



Warm Home For Lungs (WHFL)

Dianne Green

Lead COPD Nurse & Service Manager
St Helens Community Rapid Response Service
Mersey & West Lancashire Teaching Hospital

Graphnet

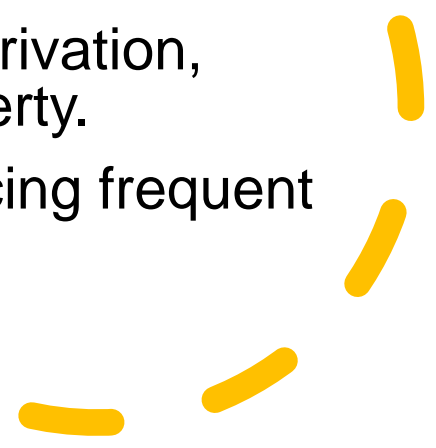
The screenshot shows a complex patient selection interface with the following filters and values:

- Age:** Range from 25 to 111.
- IMD Quintile:** 1
- QOF LTC Count:** All
- Risk of Emergency Admission:** >50%
- Sex:** All
- LA, Ward, LSOA:** All
- QOF Condition:** COPD
- MRS Quintile:** All
- Place, PCN, Practice:** All
- Ethnicity:** All
- Expanded Diagnostic Cluster (EDC):** All
- Medication, Flag:** All
- Nursing Home Flag:** N
- Fuel Poverty Quintile:** Quintile 1:LSOAs with the Highest % of Fuel ...
- Gold Standards Framework Register:** All
- Seen by Rapid Response (18M):** All
- Household Occupancy:** All
- Household Energy Rating:** All
- Patient Need Group:** All
- Disease Flag:** All
- Emergency Admissions Count (Last 12M):** Range from 0 to 50.
- Emergency Admission Specialty (Last 12M):** All
- GP Encounters in Last 12M (All types):** Range from 0 to 2479.
- Disease Flag Date:** Range from 01/01/1939 to 23/02/2024.
- A&E Attendances (Last 12M):** Range from 0 to 43.
- N Salbutamol Inhalers (Last 12M):** Range from 0 to 41.
- N Emergency Admissions: 0 LOS (Last 12M):** Range from 0 to 15.
- N Emergency Admissions: 1 LOS (Last 12M):** Range from 0 to 19.
- Optimum Inhaler Therapy (Last 12M):** All

Through Graphnet we identified:

320 patients living in quintile 1 for deprivation,
Quintile 1 Highest % living in fuel poverty.

Diagnosed with COPD and experiencing frequent
hospital admissions.



Referrals

Identified 320 patients who:

- who may never have been referred to the COPD service for support & optimisation
- coded as COPD with no confirmed diagnosis -referral into our diagnostic service
- struggling to pay their Bills
- living in a cold damp environment

WHFL outcomes:

240 patients referred for Household support Fund (171 received Payment further 69 patients awaiting assessment for payment)
Received 500.00 payment (£85,500)
43 received second payment (21,500)
Total Funds given = £107,000 (141,500)

5 patients received new replacement boilers

9 patients have had the home insulated and other are waiting

4 patients referred to Occupational Therapist

20 patients received benefits advice (one patient identified became 9K annual better off and another patient 5K better off per annum)

100 patients added to the Priority service register and 42 already on register

190 light bulbs provided

2 received emergency fuel funds

COPD patients

- 169 patients reviewed, optimised, inhaler technique and self- management plan
- 120 Oxygen saturation probes provided
- 92 volumatic spacers devices replaced
- 159 referral sent to wellbeing social prescribers, smoking cessation , health trainers, weight management
- 20 referrals to Pulmonary rehabilitation
- 20 patients referred to telehealth for monitoring
- 320 patients received a Warm Homes booklet and a vitamin D Voucher for 3 months free treatment
- 121 Type 2 oxygen alert packs & NWS Community Care plans provided



Meet Jo

- o Dual diagnosis of COPD with primary condition pulmonary fibrosis.
- o Require high flow oxygen 24 hours per day.
- o Living in a cold home, can't afford rising energy bills.
- o Self-managing a deteriorating condition.
- o Needs a bespoke ramp, struggling to get out of the house in his scooter.
- o Wife and son feel isolated, stressed and anxious.
- o Having to choose between heating his home or using his oxygen.



Household Improvement

- o Provision of replacement boiler.
- o Risk assessment of home including storage of the oxygen , ventilation, fire breakers, care of the concentrator .
- o Complete application for household support fund.
- o Installation of bespoke ramp that could not be provided by the social services.



WarmHomes for Lungs

- o Referred to Affordable Warmth Team for household assessment.
- o Referred for an OT assessment for a stair lift and ramp assessment.
- o Assisted to register on the Priority Services Register with energy provider.
- o Medication review - introduced oxygen saturation probe, oxygen concentrator and provision of a fan for fan therapy.
- o Household health education approach around his deteriorating condition including DNAR support.
- o Advanced care planning discussion including end of life and SR1.
- o Refused referral to pulmonary rehabilitation and well-being service.
- o Wife referred to St Helens carer society for support.

Patient Outcome

- ✔ **Better self-management** of condition.
- ✔ **Financial savings** because of new prescription oxygen concentrator for 8 hours and then using more cylinder in the day .
- ✔ **Safer home** reduced fire and harm risk.
- ✔ **£500 household warmth fund** paid towards improvements. This fund will also be paid again in October 2023 for preparation for winter.

St Helens WarmHomes for Lungs Project Report

Some comments from Patient Feedback Forms.

As soon as I was referred,
I got a visit.

Helped me not think about
bills as much.

These nurses are most
helpful at reducing
stress levels.

They are always there to help
with problems and
discuss ways to help.

They have made life easier.

Means I don't have to rely
on family as much.

Before, I was not using
heating but its better now.

More people should use it as
I think it has done a lot for
me and my partner, thank you.

I have felt that it has taken away
some of the pressure from my
partner, who does a lot for me,
and I know I can get in touch
any time I need you all.

These nurses are most helpful
at reducing stress levels.

You have been there when I
need you and its
has helped me a lot.