GIRFT respiratory report outlines measures to help teams manage demand and capacity to meet post-COVID challenges

The new national report for respiratory medicine published by the Getting It Right First Time (GIRFT) programme outlines how more patients' lives could be saved if all acute trusts could establish a dedicated non-invasive ventilation (NIV) unit – with the right infrastructure to support it – to care for people with conditions like Chronic Obstructive Pulmonary Disease (COPD).

The report highlights a gap in provision of NIV – only 77 acute trusts in England had dedicated NIV beds at the time of the review and many reported not having enough nurses or equipment to support them. GIRFT recommends a series of actions to help all trusts work towards a dedicated non-invasive ventilation (NIV) service to help improve outcomes for patients. These include measures to identify the right patients for treatment and starting more treatment at the right time.

NIV provision is among a range of improvement measures featured in the report, which aims to build on the experiences of respiratory medicine teams during the COVID-19 pandemic, as well as improving care for patients with conditions such as asthma, pneumonia, pleural disease and COPD.

The report is based on questionnaires to the 128 trusts in England with respiratory activity, as well as visits to 58 NHS trusts. It is author by Dr Martin Allen MBE, a consultant physician at the University Hospitals of North Midlands NHS Trust and the NHS national specialty adviser for physiological measurements.

Respiratory problems were among the most common reasons to consult a GP and for acute hospital admissions, even before COVID-19. Admissions for respiratory conditions are growing at around 13% annually, faster than other specialties. The COVID-19 pandemic placed a particular strain on respiratory medicine teams and services, and outpatient services were also heavily impacted, with a 42% reduction in activity in May 2020 compared to May 2019.

The report contains practical steps and best practice examples to help trusts better manage patient demand and optimise capacity as services are restored, with a focus on measures which can help meet the challenges of the post-COVID world. These include:

Establishing respiratory support units (RSUs) to provide the best possible care for COVID-19 and post COVID-19 patients. These units emerged as a key response to the pandemic, delivering improved outcomes for patients and allowing respiratory support for patients outside of intensive care, freeing critical care capacity for those patients who needed invasive ventilation. GIRFT aligns with the British Thoracic Society (BTS) in recommending RSUs in all NHS hospitals. The report also makes recommendations to enable remote monitoring of patients with post-COVID-19 syndrome.

Improving care for patients with asthma, COPD, pneumonia and pleural disease. These four most common respiratory conditions affect millions of people in the UK, and the report

focuses on improving care, reducing the number of admissions and the time patients spend in hospital. Recommended measures include a target of one asthma nurse per 300 admissions, introducing seven-day COPD services in areas where there is high need and having a named respiratory consultant as a clinical lead for pneumonia in all trusts.

Developing a sustainable solution to deal with winter pressures. 80% more respiratory patients are admitted to hospital in January than in August, sometimes resulting to elective work being cancelled and increased waiting lists. The GIRFT report outlines how a systematic plan could help improve patient outcomes. This might include initiatives to prevent respiratory illness, reducing the number of outpatient clinics during winter months, and an expansion of staff and infrastructure to allow respiratory patients to be managed by respiratory teams rather than locums without relevant training.

Overall the report presents 26 recommendations and an opportunity for cost efficiencies of between £28.9m and £63.9m a year.

Report recommendations

Outpatient services

1 Optimise respiratory outpatient services by reducing DNAs, limiting unnecessary follow-up, considering increased virtual consultations, one-stop clinics and moving care closer to home.

Acute and inpatient care

2 Improve acute care for respiratory patients by reviewing patient flow and considering measures to increase ward productivity.

Activity and information flows

3 Improve education and relationship building for medical and coding staff within trusts.

4 Ensure respiratory activity is coded using Treatment Function Code 340 (respiratory medicine).

5 Explore the reasons for variability in the number of respiratory patients being cared for by respiratory consultants.

Coding for physiological activity

6 Ensure physiology outpatient activity is accurately captured and remunerated using Treatment Function Code 341.

Cardiopulmonary exercise testing

7 Increase the use of Cardiopulmonary Exercise Testing (CPET) with interpretation by senior physiologists to manage breathlessness and determine patients' fitness for major or complex surgery.

Sleep medicine

8 Improve care for patients in sleep medicine by addressing delays in diagnosis of sleep problems and CPAP initiation, together with resolving gaps in infrastructure.

Managing pulmonary embolism

9 Improve experience and outcomes for patients with pulmonary embolism by reducing unnecessary tests and ensuring respiratory or joint clinician-led follow-up where possible.

Pleural services

10 Reduce acute admissions and length of stay, and deliver a high quality pleural service which achieves the Best Practice Tariff by addressing workforce and infrastructure requirements

Asthma

11 Review referral systems and patient pathways in collaboration with community, primary and acute services to improve care for patients with asthma.

12 Review departmental resourcing to improve outcomes, reduce length of stay and reduce the likelihood of readmissions for patients with asthma.

Pneumonia

13 Optimise care for pneumonia patients by ensuring the correct diagnosis (and that it is coded correctly), as well as reviewing patient pathways and infrastructure to enable care bundle delivery, reduce length of stay, readmissions, morbidity and mortality.

Chronic obstructive pulmonary disease (COPD)

14 Optimise care for patients with chronic obstructive pulmonary disease (COPD) to reduce length of stay, readmission rates, and overall mortality by using discharge bundles. Where demand exists, consider implementing seven-day services.

Non-invasive ventilation

15 Ensure a dedicated non-invasive ventilation (NIV) service is in place, with the recommended infrastructure to improve outcomes and reduce mortality.

Integrated Care

16 Review aspects of respiratory care integration and supporting infrastructure at system level to reduce variation in service provision, enable better care delivery and facilitate information flow between providers.

Improving treatment for tobacco dependency

17 Improve access to smoking cessation therapies and reduce tobacco dependence in patient populations through a comprehensive suite of interventions.

Specialised services

18 Review service infrastructure to ensure delivery against national specialised service specifications, reducing the likelihood of delays in treatment or discharge.

19 Consider hub and spoke models to amalgamate low volume specialised services.

20 Review how trusts achieve and maintain specialised status; updating service specifications. Where service demands have changed over time, specifications and subsequent resources need to be aligned to deliver appropriate care.

21 Establish formal registries to capture patient-level information which can support monitoring and inform commissioning decisions.

Medicines optimisation

22 Improve patient outcomes by reviewing infrastructure to support appropriate medicines use.

Workforce

23 Address variations in service delivery and meet the needs of the local population by staffing respiratory departments with the appropriate numbers and skill mix of doctors, specialist nurses, physiologists and allied health professionals.

Litigation

24 Reduce litigation costs by application of the GIRFT programme's five-point plan. Share learning by ensuring claims, inquests and complaints are reviewed in regular M&M meetings.

Procurement

25 Enable improved procurement of devices and consumables through cost and pricing transparency, aggregation and consolidation, and by sharing best practice.

COVID-19

26 Ensure respiratory services are able to provide optimal care for patients with COVID-19 and post-COVID-19 syndrome by establishing respiratory support units, enabling remote treatment monitoring and optimising multidisciplinary expertise.