
CONFERENCE ABSTRACT

The Development of a Hub and Spoke Respiratory Service

19th International Conference on Integrated Care, San Sebastian, 01-03 April 2019

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Introduction: In Ireland the introduction of the National Quality in Clinical Care Programmes in COPD and Asthma in 2012 has led to a vast improvement in services for these respiratory conditions. This has included the introduction of COPD Outreach teams and Respiratory Integrated Care teams and the provision of pulmonary rehabilitation. However in areas where there is a large geographical area serviced, appointed teams are only able to provide a service to a very small proportion of the population and there can be a duplicity of roles and services.

Description practice change: A re-orientation of respiratory service delivery between Primary and Secondary care in Co. Donegal, Ireland was undertaken to ensure a multifaceted integrated respiratory service which utilises finite resources efficiently.

Aim and theory of change: The main goals and aims of the re-orientation were to provide an equitable and accessible service to a wide geographical area, provide a service as close to patients homes as possible, improve access to services to referring agents and to increase the number of pulmonary rehabilitation programmes available.

Targeted population and stakeholders: Services are to be accessible to all respiratory patients with the main stakeholders being Respiratory Consultants, Non-Respiratory Consultants, GP's, Primary Care teams, COPD Outreach and Respiratory Clinical Nurse Specialists.

Timeline: A Pulmonary Rehabilitation service was established in Donegal (2007). COPD Outreach team was appointed (2012). Respiratory Integrated Care (RIC) team was appointed (2017). Pulmonary rehabilitation services expanded into three Primary Care network areas (2012). Pulmonary Rehabilitation referral pathway was reviewed to allow direct referrals from Non Respiratory Consultants & COPD Outreach (2012), GP's, Primary Care (2016) and RIC (2017). Additional respiratory services offered in the community (2015). Pilot GP screening programme undertaken in one Primary Care network (2017) Geographical split of respiratory services between RIC and Pulmonary Rehabilitation teams (2017). GP screening introduced to second Primary Care network (2018). Development and implementation of maintenance programme in two Primary Care Networks (2014 & 2018).

Highlights: The numbers of patients referred into the pulmonary rehabilitation services has increased, referral sources have widened, consultant waiting lists are thereby bypassed, community based pulmonary rehabilitation services are increasing, rehabilitation programmes have expanded and community maintenance programmes established.

Discussion/Conclusions/Sustainability/Transferability: Division of teams by geographical location has allowed a comprehensive hub and spoke respiratory service to be developed. This has reduced patient and staff travel, increased staff efficiency and expanded services provided to a

greater population area. This approach would be transferable to other services with a large geographical distribution.

There are however limitations to the service. In order to increase screening, meet continual review targets and increase the number of pulmonary rehabilitation programmes further, allocation of a third team would be required. This could achieve an equitable, sustainable service.

Lessons learned: Communication through feedback and focus groups have been essential in ensuring patient centred care that meets the needs of all patients whilst improving the patient's journey and experience. The absence of patient electronic health records results in duplication of patient care records and poor communication between services

Keywords: respiratory; integration; practice change; pulmonary rehabilitation; respiratory outreach
