**Sheffield Teaching Hospitals NHS Foundation Trust**

**Achieving compliance with best practice tariffs for chronic obstructive pulmonary disease (COPD)**

**Context**

The Best Practice Tariff (BPT) for COPD, set in place for the financial years 2017/18 and 2018/19, applies to all non-elective admissions (defined by HRG DZ65), for trusts in England.

Best practice is considered to be achieved when (at a trust level):

* 60% of patients with a primary diagnosis of COPD, admitted for an exacerbation of COPD, receive specialist input to their care within 24 hours of admission, and
* where they receive a discharge bundle (check inhaler technique and medication review, written self-management plan and emergency drug pack, smoking cessation and pulmonary rehabilitation referral and follow-up in 72 hours) before discharge.

Achievement of COPD best practice is measured by the National COPD Audit Programme’s continuous secondary care audit, which was launched on 1 February 2017, with hospitals required to enter patient data into the audit’s dedicated web-tool.

Against this background and having already delivered an Early Supported Discharge (ESD) scheme for COPD patients for many years, Sheffield Teaching Hospitals NHS Foundation Trust has formalised its existing systems and processes further, helping it to be one of the most successful trusts in terms of BPT conformity.

**What Sheffield Teaching Hospitals NHS Foundation Trust did**

Sheffield Teaching Hospitals has a long established Early Supported Discharge Scheme for COPD. Specialist nurses see patients with supported COPD and assess their suitability for supported discharge with those deemed suitable being referred on to community colleagues.

For around 15 years this system has been supported by a weekly multi-disciplinary team meeting with hospital and community representatives, and with at least one consultant physician with an interest in COPD.

It’s a successful approach that has expanded to:

* include physiotherapists from the community based Pulmonary Rehabilitation Team, the Community Respiratory Mental Health Team and the Home Oxygen Assessment team.
* widen the scope of the hospital team to review not just those patients who may be suitable for ESD but all those admitted with a primary diagnosis of COPD (as well as some of those where this is a secondary diagnosis). As part of these reviews the team checks the patient’s diagnosis, offers smoking cessation advice, and reviews inhaler technique
* refine a rapid referral pathway to post admission pulmonary rehabilitation. Follow up arrangements are checked, and patients return to secondary care if there are issues such as radiological change to monitor or consideration of interventional treatment. Many gain extra education and support as part of the early supported discharge scheme.   
    
  Patients without other follow up, and those discharged from ESD, are offered a follow up in a nurse-led community clinic with spirometry to reinforce educational messages and to ensure that all items of basic care have been attended to.

“Our thorough service has for many years used what has become labelled as a ‘discharge bundle’ and as we see all these items as good practice; we would be disappointed not to offer these items of care as a routine for the vast majority of our patients and all our core and extended team fully support this approach.”

Dr Rod Lawson

To effectively manage the data collection and entry required by the National COPD Audit, the clinical team is supported by the management and IT teams and the following processes are followed:

“We are excited by having this real time, reliable data immediately to hand in terms of future service improvement; for instance, it is immediately apparent that many admitted with COPD are readmitted soon afterwards for reasons other than COPD and work is ongoing to see if themes emerge that might allow us to target early interventions for non-respiratory as well as respiratory disease in this cohort.”

* nurses collect their routine information during assessments within 24 hours of admission and transcribe relevant audit items to separate paper records
* these are assembled and entered onto Sheffield Teaching Hospitals’ in-house bespoke database by a part time nurse
* the database pulls through process data such as time and date of admission from the hospital’s clinical systems, ensuring this is as complete, accurate and automatic as possible
* output from this database can then be uploaded directly onto the national audit database.

**The Results**

With best practice already embedded into the Sheffield Teaching Hospitals NHS Foundation Trust approach, the formalisation required by the current National COPD Audit, which is linked to BPT payments, has allowed hospital teams to check on their practice and reinforce their systems.

This streamlined data collection and entry process is helping to pinpoint any areas where improvement is required. It recently highlighted a level of inaccuracy when it came to inpatient coding, for instance, so now any discrepancies are manually checked by specialist nurses meaning the final data coding is extremely robust.

These improvements, coupled with the multidisciplinary team that has been committed to the principles and actions underpinning BPT for many years, Sheffield Teaching Hospitals NHS Foundation Trust is now amongst the most successful trusts in delivering BPT conformity.

**Conclusion**

Having further refined its approach to COPD best practice, Sheffield Teaching Hospitals NHS Foundation Trust is now focused on achieving continuous improvements. The stimulus of the National Audit and BPT has been viewed not as a completion of their efforts but as a valuable method of beginning further service review and improvement. Managerial and IT support is allowing them to make best use of this opportunity.

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