National Asthma and COPD Audit Programme (NACAP)

Pulmonary rehabilitation: Good Practice Repository – Programme completion

Version 1.0: September 2023

The national target for programme completion is: 70%

Case studies from PR services who achieved ≥70% of patients completing a full PR programme and a discharge assessment.

Introduction

The National Asthma and COPD Audit Programme (NACAP) have collated a series of case studies which highlight good practice in both audit data collection and entry, and in provision of quality pulmonary rehabilitation (PR) care. This document aims to provide services with learning to implement locally and with ideas on how local practice could be improved.

How to use the good practice repository

Get practical tips from other PR services on how to engage with patients and support them to complete their full PR programme. You can put these into practice in your own service with the help of our improvement materials: https://www.nrap.org.uk/nrap/welcome.nsf/reportsPR.html.

Useful links:

- See the rest of our good practice repository, or submit your own case study
- Explore other resources to support PR services
- Read our PR reports
- Get in touch: PRaudit@rcp.ac.uk I 020 3075 1526 I @NRAPaudit

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Birmingham Community Healthcare Community (BCHC) Respiratory Service

75% **of patients who enrol onto a BCHC respiratory service PR programme, complete the programme, and have a discharge assessment.**

The community

Five venues in a socio-economic diverse community. Barriers to uptake include language and lack of access to transport.

The team

- 1 x Band 8 – Respiratory team lead
- 1 x Band 7 – PR lead
- 1 x Band 6
- 1 x Band 4 admin
- 2 x Band 3

How BCHC respiratory service supports people to complete their PR programme

> **Pre-screen** to find out who will need more support to engage with and complete the programme. This can save clinical time at assessment.
> **Know your patients** and understand their barriers to access, exercise and needs.
> **Build a community** to make classes fun and social to encourage attendance.
> **Supporting access** by helping patients access 'ring and ride' or ambulance transport services where appropriate.

Find out more…

Getting started

- Newly referred patients are invited to a **'Pre-hab'** (a one-off, pre-screening event). Each session hosts 40-50 patients of which 90% are booked onto the initial assessment. The PR team explains:
    - what the programme involves
    - what is expected of participants
    - the support BCHC can provide
    - the benefits patients can expect.

Initial assessment appointments are booked during **'pre-habs'**, and most people who attend assessment are committed to the programme, saving clinical time. Non-attendees are discharged.

Initial assessment

- Assessments are planned so there is time to understand patient needs and explain:
    - further information on what people can expect from the programme
    - that the programme requires commitment to provide real benefit. At this point most patients commit to completing the programme.
- At assessment, the team offers to defer the start of the programme to a suitable time for the patient if necessary, making them more likely to engage.

Keeping patients engaged

- The programme is 12 sessions, and the patient sees the same clinician from start to finish. Four classes can be missed if notice is given, with two catch-up classes offered if necessary.
- Did not attend (DNA): When patients miss a class without notice, the team contacts them to ensure wellbeing and to find out the reason. If they miss two classes without giving notice, they are discharged from the programme.
- Discharge assessments are broken down and held at the end of the last few programme sessions, so that patients don't have to attend a separate assessment.

Creating a PR Community

- At the end of each PR session, staff provide refreshments and encourage patients to share their experiences and knowledge. The team holds celebrations for patient progress, successes, and birthdays.
- Expert patients attend to share their experience. The team choose people who were initially sceptical of the benefits of PR but became committed to the programme. The team aims to have one expert patient per venue.

The team supports patients by:

- offering interpreters for patients with English as a second language
- providing supporting letters to employers, to ensure people can get time off and access medical allowances
- addressing transport issues but helping patients access 'ring and ride' services or ambulance transport where appropriate
- using venues with free parking, and arranging additional parking if necessary

Make it clear that PR is a medical appointment, and patients are entitled to access the support to attend that they would for any other medical appointment.

Dudley Pulmonary Rehabilitation Programme

74% **of patients who enrol onto a PR programme, complete the programme, and have a discharge assessment.**

The community

Four venues in a socio-economic diverse community. Barriers to uptake include language and lack of access to transport.

The team

- 1 x FT Band 7 Team Lead
- 1 x FT Band 6 Physiotherapist
- 2 x FT Band 6 Nurse
- 2 x Band 4

How Dudley supports people to complete their PR programme

> **Pre-screen** to explore medical and mental health issues and ensure all necessary support is provided during the programme.

> **Know your patients** and understand their barriers to programme access and any concerns they may have.

> **Build a community** by running a local BreatheEasy course, which helps build rapport and encourages patients to join the PR programme.

> **Supporting access** by using locations that are easily accessible, liaising with local benefit services to find assistance with transport and ensuring translators are available if necessary.

Find out more…

Getting started

Newly referred patients are addressed via an initial letter which invites them for an appointment or a call, also offering an initial assessment at their home.

In a drive for referrals, the PR team worked with local GP's to identify COPD patients with high readmissions to hospital and/or severe COPD but were struggling to engage with PR. These patients were invited to an information session on the benefits of PR. Transport was paid for and a hotel venue was used to ensure all necessary facilities were available to those attending.

Initial assessment

> A comprehensive assessment is conducted, ensuring to cover physically and mental health so that all possible support is given.

> Liaison with the GP /community team is offered to understand the patient's health. This also gives patients' confidence in the team before they begin the programme.

Keeping patients engaged

- Programme cycles involve the same staff members to ensure continuity of care and so that trust/rapport is built.
- The programme is flexible to support patients to complete with them being able to conduct certain elements at home if need be. Staff explain the programme in full and make it clear what to expect. The 'did not attend' (DNA) policy is make clear in that there can be two missed appointments (without a reason or notification) before discharge from the programme. DNAs are always followed up with a call to find out if further support is required.

Creating a PR Community

- PR classes support and encourage social interaction with venues set out in a relaxed, non-clinical way and making use of existing community cafes.
- An education session is held at the end of each lesson, where clinicians facilitate patient discussions on topics covered. Patients are given time and space to talk and refreshments are offered where appropriate (not during COVID for example).
- The PR team also run local BreatheEasy course which supports further social interaction and support outside of the PR programme.

Creating an accessible and engaging PR service

> A dedicated PR team was created which helped bring down waiting lists by offering home visits. Staying on top of waiting lists helped patients get seen quickly after referral. This also helped maintain momentum and patient engagement.

> Time is taken to make patients feel comfortable, build a relationship, and understand what patients think their problems are. This helps with other issues which may not necessarily be respiratory related but benefits patients and in turn builds rapport.

> Virtual PR had been provided throughout COVID. The team still offer virtual PR for particularly elements of the programme and patients appreciate having the option.

The team supports patients by:

- offering interpreters for patients with English as a second language,
- choosing easily accessible locations (not more than a couple of miles for the patient to travel) are selected. These are on bus routes and all have free parking. The team also liaise with local benefit services to find travel assistance if necessary.
- holding maintenance sessions for those who have completed
- engage patient from the outset by listening to concerns.

Sutton SHC Community Team

81% **of patients who enrol onto a PR programme, complete the programme and have a discharge assessment.**

The community

Barriers to uptake include lack of motivation and home-bound patients.

The team

- 2 x Band 7 Physiotherapist
- 1 x Band 4

How Sutton supports people to complete their PR programme

> **Pre-screen** to understand patient needs and if any additional support is required.
> **Follow ups** for those who didn't attend initial assessment.
> **Support patients** by involving different healthcare professionals to give health education talks to address barriers. Equipment adaptation is also provided.

Find out more…

Getting started and initial assessment

> Initial assessment is used to obtain a holistic overview of the patient and to identify where intervention or additional support is needed. For example, for patients with low body mass index (BMI) receive the support of Dieticians as part of the programme.
> Patients are also asked about any personally goals they'd like to set as part of the programme.
> Concerns related to physical (covers all types) and mental health problems are addressed through multi-disciplinary team (MDT) working, including working closely with GPs.
> OTs (occupational therapists) also provide support for anxiety and stress contributing to breathlessness; and address equipment adaptation at home.
> Initial assessments are also used to build an effective rapport between the patient and the healthcare professionals involved in the programme and ensure they feel welcome.

Keeping patients engaged and creating a community

- The rapport established with programme staff at initial assessment is built on and expanded to the other patients on the programme during the programme to ensure patients trust clinicians and remain engaged.
- Patients are encouraged to mingle to facilitate peer support and social interaction. This helps develop relationships and gives further purpose/motivation to attend the sessions with their new friends.
- Feedback from patients who completed the programme is shared (with their consent) to motivate new members.
- Refreshments are provided between class and education sessions to allow time for patient interaction.
- Goals set are revisited at each session to support and motivate patients in achieving them.
- Expert patients (those who have previously completed a programme) are given the opportunity to share their experience, to encourage and motivate others.

Discharge assessments

- Final assessments include time to review and discuss improvements/outcomes with patients.

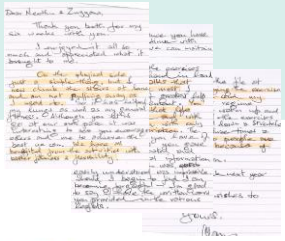
Identifying and dealing with barriers to attending PR

- For those struggling to engage with the programme, in-depth discussions take place to understand concerns and needs. The programme is then further tailored to address these. For example, the team can provide alternative exercise options if necessary.
- Telephone contact is made with those who did not attend sessions.
- Time is taken to understand issues and provide adequate support as appropriate, particularly where a patient has missed a session.

Patient feedback*

'..Thank you both for my six weeks with you. I enjoyed it all so much and appreciated what it brought me. ***On the physical side, just a simple thing, but I now climb the stairs at home and am not puffing away as I used to****. So it has helped my lungs as well as my general fitness. Although you let us go at our own pace it was interesting to see you encourage others and me to achieve the best we can.* ***We have all benefited from the activities with better fitness and flexibility.*** *Using the guidance you have given, I will continue with the exercises, we can maintain these benefits!*

I appreciate the exercises and talks go hand in hand but ***it is the talks that impressed me most.*** *I feel they were the greatest help and encouragement. You showed us that life hasn't stopped and with care we can go on with only a gradual deterioration. The understanding you have of COPD and how you gave talks about complicated … medical information in a manner which was easily understandable was impressive. Should I begin to find I am becoming forgetful – I'm glad to say I have the written word you provided in the various leaflets. I am using [these] at home, photocopying the exercise sheets for mine and my wife's use.* ***So two people are now improving because of you****.'*



**All patient feedback is provided and used with permission*

Glossary

- Discharge assessment: This is the final programme appointment and is used to assess progress against goals and outcomes.
- DNA – Did not attend: This is where a patient does not attend an appointment without giving prior warning.
- Expert patients: These are patients who have previous complete a PR programme (or element of care) and come into talk to patients about their experience as part of the programme.
- Initial assessment: This is the first formal appointment for the programme. Exercise tests and health status surveys are conducted at this point to ensure patient outcomes (progress) can be measured.
- Pre-screen: This is an appointment or phone call used by the team to have an initial discussion with the patient about their reasons for being referred to the programme, identify if there are any additional needs that require attention/action and to explain the programme and its structure to the patient.
- Programme completion: This is where a patient completes their entire PR programme and has a discharge assessment to formally review their progress, outcome and discharge them.