Community Planning Aberdeen

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|---|---|
| **Progress Report** | Project End Report: 11.8<br>Refer 20% of people living with COPD or other respiratory conditions into specific PR physical activity and other support programmes delivered in community settings by 2023. |
| **Lead Officer** | Alison MacLeod, Chair of Resilient, Included and Supported |
| **Report Author** | Grace Milne/ Ben Elliot |
| **Date of Report** | 25 September 2023 |
| **Governance Group** | CPA Board – 29 November 2023 |

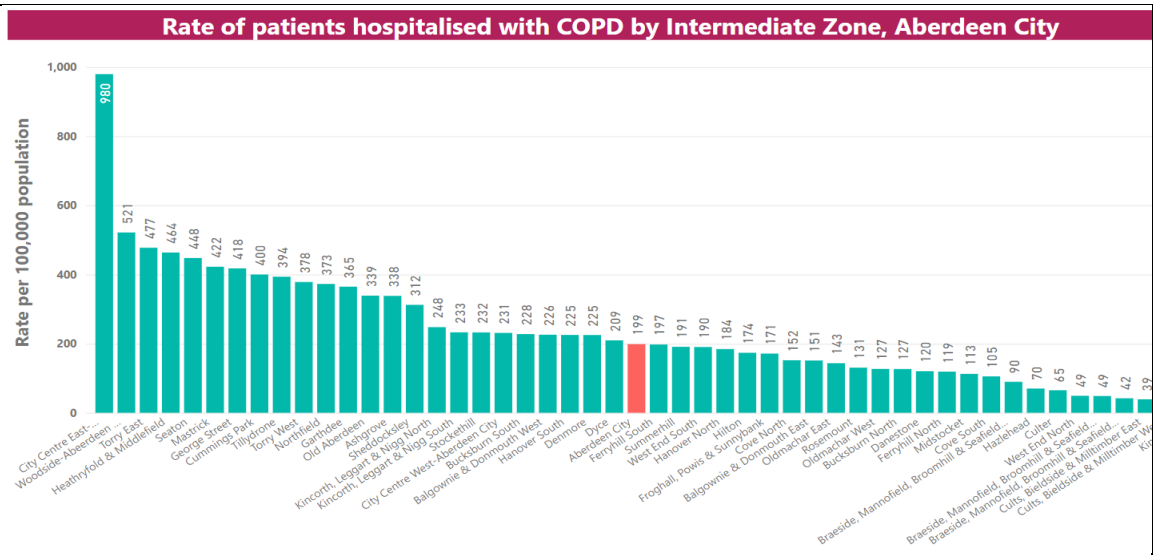
## Purpose of the Report

This report presents the results of the LOIP Improvement Project Aim 11.8 which sought to refer 20% of people living with COPD or other respiratory conditions into specific PR physical activity and other support programmes delivered in community settings by 2023 and seeks approval to close this project with bringing its learnings into other areas of project aims for LOIP Refresh 2024-2026.

## Summary of Key Information

**BACKGROUND**

1.1 Indicative in the table below, there is a worsening trend in the rate of hospitalised COPD patients in Aberdeen City. There are opportunities to improve pre-exacerbation education and support with a view to an improved (declining) trajectory in admission rates, by providing greater access to community based Pulmonary Rehab (PR) in Aberdeen City. *Of note the dataset is a 3 year rolling average number per 100,000 population. In 2018/19-2020/21 the 3-year rolling rate for patient hospitalisations in Aberdeen City was 186 per 100,000 population – lower than the rate for Scotland of 207. The rate of patient hospitalisations for COPD is higher for those in deprived areas (SIMD quintile 1 (most deprived)) compared to SIMD quintile 5 (least deprived) and varied across the City (Intermediate Zones) from a low of 0 per 100,000 population in Kingswells to a high of 980 per 100,000 population in City Centre East as shown in graph below




1.2 Pulmonary rehabilitation has established itself as a key management strategy in people with chronic respiratory disease and thus avoiding hospital admissions. Since the British Thoracic Society (BTS) statement on pulmonary rehabilitation in 2001, there has been a significant expansion in the literature for pulmonary rehabilitation. This literature has contributed to our understanding of quality clinical outcomes and markers of pulmonary rehabilitation, referral characteristics and patient selection, optimal programme structure, pulmonary rehabilitation in different settings and maintaining the benefits of the programme after completion of the course.

1.3 One of the principle functions of pulmonary rehabilitation is to improve the symptoms of patients with chronic respiratory diseases. The BTS (British Thoracic society) has developed PR guidelines which provide a framework for the delivery of individualised exercise programmes and disease related education sessions; the premise of this PR Programme :

- Patients cope better with breathlessness and feel less breathless and thus are less likely to call 101/999 for remote or virtual support.
- Improved fitness/strength for patients.
- Patients feel less anxious/isolated and increase confidence.
- Patients and supported to learn how to manage their condition and any chest infections, thus reducing GP/101/999 escalations.

1.4 For the purposes of the development of the guidelines, the Guideline Development Group (GDG) adopted the following working definition of pulmonary rehabilitation, broadly based on the NICE COPD guidelines: '*Pulmonary rehabilitation can be defined as an interdisciplinary programme of care for patients with chronic respiratory impairment that is individually tailored and designed to optimise each patient's physical and social performance and autonomy. Programmes comprise individualised exercise programmes and education'.*

1.5 NHS Grampian previously had a number of established PR services, one in Moray, one in city and one in 'Shire. These physio led classes became virtual during the Covid-19 pandemic response and uptake was low. It is widely recognised that support for a patient becoming breathless is clinically safer in person as opposed to over a virtual space. These clinical risks as identified by patients resulted in lower attendance at classes/education sessions and has led to a significant backlog of patients awaiting PR (200 city patients shown below (2022)).

| | |
|---|---|
| New patients | 174 |
| Return Patients | 31 |
| Total | 205 |

Waiting List Additions to City Pulmonary Rehab (Physiotherapy led)

| No. of new Referrals added | 2021 | | | | | | 2022 | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | July | Augst | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | June | July | |
| | 7 | 17 | 20 | 22 | 10 | 14 | 11 | 13 | 30 | 19 | 23 | 18 | 10 | 214 |

## 2 IMPROVEMENT PROJECT AIM

2.1 The CPA Board approved the project charter in September 2022 for the initiation of an improvement project which aimed to refer 20% of people living with COPD or other respiratory conditions into specific PR physical activity and other support programmes delivered in community settings by 2023.

## 3 WHAT CHANGES DID WE MAKE

3.1 The Project Team including a range of clinical, community and primary care colleagues, sports and leisure and educational colleagues as well as a person with lived experience developed and tested the following changes:

1. Test new model for delivery of PR activity where there is a wider pool of expertise in Sport and Nutrition, in Physiotherapy and in Education that could work collaboratively to extend the platforms for PR currently being delivered with Clinical input at key points of the patients' PR Programme. This is more person centred by giving patients the choice and not always having to attend classes assigned only for their condition etc but still getting that condition specific support.
2. Test whether signposting via local pharmacies would increase the referrals to and the uptake of PR in Community settings (when collecting prescription). (North Locality Plan idea)
3. Test whether new signposting within www.aberdeenlungs.co.uk and new leaflet would increase self-referrals to PR.
4. Test whether promotional activities targeted at Woodside Practice (initially) would improve PR engagement.
5. Test whether a wider range of venues available within the community to align to high referring primary care providers increases uptake. (North Locality Plan idea)

3.2 Early acknowledgement within the project team suggested that the project team coming together itself was going to be valuable for the understanding and support in promotion for Pulmonary Rehab classes. So, with that in mind, an early focus was to process and pathway map for Pulmonary Rehab.

**Pathway and Process Mapping - Pathway touchpoints**

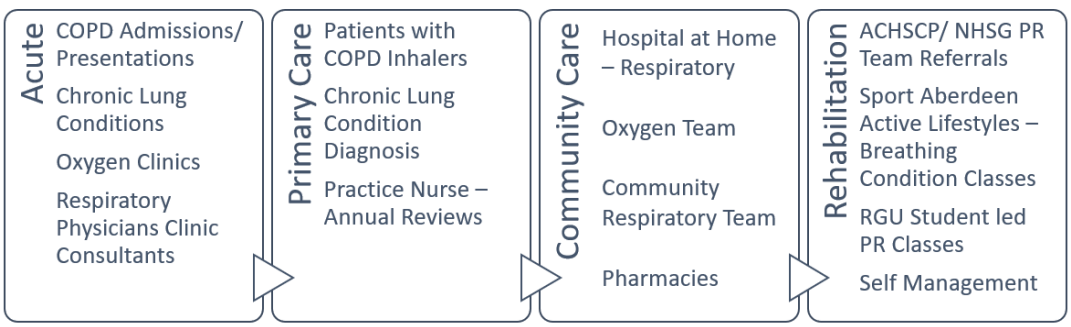



*Fig 1

**Clear Pathway for appropriate Referrals**

3.3 With the return of face-to-face classes - there is a number of classes and spaces available to support waiting lists within the community. Information is a little muddled and streamlining of this would support staff to signpost patients to the correct support. Figure 2 shows clearly what patients usually given MRC scoring at diagnosis, reviews and assessments would best be able to receive support for their ability.

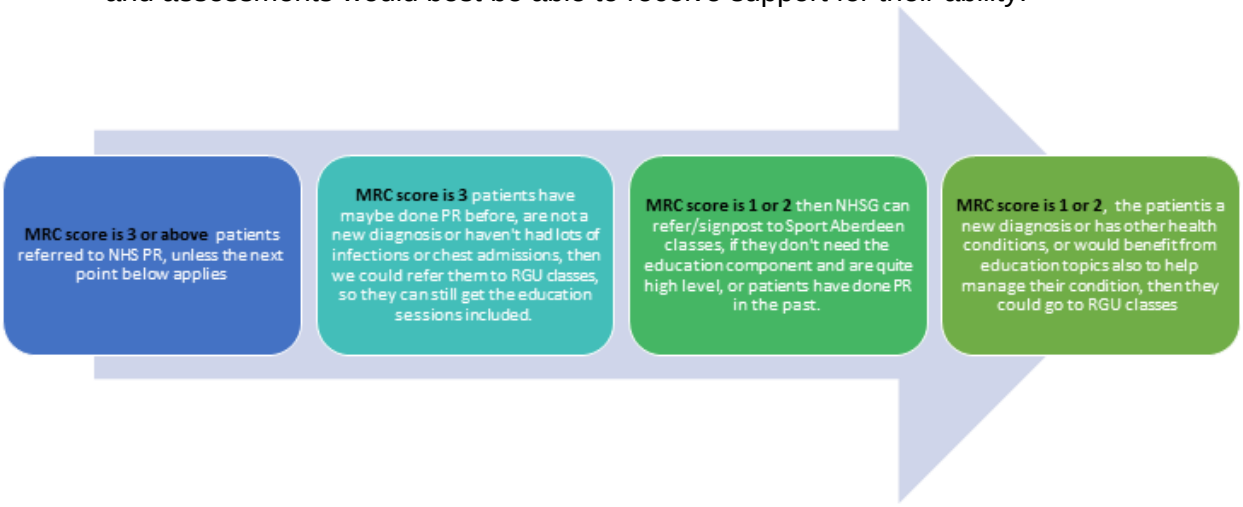



*Fig 2*

**New classes**

3.4 Pulmonary Rehab Physio led class was beginning face to face classes at Westburn Sport Aberdeen venue, this was established pre Covid and was a class supported by Sport Aberdeen colleagues as well as ACHSCP Physio colleagues. This project initiated additional classes to be incorporated into GetActive@Northfield site two afternoons a week. There is a ACHSCP Community Room within the facility that would support small groups for classes, however as these classes began, it was more beneficial for the Community Room to be utilised for assessments, allowing classes to take place in studio space at the same time. Supporting waiting lists and initial assessments for signposting patients to appropriate services.

3.5 Staffing has been a challenge for wider testing of Pulmonary Rehab with 3 staff WTE (whole time equivalent) in the ACHSCP Pulmonary Rehab Team with other community responsibilities competing for time. The Pulmonary Rehab Physio Team, although small, are now looking to incorporate new classes and spread learnings into Health Village Aberdeen and the new Torry Community Hub over the next few months.

3.6 Sport Aberdeen Active Lifestyles Classes- Westburn classes take place on Friday afternoon, with PR Virtual classes taking place frequently with a small number of patients ongoing keeping people active at home. Sport Aberdeen PR Steady Steps virtual classes similarly supports this keeping fit at home.

3.7 RGU Student led classes – 6 week rolling programme for Students to lead courses providing PR Classes with additional educational information for patients. This project initiated referral data to be collected and is now embedded in supporting capacity within PR Support across Aberdeen patients.

**Patient & Pathway Information**

*3.8* Online Information

Aberdeen Lungs - Pulmonary rehabilitation (P.R) (aberdeenlungs.com)

Chest Heart and Stroke

https://www.chss.org.uk/documents/2013/08/e21_pulmonary_rehabilitation.pdf

Sport Aberdeen – YouTube Playlist and Support Winter Pulmonary Rehabilitation YouTube playlist

Hard Copy Leaflet

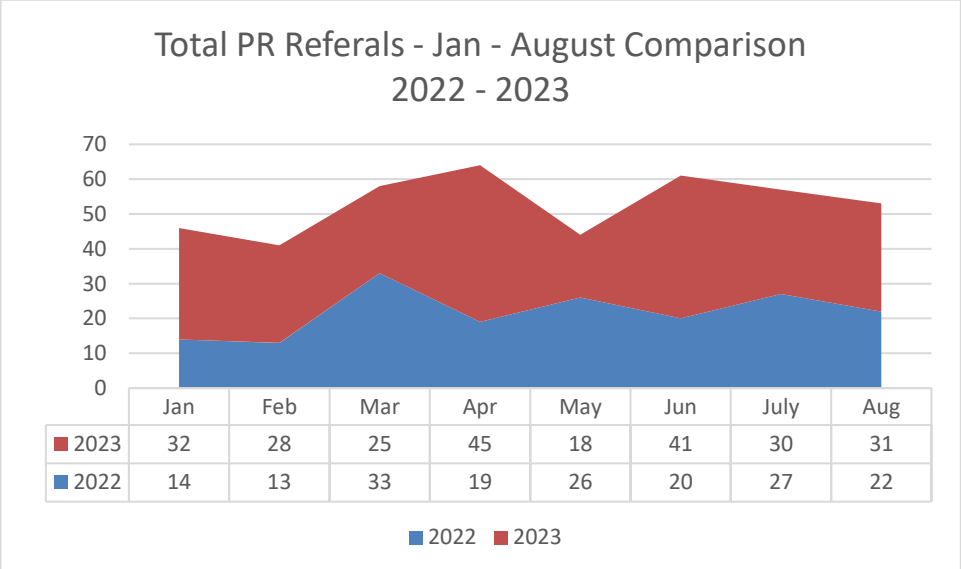
3.9 NHSG/ACHSCP PR Team have a long-standing leaflet, it was felt that this was a good time to update the information we have available paper copies and review the distribution of this leaflet. With consideration at each touchpoint of patients journey (figure 1) as above.

3.10 It was also considered that this should be a partnership combined leaflet, giving patients all the information they need, for all levels of Pulmonary Rehab Support across Aberdeen City. This will help patients make an informed choice on the level of support for them, with the support of PR Team to advise if necessary. The leaflet will include support for patients and what they need to attend any assessments or classes. Supporting right care, right place, right time.

3.11 A new leaflet was produced and designed alongside our patient rep project team member, which we are very grateful for her input, it has been invaluable for understanding the information needed for patient support. This leaflet has been added to a new webpage on ACHSCP Website for support for Respiratory Condition Management Page which links to a very well established Aberdeen Lungs Page with a wealth of information, support and advice. Digital copy was sent directly to those with COPD inhalers via text from Woodside Medical Practice. Hard copies of the leaflets were distributed to the pathway touch points as well promoting online.

## 4 HAVE OUR CHANGES RESULTED IN IMPROVEMENT?

4.1 Yes our aim has been achieved with a 30.4% increase (174 to 250) in the total number of referrals for PR support from Jan – August 2022, compared to Jan- Aug 2023 as shown in the chart below.




| | Jan | Feb | Mar | Apr | May | Jun | July | Aug |
|---|---|---|---|---|---|---|---|---|
| 2023 | 32 | 28 | 25 | 45 | 18 | 41 | 30 | 31 |
| 2022 | 14 | 13 | 33 | 19 | 26 | 20 | 27 | 22 |

*Fig 3*

4.2 Latest data has also shown In 2019/20-2021/22 has shown that the 3-year rolling average rate of patient hospitalisations for COPD in Aberdeen City has reduced to 186 per 100,000 population, compared to 199 in 2018/19-2020/20 and lower than the rate for Scotland of 207. Whilst, the rate of patient hospitalisations for COPD is higher for those in deprived areas data shows that the area in which the project targeted its

testing (City Centre East there has been a 13% reduction in the rate of COPD hospital admission (980 to 857 per 100,000 population in City Centre East).

4.3 Below is a breakdown of the referrals per setting within which the project tested to show the impact of the changes.

4.4 Pulmonary Rehab attendances have significantly increased since the return of face to face classes. This data also shows that with the increase of exit/ final assessment attendances there is also an increase of new patient attendance total too, showing a turnover in the waiting list for pulmonary rehab overall. We have to be mindful that it is difficult to get consistency in attendance due to the nature of people conditions/ exacerbations, however significant improvement from 2022 figures. (fig 3)

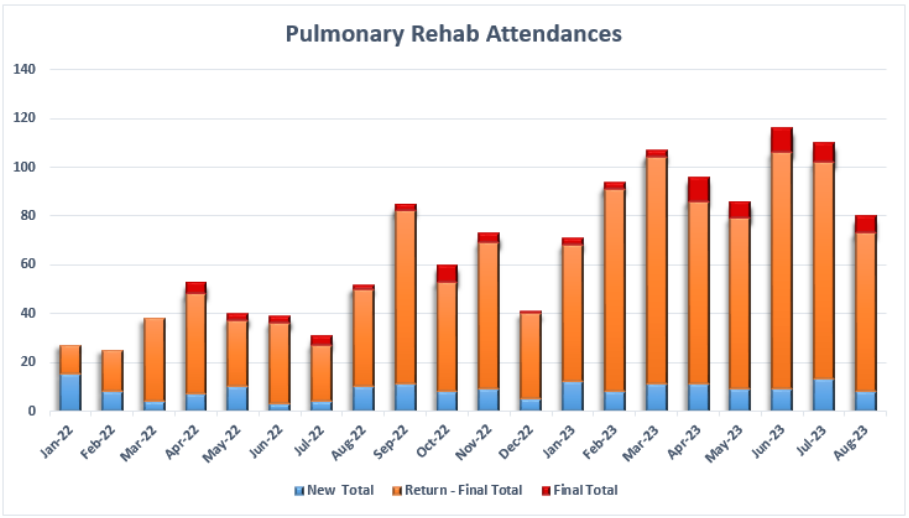



Fig 4

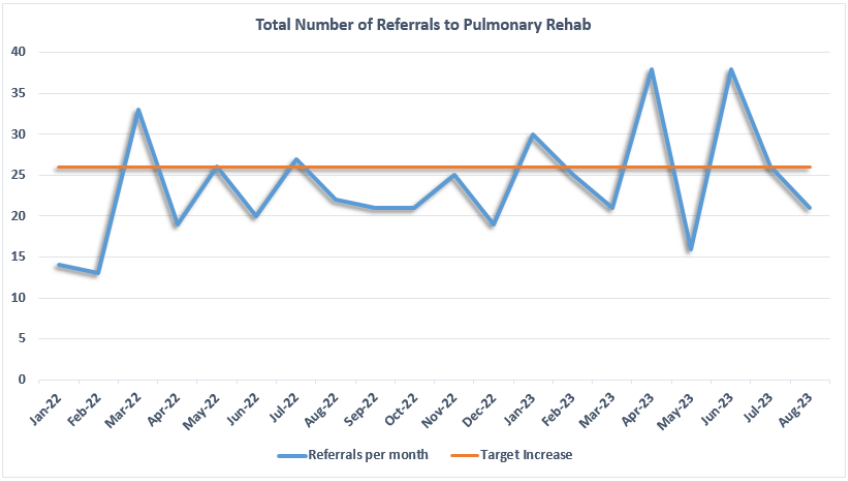



*Fig 5*

4.5 Above figure is for referrals to ACHSCP/NHSG PR Team, referral numbers have increased of 19% across comparable figures from Jan – Aug 2022 (174) & 2023 (215).

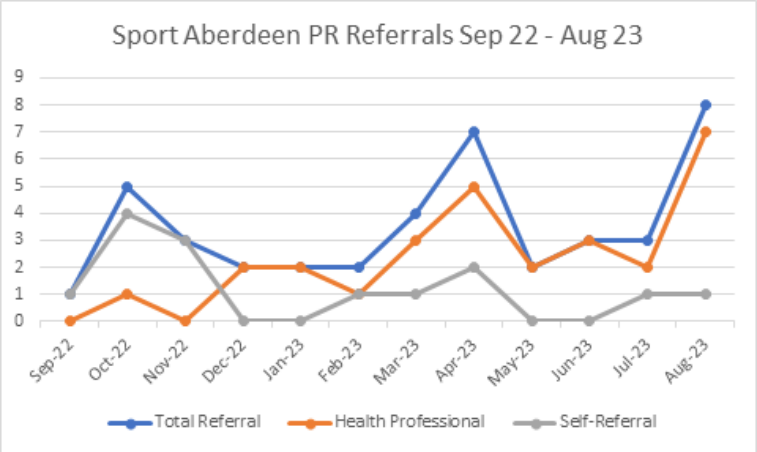



*Fig 6*

4.6 Referral numbers for Sport Aberdeen PR classes are as above, with a breakdown of attendances and participations below. Interestingly the number of referrals peaks of referral numbers coincide with referrals to PR Team, showing good signs of signposting to relevant support services. Sport Aberdeen received 41 referrals in total from September 2022 – August 2023, 15 of those being self-referral and 26 via Health Professionals. Figures from January to August has been included in the total PR Figures above (fig 3).

| **Sport Aberdeen PR Class attendances September 2022 – August 2023** | |
|---|---|
| Sport Aberdeen PR Maintenance Class<br>Fridays Get active @ Westburn | 16 unique individuals<br>37 sessions<br>117 participations |
| Sport Aberdeen virtual PR class<br>Thursdays via Zoom | 8 unique individuals<br>45 sessions<br>110 participations |
| Sport Aberdeen virtual PR Steady Steps<br>Thursdays via Zoom | 9 unique individuals<br>50 sessions<br>207 participations |
| **Total Engagement** | **33 unique individuals**<br>**132 sessions**<br>**434 participations** |

4.7 Significant numbers of participations for individuals showing sustaining and continued physical activity with Sport Aberdeen over project period.

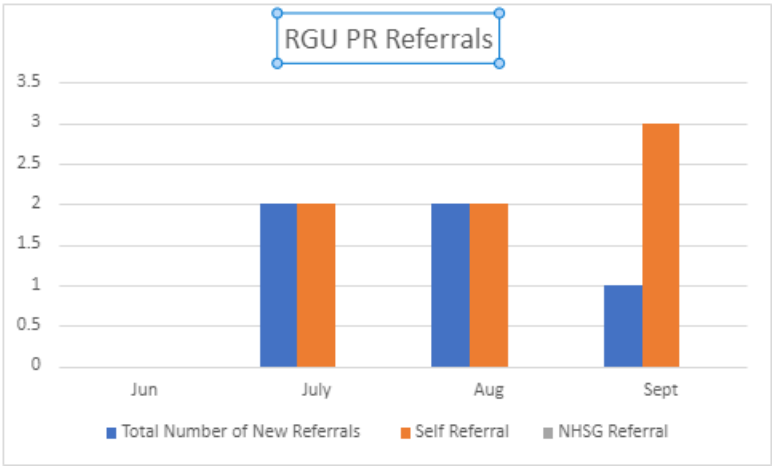



Fig 7

4.8 New established data collation for number of referrals coming through to RGU Student led classes, starting in June with data being gathered, coinciding with the new partnership leaflet distribution in July showing number of self-referrals into RGU Student led classes. Momentum gathering for promoting service. These figures have been added to (Fig 3) supporting total referrals Jan – August 2023.

## 5 HOW HAVE OUR COMMUNITIES/PROTECTED GROUPS PARTICIPATED IN THE PROJECT AND THE IMPACT OF THIS

5.1 The project team included an active project member currently living with COPD. She was invaluable contribution to the project, supplying information and direction into the partnership leaflet, useful guidance about significant pathway points and when useful to receive information. She also contributed to the idea of a partnership leaflet challenging the Project Team to consider the patients having information available across in Aberdeen in one place.

5.2 Engagement with community groups as to locations for the PR sessions has been vital in identifying the right locations and ensuring that classes are at the heart of the community.

5.3 In the North locality Plan there were a number of community ideas aligned to the project and the following have been tested as detailed above:

- More health and social care services to be available within community centres.
- Expand sites providing specialist support activities for long-term conditions.
- Promote referral to online and face to face condition specific classes

## 6 HOW WILL WE MONITOR AND SUSTAIN THESE IMPROVEMENTS?

6.1 The project team/ network, and the changes tested have now been embedded as business as usual and will continue to be monitored and developed. As above, project is looking at areas to expand PR classes to other areas of the city.

6.2 Data will continue to be collected and reported, as appropriate through the Resilient, Included and Supported Group.

## 7 OPPORTUNITIES FOR SCALE UP AND SPREAD

7.1 Pulmonary Rehab Physio Team are ready to scale up and spread classes to other areas of Aberdeen including the City at Aberdeen Heath Village and South Locality in Torry Community Hub in the coming months.

7.2 Sport Aberdeen and the PR Team are looking to take learnings of joint working from Westburn classes to other venues and looking at training to support Sport Aberdeen colleagues to participate and upskill their learning.

7.3 Overall project achievements with wider pathway networks/ project teams with short-term focus on patient information and pathway understanding can be spread to other health and social care services.

| Recommendations for Action |
| --- |
| It is recommended that the CPA Board:<br><br>i) Agree that testing is concluded and that this Improvement Project is brought to an end on the basis that the aim has been achieved and the changes embedded as business usual and now being scaled up; and<br>ii) Agree that the Resilient, Supported and Included Group incorporate project learnings and wider achievements into future aims for LOIP Refresh. |

| Opportunities and Risks |
| --- |
| Opportunities<br>• Spread the learning of partnership information for pathways to be centralised and easily accessible for patients.<br>Risks<br><br>• Community based engagement and more available venues for services comes with challenges, including staff capacity, IT access and infrastructure. Good partnership working demonstrated in this project can mitigate against risk and still provide choice and accessibility for patients. Risk that we use this as an after thought rather than how we design services from beginning. |

| Consultation |
| --- |
| Project Team<br>OIG – RIS<br>CPA Management Group |

| Background Papers |
| --- |
| Project Charter<br>Local Outcome Improvement Plan<br>North Locality Plan<br>Aberdeen Lungs Home (aberdeenlungs.com)<br>Chest Heart and Stroke<br>Sport Aberdeen – YouTube Playlist and Support<br>ACHSCP Respiratory Management \| Aberdeen City HSCP<br>Digital Partnership Leaflet 230106-pulmonary-leaflet-digital.pdf (aberdeencityhscp.scot) |

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