PROMOTING BEST PRACTICE BY PRIMARY CARE PROFESSIONALS IN THE MANAGEMENT OF COPD

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KEY PRACTICE POINTS

- In primary care, a gap between current and evidence based care for COPD exists.
- This paper describes an educational intervention that helped to close this gap.
- Involving clinical teams, local speakers and patients and project work was crucial.
- Positive changes occurred at clinician and organisation level.

INTRODUCTION

Chronic Obstructive Pulmonary Disease (COPD) has a major impact on the health and quality of life of patients and is the second largest cause of emergency hospital admissions in the UK[1]. An increased adoption of evidence based practice, particularly in primary care, could have a major impact on these outcomes.

AN EDUCATIONAL INITIATIVE TO DRIVE IMPROVEMENTS IN PRIMARY CARE FOR COPD

Box 1 lists key stages in developing and delivering the initiative, a joint venture involving health care professionals, patient groups and academics.
Its introduction was prioritised by the Heath Education and Innovation Cluster West Midlands North, the West Midlands Academic Health Sciences Network and the CCGs where it was to be introduced.

Box 1: Key steps in developing and implementing the educational initiative

- Obtain high level strategic support for the venture.
- Agree educational content and delivery modes.
- Involve patient self-help groups and organisations.
- Target primary care teams to be recruited.
- Review the impacts of the initiative.

A review of best practice documents (see Box 2) and feedback from key local informants (GPs, respiratory and pulmonary care leads and researchers) generated its educational content (see Box 3). Most sessions were delivered by "local" health professionals but the "living with" COPD session was given by members of "Breathe Easy", a patient self-help group, and a representative of the British Lung Foundation. Sessions were interactive and limited to around 30 delegates with primary care teams (GPs and nurses) from practices with high prevalence rates for COPD being targeted. Four full days were devoted to delivering taught sessions with participants also required to undertake a small service delivery project within their practice.

Box 2: More information to guide improvements in care for patients with COPD

An outcomes strategy for Chronic Obstructive Pulmonary Disease (COPD) and Ashma. Department of Health/ Medical Directorate/ Respiratory Team 2011. London: Department of Health.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128428.pdf

The Global Initiative for Chronic Obstructive Lung Disease (GOLD) (2013). Global Strategy for Diagnosis, Management and Prevention of COPD. Updated February 2013. http://www.goldcopd.org/uploads/users/files/GOLD_Report_2013_Feb20.pdf

COPD overview. NICE 2016. http://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease

Chronic Obstructive Pulmonary Disease in adults. NICE quality standard (QS10). Published date: July 2011. https://www.nice.org.uk/guidance/qs10

COPD (chronic obstructive pulmonary disease). British Lung Foundation. https://www.blf.org.uk/support-for-you/copd

Foster F, Piggott R, Riley L, Beech. Working with primary care clinicians and patients to introduce strategies for increasing referrals for Pulmonary Rehabilitation. Primary Health Care Research & Development; 17 (3): 226-237.
http://journals.cambridge.org/download.php?file=%2FPHC%2FS1463423615000286a.pdf&code=8e2b836cea83beb0ef0a6e06d5ccf9fa

National COPD audit programme:

Overall programme, https://www.rcplondon.ac.uk/projects/national-copd-audit-programme
Primary care work stream, https://www.rcplondon.ac.uk/projects/national-copd-audit-programme-primary-care-workstream
Secondary care work stream, https://www.rcplondon.ac.uk/projects/national-copd-audit-programme-secondary-care-workstream
Pulmonary rehabilitation work stream, https://www.rcplondon.ac.uk/projects/national-copd-audit-programme-pulmonary-rehabilitation-workstream

HQIP. National Chronic Obstructive Pulmonary Disease (COPD) Audit full Pulmonary Disease report 2015 (published 2016)
http://www.hqip.org.uk/resources/national-copd-audit-report-2015/

Box 3: Key components of the education offered

- COPD diagnosis and monitoring.
- Clinical management of COPD.
- "Living with" COPD.
- Pulmonary Rehabilitation.
- Patient self-help/ management.
- Palliative/ end of life care.

EXPLORING THE IMPACTS OF THE INITIATIVE

The educational initiative has been delivered three times (most recently in 2015) to primary care teams from over 35 practices in 3 different CCGs. Surveys of participants, during and at the end of the taught programme, assessed whether session content was relevant to participants' needs and how it was affecting the delivery of care. Longer term impacts have also been explored via interviews held 10 months after the final session with 9 primary care team members who attended the first running of the initiative (see Box 4 for key feedback).

Box 4: Participants' assessments of the value of the educational initiative

Was the course relevant?

Course content and learner satisfaction were rated highly. One stated.

> "*It was a really good course. Nice to see such a variety of things – rehab, spirometry, Breathe Easy. So broad it was very good"* Practice Nurse (PN)

Did professional behaviour change?

The quotes below indicate some of the ways in which delegates thought their practice had changed.

> *"My knowledge of spirometry has improved tenfold" PN*
> *"My prescribing is more logical and reflects NICE" General Practitioner (GP)*
> *"I'm now promoting PR (Pulmonary Rehabilitation)" PN*
> *"Patient participation was good. I wasn't aware of them (Breathe Easy) beforehand but I have referred patients there since"* PN

Did the organisation of care in practices change?

Some of the wider changes made or planned were:

- Audits of referrals to PR for eligible patients and an increased use of support materials to increase patient and practitioner awareness and understanding of PR.
- A joint patient/ practitioner initiative to establish a "Breathe Easy" group.
- Improved measures for the identification and management of patients at increased risk of exacerbations of COPD:
  "We conducted an audit of people who'd had exacerbations and identified about 50 patients. We invited them in to discuss rescue meds—at the end 36 out of 50 were given rescue packs" GP.

WHAT WORKED AND WHY

Feedback from participants indicates that the goal of increasing the adoption of evidenced based care for COPD by the primary care team was achieved. Key drivers for success are summarised in Box 5.

Box 5: Key reasons why best practice became everyday practice.

- Primary care staff had dedicated time away from the practice and participated as a team.
- Taught sessions were delivered by local "experts".
- Small practice based projects were a component of the educational initiative.
- People with COPD/ patient groups had a lead role in the delivery of taught sessions.

Team involvement (a GP and a nurse as a minimum) increased the impetus and support required changes in host practices. Local speakers not only imparted knowledge of evidence based care but also vital local information about local services which, in turn, helped improve the integration of services. The small practice based projects were embraced by participants and provided demonstrable markers of success.

However, the session that probably provided the biggest driver for service change was the living with COPD session[2]. Details of the format of this session and its impacts on members of the primary care team are given in Box 6.

Box 6: The "living with COPD" session and its impacts

Session format

A representative of the British Lung Foundation asked a panel of people with COPD and/or their carers to respond to the following pre-planned questions:

- "When did you first realise that something was wrong?"
- "How long did you have your symptoms before going to see a GP?"
- "How were you diagnosed?"
- "How do you feel about the information you received?"
- "Give me an example of how COPD impacts on your life?"
- "What works for you in managing your health?"
- "What are your thoughts on pulmonary rehabilitation?"
- "What about other things that have worked?"

These questions allowed them to tell their stories about life with COPD with primary care staff joining in the ensuing discussion.

Written feedback from primary care staff included:

- *"Remembering the individual and their journey of COPD and the impact it has on their life is the most important aspect the Health Worker should consider in providing supportive care".*
- *"The session was really informative and has given me an insight to patients with breathing conditions which I can use in a positive way during my consultations".*
- *"Very motivating session, especially from people who are experiencing the condition. It has made me more confident in my clinics to advise patients regarding pulmonary rehab and Breathe Easy".*
- *"Very informative. I plan to try and set up a Breathe Easy group in my area. It was eye opening to know a patients journey to the point of diagnosis".*

Conclusion

Making best practice everyday practice depends on practitioners having the capability, opportunity and motivation to change care[3]. This initiative increased participants' knowledge and awareness of services for COPD (capability) and offered time for reflective learning (opportunity). It is fitting that a main motivation for change came from the moving accounts of people living with COPD.

Conflict of interest statement

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