth. Because DNA rates in socially deprived areas are much greater than in affluent areas, you have to look at different ways of delivering care perhaps by taking mobile clinics to the patient. We need to think in more imaginative ways of delivering care to those patients who find accessing it very difficult."

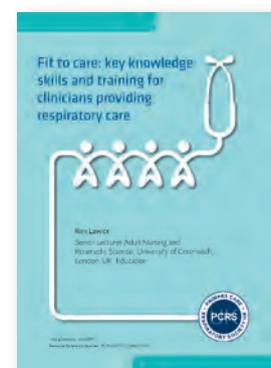
Daryl says the solution is for a greater focus on providing integrated care and support for primary care in deprived areas.

Do a skills audit to improve education

The new community respiratory service that Daryl is proposing to the STP would be an extension of a practice-based respiratory service that she designed and delivered while working in a previous role as respiratory lead for North Norfolk CCG. Working with advanced respiratory nurse specialist and PCRS-UK Executive Committee member Val Gerard, they went in to practices and worked alongside primary care teams to improve their respiratory skills and help them identify and manage respiratory patients who needed more support. This improved care and resulted in a significant reduction in emergency respiratory admissions.

Daryl and Val found that the skills of practice nurses were variable, particularly in spirometry interpretation. Diagnoses were being missed and some patients were not being managed in line with guidance.

Daryl says a starting point for improving education should be to conduct a skills audit using the PCRS-UK Fit to Care document (<https://www.pcrs-uk.org/fit-care>) which sets out the training practitioners need for the level of care they are providing. This has been performed by the STP working group and has confirmed concerns about the training level of primary care clinicians undertaking respiratory clinics.



However, in Norfolk it can be difficult for nurses in the more rural areas to access training. Most evening courses are based in Norwich in order to attract the most people. But nurses working in rural areas are unlikely to travel for an hour or more to attend these courses after a busy day.

Daryl says there is a need to deliver more education programmes locally in the rural areas. Val and Daryl currently have three local PCRS affiliated groups in Norfolk that deliver education CCG-wide rather than in Norwich, and she says they have been experimenting with delivering education to three or four practices at a time with a good uptake.

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She is hoping that linking a skills audit and improved education to a reduction in admission rates will make a powerful case for more funding for education of the primary care workforce.

Making community hospitals work in the 21st century

One part of Daryl's job for the Community Trust is to oversee Norfolk's six community hospitals. She is hoping to extend the role of these hospitals to provide an expanded service to the community for respiratory and other chronic conditions, providing care closer to home.

"I want to have a service where patients aren't just admitted and discharged but discharged with outreach follow-up. Maybe in the fullness of time we will have a team based at the community hospital then, if a patient does become poorly, we can go out and assess and support them at home."

"I would like community hospitals to deliver more local care both pre and post admission, whether it's respiratory, cardiac etc. I believe their potential, certainly in Norfolk, is underutilised."

"CCGs have been closing community hospitals because they say they're not cost-effective. One of the challenges I have is to find ways of using them differently to stop them being closed. If we carry on doing the same old thing they will be under threat. We need to roll back the clock and make them more part of the community, and certainly in some parts of the country that's being achieved."

Daryl is optimistic about the future but recognises that she is going to have to really argue her case for change. "The only way I can do that is to demonstrate there is potential to reduce admission rates for respiratory conditions because that's the only place (admission avoidance) where there is new money".

"Norfolk Community Health and Care is considering altering the way the community hospitals work. We have taken on four new members of staff for the wards (all advanced nurse practitioners) and including me there are two new associate clinical directors. We all want to see the wards start to take more patients directly from primary care, community matrons and directly from the ambulance trust."

"The CCGs, the ward staff and the STP boards are keen this goes ahead. We do, however, face some obstacles from secondary care who have provided consultant cover for the wards for the past four years. We are sure that, in line with the STP ethos of us all working to provide care for patients closer to home, we can come to an agreement which continues to provide excellent care for patients in units within their community."

Any member who wishes to discuss these issues further with Daryl can contact her via the members' directory <https://www.pcrs-uk.org/directory> or email us at info@pcrs-uk.org and we will facilitate contact.