CCG name: North East Hampshire & Farnham CCG		
Case study title: An Integrated Care Pathway for COPD Patients Nearing End of Life		
CCG case study number: (specify 1 to 5)	*x* of 5	**Word length for this case study** (up to a maximum of 3,000 words in total across the submitted case studies)
Does the case study provide core evidence?	Y	**If yes, state domain criteria by deleting as appropriate:** 1.1, 2.2, 3.2, 4.3.1, 6.2
Does the case study provide supplementary evidence?	Y/N	**If yes, state for which domain criteria:**

Patient groups	**Please tick all relevant:**
• Mothers and newborns	
• People with need for support with mental health	
• People with learning disabilities	
• People who need emergency and urgent care	X
• People who need routine operations	
• People with long-term conditions	X
• People at the end of life	X
• People with continuing healthcare needs	X

Context

North East Hampshire CCG is committed to improving services for local people who have COPD and are at the end of life. The project to implement an integrated care pathway for COPD patients nearing end of life supports the CCGs key strategic clinical programmes and objectives related to the End of Life and Unscheduled Care QIPP and Reform work streams, to improve quality of care, patient experience and reduce inappropriate admissions to hospital.

Currently patients within North East Hampshire & Farnham CCG receive a wide range of services from a number of different providers, across health and social care borders. Community services are provided by Southern Health which includes complex COPD services and home oxygen assessment services. Community Pulmonary Rehabilitation services are provided by Solent Health. Acute services are provided by Frimley Park Hospital Foundation Trust. Primary care services are provided by the 24 practices and there are a range of other essential services (e.g. hospice care, social care, third sector providers) which make up the complex current healthcare landscape.

It was acknowledged that there were immediate opportunities to improve the services that patients with COPD receive at the end of life. As a result we are developing a pilot integrated care team and establishing a clear integrated pathway of care for these patients. Within 12 months (as of April 2012) we aim to have an effective integrated team established receiving appropriate referrals, supporting patients along an agreed pathway of care, delivering an education programme for healthcare professionals and raising awareness for patients and carers of support and services available.

The project's objective is to develop excellence in service provision for patients with COPD at the end of life through:

- Establishing an integrated care team, made up of health and social care professionals working across North East Hampshire & Farnham, who currently provide COPD services to patients at the end of life.
- Establish a clear patient pathway for COPD patients at the end of life which is based on best practice, is easy to access and simple to understand (for patients, carers and health and social care professionals).
- Establishing a COPD education programme to deliver a joint professional training programme for those caring for patients with COPD at end of life.
- Improving awareness and accessibility of local COPD services for patients and carers with COPD at the end of life.
- Working collaboratively with clinical commissioners to establish the feasibility of jointly commissioning services along the patient pathway.

Action

The actions taken thus far include the establishment of a project team which has regular meetings to carry the work forward. Membership includes a representative from the CCG, Practice Nurses, Specialist Community Nurses, Community Matrons, GPs, Hospice Clinicians, Secondary Care Clinicians, Social Services, the Voluntary Sector, and a patient representative.

The project team has completed a mapping exercise to deduce the current patient pathway as it stands. This has been analysed for areas in the pathway which do not fulfil the integrated aspect of care we are striving for and also to identify gaps and shortcomings in the pathway from a patient perspective. From this exercise the project team has designed a new integrated pathway which should facilitate improved care for patients with COPD nearing end of life.

Questionnaires have been sent to practice nurses who lead on COPD to help determine areas of education and professional development to assist in improving care for COPD patients nearing end of life. Responses from the questionnaires have been analysed and are assisting the project team in designing an education programme for both practice and community nurses.

The following are the next steps for the project:

- Obtain baseline secondary care activity data for COPD patients nearing end of life to compare with when the 12 month project has completed. This will help determine whether secondary care activity has reduced as a result of the new pathway.
- Implement healthcare professional education programme focussing on end of life advanced communication skills with the aim of cascading training to health and social care teams.
- Run an awareness campaign for patients, carers, and health and social care teams regarding the new pathway and services available.
- Take the new care pathway to a Patient Participation Group to gain feedback and amend where necessary.

Impact

As the project is still at an early stage it is difficult to define any impact made so far. However, the project is similar to a pilot COPD pathway developed by Northumbria Healthcare NHS Foundation Trust in 2009 which showed evidence of reduced hospital admissions, reduced exacerbations for patients, and improved quality of care from a patient perspective. We envisage our project to produce similar outcomes and also assist in ensuring more patients die in their preferred place of care.

Word Count = 785