Report of
The National Chronic Obstructive Pulmonary Disease Audit 2008,
UK Primary Care Organisations:
Resources and Organisation of Care

St Elsewhere Primary Care Organisation

Royal College of Physicians of London,
British Thoracic Society and
British Lung Foundation

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On behalf of the National COPD Audit 2008 Steering Group

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- Dr Steve Holmes, General Practitioner, General Practice Airways Group.
- Dr Stephanie Taylor, Honorary Consultant in Public Health, Tower Hamlets Primary Care Trust.
- Dr Ian Basnett, Public Health Consultant, Tower Hamlets Primary Care Trust.

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- Dr Paul Tate and Dr David Ross: St Richard's Hospital, West Sussex.
- Dr Catherine Thompson, Victoria Parker and Felicity Chastney: Salisbury District Hospital, Wiltshire.
- Stephen Callaghan: Liverpool Primary Care Trust.
- Nicky Hughes: Cardiff Local Health Board.
- Dr Margaret O'Brien: Northern Health & Social Services Board.
- Maureen Carroll and colleagues: NHS Lanarkshire.
- Taunton Breathe Easy Group.
- The Lung Club, Whipps Cross University Hospital Chest Clinic.
- Blackdown Hills Breathe Easy Group.

We acknowledge and very much appreciate the time and effort given by all clinical and audit colleagues across the NHS, in order to contribute to this project.

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Executive summary

Chronic Obstructive Pulmonary Disease (COPD) is the fifth biggest cause of death in the UK, the second most common cause of emergency admission to hospital, one of the most costly in-patient conditions treated by the National Health Service (NHS) (British Lung Foundation 2007)[1] and a major cause of morbidity within Primary Care. With effective services and treatment, exacerbations of COPD can be shortened so reducing the need for hospital admission and improving the outcomes and quality of life for patients.

Previous national audits of COPD, in 1997 and 2003, focussed on care in Acute NHS Hospitals. Since that time, the National Institute for Clinical Excellence (NICE)[2] has published its guideline on the management of chronic obstructive pulmonary disease in adults in primary and secondary care (2004), followed by two Commissioning Guides to support COPD clinical service design; namely assisted-discharge service for patients with COPD, and pulmonary rehabilitation services for patients with COPD (2006)[3]. More recently the Department of Health has embarked on developing a COPD Programme for England [due for publication in 2009].

This third round of national COPD audit has been carried out to assess progress since the 2003 National COPD Audit and the 2004 NICE guidance. It builds on the two audits of acute COPD care in 1997 and 2003 and, for the first time, recognises the developing integration of COPD services across the primary and secondary care interface by including Primary Care Organisations (PCOs).

An organisational survey of United Kingdom NHS Primary Care Organisations was undertaken, with participating PCOs completing a cross-sectional paper-based survey (see Appendix B) about the resources and organisation of care for people with COPD in their locality. One hundred and forty-one PCOs from across the UK completed and returned the survey, a participation rate of 73% NHS PCOs. Data collection and submission took place between 30th March and 20th June 2008.

This report only describes the Primary Care Organisation 'resources and organisation of care' element of the 2008 national COPD audit. The four other elements of the audit (listed below) will be reported separately and will be available at the RCP web-site when published:
http://www.rcplondon.ac.uk/clinical-standards/ceeu/Current-work/Pages/copd-audit.aspx

[1] British Lung Foundation, 2007. Invisible lives: Chronic Obstructive Pulmonary Disease (COPD) finding the missing millions. Available at: http://www.lunguk.org/NR/rdonlyres/E027CA18-B5C6-49AB-96FA-C4AF55E6F484/0/InvisibleLivesreport.pdf (20 August 2008)
[2] National Institute for Clinical Excellence, 2004. National clinical guideline on management of chronic obstructive pulmonary disease in adults in primary and secondary care.
[3] National Institute for Clinical Excellence, 2006. Commissioning guides: supporting clinical service redesign. Available at: http://www.nice.org.uk/usingguidance/commissioningguides/commissioning_guides_8211_supporting_clinical_service_redesign.jsp (26 August 2008)

- The National COPD Audit 2008: resources and process of care in acute NHS units across the UK.

- The National COPD Audit 2008: clinical audit of COPD exacerbations admitted to acute NHS units across the UK.

- The National COPD Audit 2008: General Practitioner survey.

- The National COPD Audit 2008: patient survey.

Key messages from UK PCO Survey

- PCOs demonstrated a high level of participation in this national audit of services for people with COPD.

- PCOs commonly have COPD development groups, although it is unclear how these translate their administrative activity into delivery of care as only 46% of PCOs have an agreed COPD care pathway. This may reflect the developmental stage of such groups as 84% of the remainder have plans to develop pathways.

- The majority of PCOs state that they provide Community Pulmonary Rehabilitation (70%), Early Discharge (73%) and Admission Avoidance Schemes (75%).

- Only 44% of PCOs report formal palliative care arrangements for patients with COPD. Of the PCOs that had either a written agreed plan for developing their COPD services or had a plan in progress, 22% did not include palliative care services as part of these developments.

- There is significant investment in schemes involving case management, community matrons and admission avoidance despite a conflicting evidence base for effectiveness.

- There are multiple cited examples of self evaluation of local schemes reporting impressive outcomes but no external validation of these data.

- There are not many stated examples of good practice exemplifying good team working and collaboration between Primary and Secondary Care.

- There is a wide range of staff, with very variable job titles and professional backgrounds, apparently responsible for developing COPD services within PCOs.

Recommendations

- We recommend that further careful prospective audits of outcomes as well as economic benefit are planned and undertaken as Community COPD services develop or emerge.

- Schemes involving case management and admission avoidance in particular should be subject to high quality evaluation including peer review scrutiny.

- There is a significant gap in the provision of palliative care for patients with COPD, despite evidence of effective interventions that are not being currently commissioned. We recommend PCO service improvement plans contain a mandatory consideration of end of life care services for patients with COPD.

- There should be a mechanism to facilitate the sharing of information and evidenced data between PCOs who are developing their COPD services in order to avoid repetition and maximise the benefit of these changes to patients and local health economies.

- We endorse the good practice reported by those PCOs that are developing multidisciplinary services which cross sector and service boundaries.

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Introduction

The National COPD Audit 2008 was overseen by a partnership between the Clinical Effectiveness and Evaluation unit (CEEu) of The Royal College of Physicians of London (RCP), the British Thoracic Society (BTS) and the British Lung Foundation (BLF).

The audit aims to:

- Enable units to compare their performance against national standards.
- Identify resource and organisational factors that may account for observed variations in outcome.
- Facilitate improvement in the quality of care.
- Identify changes since the 2003 National COPD Audit (Royal College of Physicians and British Thoracic Society, 2003)[4].
- Collect data about the resources and organisation of COPD services in Primary Care Organisations across the UK.

Governance of the project

The National COPD Audit 2008 was governed by two groups (Appendix A).

- A Steering Group, comprising representatives from Respiratory Medicine and Nursing, Physiotherapy, Geriatric and Intensive Care Medicine, Public Health, Primary Care and Patients. The Group met on a quarterly basis to ensure the audit's relevance to those receiving and delivering COPD services in the UK.
- A smaller executive Implementation Group, drawn from membership of the Steering Group, met on a monthly basis to monitor progress, support and direct the project.

Audit Methodology

The 2008 National COPD Audit was similar to previous audits of acute COPD care undertaken in 1997 and 2003, albeit with three additional elements. Thus, a cross-sectional resource and organisation of care audit was followed by a clinical audit of up to 60 cases admitted to hospital with an exacerbation of COPD during the data collection period. Cases were identified prospectively, with process of care and 90 day clinical outcomes audited retrospectively.

Furthermore, for the clinical case audit, hospital teams were requested to forward a survey to the General Practitioners of the first 30 audited patients admitted with a COPD exacerbation. The teams were asked also to request that 30 of their 60 audited patients complete a survey and return it anonymously to the project team at the CEEu via a pre-paid envelope.

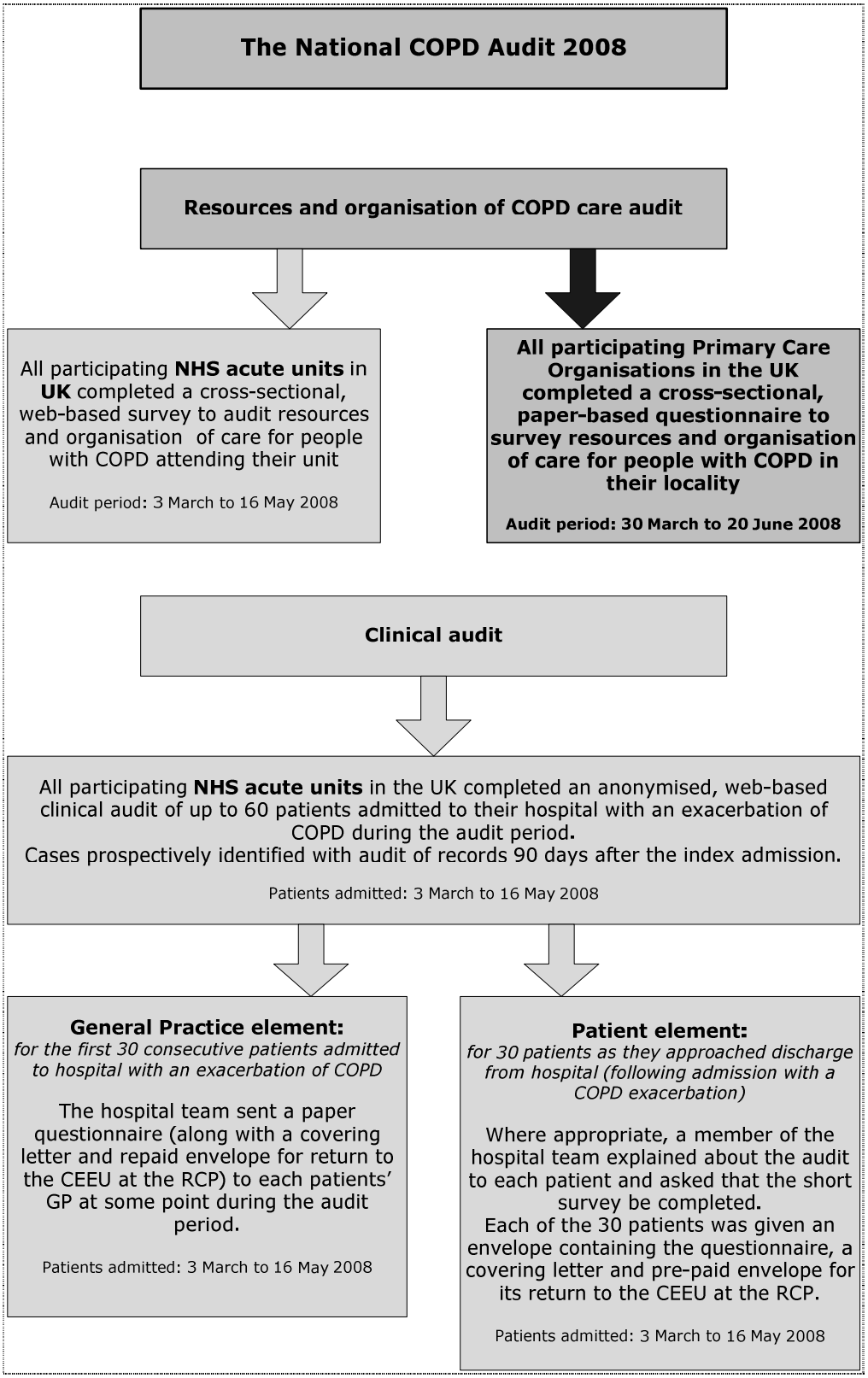
[4] Royal College of Physicians and British Thoracic Society, 2003. Report of the 2003 National COPD Audit. Available at: http://www.rcplondon.ac.uk/clinical-standards/ceeu/Current-work/Documents/NCROP%20nationalCOPDaudit2003report.pdf (20 August 2008)

The purpose of these surveys was to explore aspects of COPD around the acute care pathway from different perspectives.

In 2008, for the first time, an organisational survey of United Kingdom NHS Primary Care Organisations (PCOs) was undertaken, with participating PCOs completing a cross-sectional paper-based questionnaire about the resources and organisation of care for people with COPD in their locality. The methodology for the entire National COPD Audit 2008 is illustrated in Figure 1 below.

This report describes the results from the resources and organisation of care element of the Primary Care Organisation survey only (illustrated dark grey in Figure 1 below). Reports of the other audit elements can be obtained from the RCP web-site when published: http://www.rcplondon.ac.uk/clinical-standards/ceeu/Current-work/Pages/copd-audit.aspx

Figure 1: The National COPD Audit 2008: methodology



Recruitment of PCOs to complete the resources and organisation of care survey

A letter to introduce the audit was sent to the Chief Executive Officers of all UK NHS Primary Care Organisations in October 2007. The letter provided information about the forthcoming audit and requested support by way of a representative being nominated to complete a paper-based questionnaire about local COPD services. The nominated person was to have an understanding of the local COPD services: for example, a Commissioner, Service Manager or Clinical Governance team member. The project team at CEEu would then work closely with this person during the audit period.

Sustained efforts were made to co-opt Primary Care Organisations that did not respond to the initial request for support: Chief Executive Officers were contacted again by letter in December 2007. In January 2008, letters were sent to Public Health Consultants, Clinical Governance Managers, Quality and Outcomes Framework Leads and Commissioner / Service Leads responsible for COPD services to share news of the audit and co-opt participation. A further email was sent to individual Chief Executive Officers of the Primary Care Organisations that still had not registered to participate at the start of the audit.

Methods

Surveys were sent by post to the nominated person at each participating PCO at the end of March 2008, along with a covering letter and pre-paid envelope to return completed surveys to the CEEu. In addition, surveys were also sent to the Chief Executive Officers of all non-registered PCOs. A number of PCO contributors requested an electronic copy of the survey so that it could be completed and returned to the project team at the CEEu by email.

Development of the survey questions

There was wide consultation (e-mail, phone and face-to-face meetings) on the survey questions amongst the project Steering Group members and their primary care colleagues. This was followed by a pilot phase to test the survey with a PCO representative from each country who had been co-opted to participate.

An evaluation of the pilot phase emphasized major differences in the organisation of healthcare in each of the four home countries and thus further debate ensued. Changes to the survey were subsequently made in order to ask generic quantitative questions about the resources and organisation of COPD services in each country. In order to acknowledge and capture the differences in healthcare organisation in each country, contributors were able to clarify the data they submitted and provide examples of what they considered to be good or innovative practice as free-text when completing the survey.

Data collection

Data collection and submission took place between 30th March and 20th June 2008. Completed surveys were sent either by post via pre-paid envelopes, or email, to the project team at the CEEu where data were entered to a SPSS database (SPSS V15.0) in preparation for analysis.

Wherever possible, clarity was sought from the contributor where a response was unclear or there was contradiction in the data they supplied.

Systematic checking of data entry to SPSS was followed by analysis by the medical statistician.

Telephone and email support

The project team provided dedicated support to deal with queries or comments from contributors throughout the audit; a telephone helpline was available from Monday to Friday, 9.30am to 4.30pm, and queries could be emailed directly to the project team using a dedicated address: copd.audit@rcplondon.ac.uk

PCO contributors were kept informed of project progress by a project update halfway through the data collection period, and with copies of the quarterly National COPD Audit 2008 Newsletter.

Presentation of results

This report gives your individual PCO results alongside the summary results for all PCOs responding to this survey.

Results

Responses were received from 141 PCOs: 114 England, 17 Wales, 5 Scotland, 3 Northern Ireland, 2 the Islands (Appendix C). The percentage return rate overall was 73% (141/192) and by country was 77% (114/148) for England, 77% (17/22) for Wales, 36% (5/14) for Scotland, 75% (3/4) for Northern Ireland and 50% (2/4) for the Islands.

COPD register				
	Median	IQR	PCOs	**Your PCO**
How many patients are on the COPD register in your Primary Care Organisation? (at the time of completing questionnaire)	4331	2909-7047	129 with data	

Development of COPD services			
		PCOs	**Your PCO**
Is there a group that is responsible for developing COPD Services across your Primary Care Organisation? (e.g. a commissioning or service development group or a Managed Care Network)	86% Yes	119/139	
Is there a written, agreed plan to develop COPD services across your Primary Care Organisation?	50% Yes 39% in development 11% No	70/140 55/140 15/140	
If YES or in development:			
• It includes PULMONARY REHABILITATION	97% Yes	112/116	
• It includes EARLY DISCHARGE SCHEME	90% Yes	103/115	
• It includes ADMISSIONS AVOIDANCE	93% Yes	106/114	
• It includes PALLIATIVE CARE	78% Yes	90/115	

Agreed care pathway			
		PCOs	**Your PCO**
Is there an agreed care pathway for managing COPD across your Primary Care Organisation?	46% Yes 45% In development 9% No	64/139 63/139 12/139	

Pulmonary Rehabilitation			
		PCOs	**Your PCO**
Is a Community Pulmonary Rehabilitation Programme* currently provided within your PCO?	70% Yes	99/141	
If Yes, who funds the programme:	83% by PCO 4% by Local Hospital 11% Jointly by PCO and local Hospital 2% Not funded	82/99 4/99 11/99 2/99	

* Multi-disciplinary rehabilitation in a community setting including an exercise component and at least weekly for minimum of 6 weeks. Excluding hospital-based/organised programme

Patient access to an Early Discharge Scheme			
		PCOs	**Your PCO**
Do COPD patients within your Primary Care Organisation currently have access to an Early Discharge Scheme? (including 'Hospital at Home'	73% Yes	101/139	

Admission avoidance scheme			
		PCOs	**Your PCO**
Do COPD patients within your Primary Care Organisation currently have access to an Admissions Avoidance Scheme*?	75% Yes	104/138	

***A scheme that cares for patients in the community, so avoiding hospital admission**

Long-term oxygen therapy (LTOT)			
		PCOs	**Your PCO**
Where do Long Term Oxygen Therapy (LTOT) assessments currently take place for patients within your Primary Care Organisation?	53% Hospital only	75/141	
	4% Primary care only	5/141	
	40% both hospital and primary care	57/141	
	3% None	4/141	

Oxygen register				
	Median	IQR	PCOs	**Your PCO**
How many COPD patients are on the oxygen register at your PCO? (Please include only COPD patients, exclude children or palliative care patients)	368	199-600	89 with data	

Palliative care			
		PCOs	**Your PCO**
Are there formal arrangements for patients with COPD to receive palliative care in your area?	44% Yes	59/135	

Self-reporting of good or innovative practice

PCOs were asked to volunteer examples of good or innovative practice. 92 PCOs commented, and it is apparent that PCOs are enthusiastic in wishing to share these examples with one another, even if there is no formal mechanism for doing so. It is also clear that much work is being done to benefit patients with COPD in Primary Care.

We have grouped responses into themes below, but verbatim responses are also listed in Appendix D at the end of the report, alongside e-mail contacts for those wishing to obtain further information or make contact with another service.

Key Messages arising from self-reporting:

- There is a wide variety of development activity, clinical and commissioning, occurring in PCOs across the UK with many innovative concepts.
- These areas of good practice may be grouped into themes as described below.
- Many PCOs now have Community COPD teams but there doesn't seem to be a consistent structure or care model developing for these groups.
- Some Community Teams report a marked effect on reducing hospital admissions but there are no corroborating published data.
- Although not specifically asked to do so, there are few reported examples of patient involvement in developing Community COPD services cited as good or innovative practice.
- There are few reported examples of Primary and Secondary Care collaboration.
- PCOs have not reported evidence that systematic audit is undertaken to assess the quality of emerging services.
- PCOs have not presented evidence to assess the health, and economic, benefits of the projects described.

MAIN THEMES	Sub-Themes	PCO codes (see Appendix D)
Developing Community COPD team	Nurse-led services. Rehab. Oxygen. Admission avoidance. Intermediate care. Rapid response. Community COPD Units. Community care pathways.	802, 803, 805, 808, 809, 810, 823, 828, 830, 835, 837, 860, 867, 871, 879, 885, 896, 908, 911, 918, 920, 924, 928, 929, 939, 940, 943, 954, 981, 982
Community Matrons	Enhancing their role. Developing Community COPD Matrons.	805, 813, 846, 879, 892, 908, 933, 935, 966
Enhancing Primary-Secondary Integration	Developing comprehensive integrated care pathways. Partnerships between Acute and Primary Care Trusts. Joint managerial posts.	802, 803, 836, 849, 865, 866, 871, 883, 895, 941, 942, 963, 987
Focus on Education	Supporting Practices. Using Map of medicine. Staff training and education.	815, 827, 831, 835, 846, 863, 867, 871, 890, 892, 895, 898, 902, 911, 920, 948, 961, 986, 987
Focus on Spirometry	Using spirometry for early diagnosis. Community spirometry service.	867, 883, 932, 952, 960, 975, 987
Using Tele-health	Self-reporting. Vulnerable patients.	835, 836, 847, 860, 867, 897, 911, 961, 966, 990, 992
Enhancing Home Care	Visiting. Dedicated home care. Involving care home staff.	803, 805, 809, 835, 860, 898, 934, 942, 945, 992
Enhancing Palliative Care Services	Include palliative care in pathways. Linking to palliative care in development.	831, 864, 871, 897, 898, 908, 933, 934, 949, 969, 987
Patient Involvement	Involving patient support groups. Involving patients in planning. Involving Voluntary Sector.	836, 895, 911, 926, 929, 945, 982, 986
Self-care	Promoting self-care. Personal COPD plans.	809, 827, 836, 845, 846, 897, 902, 911, 933, 960, 966, 981
Use of Weather warning	Met Office scheme	813, 835, 883, 911, 934, 938, 969, 975, 985, 991
Audit	Evidence of audit taking place. Audit integral to service design.	808, 823, 828, 830, 851, 875, 885, 931, 943, 945, 948, 963

Professional roles of those completing the survey

PCO Chief Executives were requested to nominate an individual responsible for developing their COPD service. The table below outlines the broad categories of staff nominated by PCO Chief Executives to complete the Audit. The data suggest there is a wide variety of professional roles tasked with developing COPD services in PCOs.

JOB ROLE	% of total	Number
CLINICAL CATEGORIES		
Nursing	18%	25
Medical	13%	19 (11 Scotland)
Service Lead	2%	3
Physiotherapist	1%	2
MANAGERIAL CATEGORIES		
Miscellaneous	22%	31
Commissioning	16%	22
Service Improvement	11%	15
Directors of Care	7%	10
Programme Management	7%	10
Long-term Conditions	6%	9
Audit Management	6%	9
Unknown	1%	1

* 141 PCOs responded, with some overlap in roles (hence total number of job roles is 156). Percentages reached with denominator of 141. Appendix E shows the actual role of the person completing the PCO survey and the frequency with which they occurred.

Appendix A: Membership of the National COPD Audit 2008 Steering and Implementation Groups

The National COPD Audit 2008 Steering Group

- Professor Mike Roberts, Associate Director of the National COPD Audit 2008: Consultant Respiratory Physician, Whipps Cross University Hospital, London, Barts and The London School of Medicine and Dentistry, Queen Mary University of London.
- Dr Robert Stone, Associate Director of the National COPD Audit 2008: and Consultant Respiratory Physician, Musgrove Park Hospital, Taunton.
- Dr Ian Basnett, Public Health Consultant, Tower Hamlets Primary Care Trust, London.
- Rhona Buckingham, National COPD Audit 2008 Project Manager, Clinical Effectiveness and Evaluation unit, Royal College of Physicians.
- Maria Buxton, Consultant Physiotherapist, Central Middlesex Hospital and Brent Primary Care Trust.
- Dr John Coakley, Medical Director, Homerton University Hospital NHS Foundation Trust.
- Denise Daly, Consultant Physiotherapist, Royal Surrey County Hospital, Guildford.
- Sheila Edwards, Chief Executive, British Thoracic Society.
- Professor Brian Harrison, British Thoracic Society.
- Dr Steve Holmes, General Practitioner, General Practice Airways Group (GPIAG).
- Kevin Holton, Head of the COPD National Service Framework (NSF) Team, Department of Health.
- Dr Harold Hosker, Consultant Respiratory Physician, Airedale General Hospital, Keighley.
- Jane Ingham, Director of Clinical Standards, Royal College of Physicians.
- Dr Lawrence McAlpine, Consultant Physician, Monklands Hospital, Airdrie.
- Dr Phyo Myint, Honorary Consultant Physician, Norfolk and Norwich University Hospitals.
- Fiona Phillips, Public Health Consultant, COPD National Service Framework (NSF) Team, Department of Health.
- Dr Jonathan Potter, Clinical Director, Clinical Effectiveness and Evaluation unit, Royal College of Physicians.
- Samantha Prigmore, Respiratory Nurse Consultant, St George's Hospital, London.
- Nancy Pursey, National COPD Audit 2008 Project Co-ordinator, Clinical Effectiveness and Evaluation unit, Royal College of Physicians.
- Carol Rivas, Research Fellow, Queen Mary's School of Medicine & Dentistry, University of London.
- Anil Seiger, Manager, Clinical Effectiveness and Evaluation unit, Royal College of Physicians.
- Dame Helena Shovelton, Chief Executive, British Lung Foundation.
- Teresa Smith, Chest Clinic Manager, King Edward VII Hospital, Windsor.
- Dr Stephanie Taylor, Senior Clinical Lecturer Health Services Research & Development, Queen Mary's School of Medicine & Dentistry, University of London / Honorary Consultant in Public Health, Tower Hamlets PCT.

The National COPD Audit 2008 Implementation Group

- Professor Mike Roberts, Associate Director of the National COPD Audit 2008: Consultant Respiratory Physician, Whipps Cross University Hospital, London, Barts and The London School of Medicine and Dentistry, Queen Mary University of London.
- Dr Robert Stone, Associate Director of the National COPD Audit 2008: and Consultant Respiratory Physician, Musgrove Park Hospital, Taunton.
- Rhona Buckingham, National COPD Audit 2008 Project Manager, Clinical Effectiveness and Evaluation unit, Royal College of Physicians.
- Sheila Edwards, Chief Executive, British Thoracic Society.
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- Dr Harold Hosker, Consultant Respiratory Physician, Airedale General Hospital, Keighley.
- Jane Ingham, Director of Clinical Standards, Royal College of Physicians.
- Dr Jonathan Potter, Clinical Director, Clinical Effectiveness and Evaluation unit, Royal College of Physicians.

- Samantha Prigmore, Respiratory Nurse Consultant, St George's Hospital, London.
- Nancy Pursey, National COPD Audit 2008 Project Co-ordinator, Clinical Effectiveness and Evaluation unit, Royal College of Physicians.
- Carol Rivas, Research Fellow, Queen Mary's School of Medicine & Dentistry, University of London.
- Anil Seiger, Manager, Clinical Effectiveness and Evaluation unit, Royal College of Physicians.
- Dame Helena Shovelton, Chief Executive, British Lung Foundation.
- Dr Stephanie Taylor, Senior Clinical Lecturer Health Services Research & Development, Queen Mary's School of Medicine & Dentistry, University of London / Honorary Consultant in Public Health, Tower Hamlets PCT

Appendix B: The National COPD Audit 2008 - Primary Care Organisation Questionnaire

The National Chronic Obstructive Pulmonary Disease (COPD) Audit 2008
Primary Care Organisation - Resource and Process of Care Survey

The term 'Primary Care Organisation' (PCO) is the generic term used throughout this survey and should be interpreted locally as Primary Care Trust in England, Local Health Board in Wales, Health Board in Scotland and Area Health Board in Northern Ireland.

Please complete the survey reporting the *current* status of COPD services within your Primary Care Organisation - at the time of completing the survey.

Please answer every question in the space provided by ☑ in the box where appropriate, or writing free text in the space provided. At the end of the questionnaire there is space to clarify your answers if you feel this is necessary. Additionally we are very keen to hear examples of good or innovative practice so if there's an element of COPD care in your area that you feel is worthy of a mention, please tell us about it in the space at the end of the survey.

If you prefer to complete this survey electronically, please contact the project team via email at copd.audit@rcplondon.ac.uk and they will send the survey to you.

The deadline for return of completed Q's is **Friday 31st May 2008.**

Any questions? If you have any questions about completing this survey or indeed wider aspects of The National COPD Audit 2008, please contact us by email via copd.audit@rcplondon.ac.uk or by phone via the National COPD Audit 2008 helpline 020 7935 1174 ext 551.

1	**Site Code** (already allocated)	
2	**Site Name**	
3	**Surname of auditor**	
4	**First name of auditor**	
5	**Email address of auditor**	
6	**Role of auditor** (please record your job title)	
7	**Date of completion**	

8	**How many patients are on the COPD register in your Primary Care Organisation?** (Please record the number of patients on the PCOs COPD register at the time of completing this questionnaire)	
9a	**Is there a group that is responsible for developing COPD Services across your Primary Care Organisation?** (For example, a commissioning or service development group or a Managed Care Network)	☐ Yes ☐ No
9b	**Is there a written, agreed plan to develop COPD services across your Primary Care Organisation?**	☐ Yes ☐ No ☐ In development
9c	**If there is a written, agreed plan to develop COPD services across your Primary Care Organisation (or one in development), please indicate whether it includes each of the following service areas:** **i. Pulmonary rehabilitation** **ii. Early discharge scheme** **iii. Admissions avoidance** **iv. Palliative care** If you wish to provide further information about your plans, there is space at the end of the survey for you to do this.	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
10	**Is there an agreed care pathway for managing COPD across your Primary Care Organisation?**	☐ Yes ☐ No ☐ In development
11a	**Is a Community Pulmonary Rehabilitation Programme currently provided within your PCO?** (This is a multidisciplinary package of rehabilitation for COPD patients delivered in a community setting including an exercise component and taking place at least weekly for a minimum of 6 weeks. This excludes hospital-based or hospital-organised programmes)	☐ Yes ☐ No
11b	**If yes, who funds the Community Pulmonary Rehabilitation programme?**	☐ Primary Care Organisation ☐ Local hospital ☐ Jointly funded by PCO and local hospital ☐ Charitable funds ☐ Not funded

12	**Do COPD patients within your Primary Care Organisation currently have access to an Early Discharge Scheme?** (Early Discharge Schemes have a variety of names including 'Hospital at Home', The scheme is provided for patients who present at hospital and would otherwise have been admitted but are accepted by an Early Discharge Scheme or Hospital at Home Scheme, or are discharged early from hospital into the care of one of those schemes)	☐ Yes ☐ No
13	**Do COPD patients within your Primary Care Organisation currently have access to an Admissions Avoidance Scheme?** (A scheme that cares for patients in the community, so avoiding hospital admission)	☐ Yes ☐ No
14a	**Where do Long Term Oxygen Therapy (LTOT) assessments currently take place for patients within your Primary Care Organisation?**	☐ Hospital only ☐ Primary Care only ☐ Both Hospital and Primary Care ☐ None
14b	**How many COPD patients are on the oxygen register at your PCO?** (Please include only COPD patients, exclude children or palliative care patients)	
15	**Are there formal arrangements for patients with COPD to receive palliative care in your area?**	☐ Yes ☐ No
16	**Please use the space below to clarify any of your answers to the above questions.**	

17	**We are very keen to hear examples of good or innovative practice – if you wish to share examples, please tell us about them here.**

Thank you very much for completing this survey.

Please return it to the project team via the pre-paid envelope provided:
The National COPD Audit 2008, Clinical Effectiveness and Evaluation Unit, The Royal College of Physicians
St Andrews Place, Regent's Park, London NW1 4LE

Appendix C: List of participating NHS Primary Care Organisations

Barking and Dagenham Primary Care Trust
Barnet Primary Care Trust
Bassetlaw Primary Care Trust
Bath & North East Somerset Primary Care Trust
Bedfordshire Primary Care Trust
Berkshire East Primary Care Trust
Berkshire West Primary Care Trust
Bexley Care Trust
Birmingham East & North Primary Care Trust
Blackpool Primary Care Trust
Bolton Primary Care Trust
Bournemouth and Poole Primary Care Trust
Bradford and Airedale Teaching Primary Care Trust
Bridgend Local Health Board
Brighton & Hove City Primary Care Trust
Bromley Primary Care Trust
Buckinghamshire Primary Care Trust
Bury Primary Care Trust
Caerphilly Teaching Local Health Board
Cambridgeshire Primary Care Trust
Camden Primary Care Trust
Cardiff Local Health Board
Carmarthernshire Local Health Board
Central and Eastern Cheshire Primary Care Trust
Central Lancashire Primary care Trust
Conwy Local Health Board
Cornwall and Isles of Scilly Primary Care Trust
County Durham Primary Care Trust
Coventry Teaching Primary Care Trust
Croydon Primary Care Trust
Cumbria Primary Care Trust
Darlington Primary Care Trust
Denbighshire Local Health Board
Derby City Primary Care Trust
Derbyshire County Primary Care Trust
Devon Primary Care Trust
Doncaster Primary Care Trust
Dudley Primary Care Trust
Ealing Primary Care Trust
East and North Hertfordshire Primary Care Trust
East Lancashire Primary Care Trust
East Riding of Yorkshire Primary Trust
Eastern Health & Social Services Board
Enfield Primary Care Trust
Flintshire Local Health Board
Gloucestershire Primary Care Trust
Great Yarmouth & Waveney Primary Care Trust
Gwynedd Local Health Board
Halton and St Helens Primary Care Trust
Hammersmith and Fulham Primary Care Trust
Hampshire Primary Care Trust
Haringey Teaching Primary Care Trust
Harrow Primary Care Trust
Havering Primary Care Trust
Heart of Birmingham Primary Care Trust
Heywood, Middleton & Rochdale Primary Care Trust
Hillingdon Primary Care Trust
Hounslow Primary Care Trust
Hull Teaching Primary Care Trust
Islington Primary Care Trust
Kensington and Chelsea Primary Care Trust
Kirklees Primary Care Trust
Knowsley Primary Care Trust
Leeds Primary Trust
Leicester City Primary Care Trust
Leicestershire County and Rutland Primary Care Trust
Lewisham Primary Care Trust
Lincolnshire Primary Care Trust
Liverpool Primary Care Trust
Luton Teaching Primary Care Trust
Manchester Primary Care Trust
Merthyr Tydfil Local Health Board
Mid Essex Primary care Trust
Middlesbrough PCT & Redcar and Cleveland PCT
Milton Keynes Primary Care Trust
Monmouthshire Local Health Board
Neath Port Talbot Local Health Board
NHS Ayrshire & Arran
NHS Greater Glasgow & Clyde
NHS Lanarkshire
NHS Lothian
NHS Orkney
North East Essex Primary Care Trust
North East Lincolnshire Care Trust Plus
North Lincolnshire Primary Care Trust
North Somerset Primary Care Trust
North Tees & Hartlepool Primary Care Trusts
North Yorkshire and York Primary Care Trust
Northamptonshire Teaching Primary Care Trust
Nottingham City Primary Care Trust
Nottinghamshire County Teaching Primary Care Trust
Oxfordshire Primary Care Trust
Pembrokeshire Local Health Board
Peterborough Primary care Trust
Plymouth Teaching Primary Care Trust
Portsmouth City Teaching Primary Care Trust
Powys Local Health Board
Redbridge Primary Care Trust
Rhondda Cynon Taff Teaching Local Health Board
Richmond & Twickenham Primary Care Trust
Rotherham Primary Care Trust
Salford Primary Care Trust
Sandwell Primary Care Trust
Sefton Primary Care Trust
Shropshire County Primary Care Trust
Solihull Care Trust
Somerset Primary Care Trust
South Birmingham Primary care Trust
South East Essex Primary Care Trust
South Staffordshire Primary Care Trust
South West Essex Primary Care Trust
Southampton City Primary Care Trust
Southern Health and Social Services Board
States of Guernsey Health & Social Services
States of Jersey Health & Social Services
Stockport Primary Care Trust
Stoke on Trent Primary Care Trust
Suffolk Primary Care Trust
Surrey Primary Care Trust
Sutton & Merton Primary Care Trust
Swindon Primary care Trust
Tameside and Glossop Primary Care Trust
Telford and Wrekin Primary Care Trust
Torbay Care Trust
Torfaen Local Health Board
Trafford Primary Care Trust
Vale of Glamorgan Local Health Board
Wakefield Primary Care Trust
Waltham Forest Primary Care Trust
Warrington Primary Care Trust
Warwickshire Primary Care Trust
West Essex Primary care Trust
West Hertfordshire Primary Care Trust
Western Cheshire Primary Care Trust
Western Health and Social Services Board
Westminster Primary Care Trust
Wirral Primary Care Trust
Wolverhampton Primary Care Trust
Worcestershire Primary Care Trust
Wrexham Local Health Board

Appendix D: The National COPD Audit 2008 – verbatim reports of good or innovative practice, with email contact details

A glossary of terms and acronyms is provided in Appendix F.

Site Code	Site Name	Q17 We are very keen to hear examples of good or innovative practice - if you wish to share examples, please tell us about them here	Email address of auditor
802	Barking and Dagenham Primary Care Trust	A community based Respiratory Service is in place which provides: Community Consultant outpatient clinics / Respiratory Nursing support, Pulmonary Rehabilitation Programme / Physiotherapist Lead, Oxygen assessment service, Education and training / support for practices. Breathe easy patient support group, Psychology support. Additional resource is being introduced this year to expand the Pulmonary Rehabilitation Programme and Oxygen Service.	lorraine.brown@bdpct.nhs.uk
803	Barnet Primary Care Trust	Hospital at Home scheme which includes early supported discharge and admission avoidance has been developed and uses a combined model with a community based specialist respiratory team being supported by intermediate care. This has the advantage of being able to access increased social care within 4 hours of referral to HaH scheme as well as weekend and evening nursing support. The community based Pulmonary Rehabilitation programme provides a rolling programme which runs on 3 different sites across Barnet (10 courses per year at present), offering local access and a choice of location to patients. The programme has referrals from both primary and secondary care and represents the patient focused shared vision between Barnet acute hospital and the PCT.	glenda.esmond@barnet-pct.nhs.uk
805	Bassetlaw Primary Care Trust	COPD Matron has been placed within the Intermediate Care Rapid Response Team to support the specific needs of COPD patients. COPD Matron can access community equipment and put in Community Rehabilitation Support Workers for up to 4 visits per day, for 7 days to support individuals in their own home and prevent unnecessary admission to hospital.	julie.walker@bassetlaw-pct.nhs.uk
808	Berkshire East Primary Care Trust	We have an established COPD nurse led service. This service provides a holistic assessment of patients needs including social and financial. This service is based in several sites across the district. Audit suggests that patients feel they benefit from the service. Rehabilitation is now a rolling programme and so patients can join fairly quickly after referral. Anyone can refer to this service; again this takes place across the district.	richard.sekula@berkshire.nhs.uk
809	Berkshire West Primary Care Trust	I attach a copy of the Newbury & district PBC Consortia proposal for a Community Respiratory Team. [The document is available from Berkshire West PCT.] I also attach a copy of the service specification for the roll-out of a pulmonary rehabilitation programme across Berkshire West to be provided by the Berkshire West PCT Clinical Services Directorate.	jill.dean@berkshire.nhs.uk
810	Bexley Care Trust	This was a new service developed in 2006 and in constant development. Once seen and stabilised patients can self refer back in the event of any exacerbations or problems for a home visit, clinic appointment or telephone advice. There is only one respiratory nurse to cover the trust.	deborah.roots@bexley.nhs.uk
813	Blackpool Primary Care Trust	The PCT has been working with three practices in Blackpool as part of a Foul Weather Project. The outcome of the pilot is due to be evaluated in the near future. The patients	brian.harrop@blackpoolpct.nhs.uk

		receive a pack containing: at home, information on COPD and how to keep warm, working in collaboration with the council warmer homes, loft insulation, helping vulnerable patients. The patients receive telephone contact when cold snaps are due. The practices are alerted that their patients are included in the pilot to ensure they are identified as being priority; they are also supported by community matrons. The patient satisfaction survey was excellent; patients appreciated the help from this service.	
815	Bolton Primary Care Trust	The PCT has developed a Chronic Disease Management team, headed up by a GPwSI for COPD. The team are supporting practices to ensure COPD registers are accurate; patients receive optimal care and case finding. They are also providing education for patients and staff and working to promote awareness of COPD amongst the public.	ann.berry@bolton.nhs.uk
823	Buckinghamshire Primary Care Trust	I am due to commence a nurse-led clinic for COPD patients, alongside the existing community based pulmonary rehab programme in Winslow Bucks; weekly 2 - 4pm for six months. I shall then audit the cost-effectiveness / value / patient perceived outcomes / hospital admission avoidances / H.A.D and CDRQ scores pre and post course to enhance the service & assess if future clinical at the other 4 sites would be cost effective and improve care.	
827	Cambridgeshire Primary Care Trust	Cambridgeshire PCT and Cambridge University Hospital are part of a project funded by The Health Foundation called 'Co-creating Health'. The focus currently is on COPD and the project has 3 dimensions - self management, advanced development for clinicians and service improvement. COPD is a priority within the PCT commissioning intentions. Recent workshops for COPD held looking at how we take forward services.	sandra.moore@cambridgeshirepct.nhs.uk
828	Camden Primary Care Trust	Camden PCT has commissioned a COPD Enhanced Service within general practice. Currently 90% of registered COPD patients covered by enhanced service practices and PCT currently agreeing alternative providers for remaining 10%. Service specification is available. A community COPD management project based within Camden REACH providing admission avoidance and physical rehabilitation service to COPD patients from 2 Camden GP practices (approx 200 patients). Resulted in dramatic reduction in admission to hospital and exacerbation rates in first phase of project (52 admission reduced to 2 over 6 month period with 30 patients).	graham.macdougall@camdenpct.nhs.uk
830	Carmarthenshire Local Health Board	As part of the Chronic Disease Management Team there is a COPD Team which has helped reduce emergency medical admissions for COPD by 36%. We have also seen a reduction in hospital bed days. Recently won an award for leading in service improvement.	claire.hurlin@carmarthenlhb.wales.nhs.uk
831	Central and Eastern Cheshire Primary Care Trust	15 bed local Hospice is utilised for palliative/respite care and complementary therapies are also accessed for patients with COPD. Local Health economy has recently delivered, as part of continuing programme of education, a 2 day COPD workshop for District Nurses on care of patients who are housebound and have COPD.	malkia.ibbotson@cecpct.nhs.uk
835	Conwy Local Health Board	a) Conwy Local Health Board aim to undertake a Health Forecasting and COPD Pilot with the Met Office and GP Practices. This is a proactive intervention offered by the Met Office whereby it uses the science of weather forecasting to predict changes in the weather that could exacerbate existing health conditions for example COPD and lead to hospital admissions. This information can be e-mailed by the Met Office to medical staff/ health care providers in advance so that it can be used to deliver anticipatory care for individuals with COPD. It is thought this can help the	marie.waugh@conwylhb.wales.nhs.uk

		individual with COPD improve their health and well being and will help them gain a greater understanding of their condition and support the individual towards self management. It could assist in avoiding unscheduled hospital admissions and provide an early intervention approach towards effective management of COPD. b) There is an Oxygen Assessment Team in place that provides assessments for individuals who are on oxygen or new referrals. The service provides home visits and community clinics. There is also the provision of psychological support /anxiety management in relation to supporting an individual to come off Oxygen when there is no longer a clinical need for the therapy. c) We are commencing a small Tele-health (clinical home monitoring) pilot starting early June in one Conwy Locality. This will be based within the District Nursing Team and Intermediate Care covering that locality and will be available to individuals with a chronic condition(s) which includes COPD. The development of Tele-health services in Conwy will address a shift towards proactive and preventative measures in the management of chronic conditions as well as focusing the individual towards active self management. It will assist in bringing services closer to home in a timely way and give an early alert prior to a significant deterioration in an individual's condition that might otherwise result in an emergency admission. d) Case Management is currently underway in pilot format within part of a Conwy Locality. Case Management is an innovative way to care for individuals who have complex needs resulting from there chronic condition(s) who are at risk of hospital admission. The aim of the pilots is that case managers can anticipate and manage problems before they escalate thus reducing the impact on the individual's well being and that of the health service. In turn patients remain in their own homes and communities. There is a case finding criteria for case management and COPD is included in this. e) We have developed a district nurse rolling programme in Chronic Condition Management which is a competency based programme linked with the KSF. Within this we have dedicated disease specific days. One of these days is related to respiratory and covers COPD management and education. f) The respiratory team with Conwy and Denbighshire meet with the team in North West Wales to share innovation and good practice.	
836	Cornwall and Isles of Scilly Primary Care Trust	Various documents attached to survey - 'Whole system LTC Programme - the monthly newsletter from the programme team' October 2007, Nov 2007 & Feb / Mar 2008 attached, Business Case - Active Self Care for COPD patients, and this is an extract from another document but demonstrates Cornwall PCT's commitment to helping people manage long term conditions including COPD. The documents are available from Cornwall and Isles of Scilly PCT.	julie.green@ciospct.cornwall.nhs.uk
837	County Durham Primary Care Trust	Sedgefield Practice based Commissioning consortia piloted a local pulmonary rehabilitation service which is now being considered for roll out across the County Durham area. Easington PBC consortia are about to pilot a service which looks at hospital admission avoidance through an intermediate care service.	wendy.stephens@cdpct.nhs.uk
842	Darlington Primary Care Trust	Have worked in partnership with local hospital to deliver community based services through the establishment of an ARAS team and recently established DART team.	wendy.stephens@cdpct.nhs.uk
845	Derbyshire County Primary Care Trust	The PCT have developed and implemented COPD patient information and self care diaries. These diaries provide people living with COPD information about their condition	vanessa.vale@derbyshirecountypct.nhs.uk

		enabling them to self manage. This information also helps with lifestyle modification and behaviour change.	
846	Devon Primary Care Trust	Within the Mid Devon area we have held education sessions across professionals to support the COPD patient pathway, this is a good example to now embed in our complex care teams which have the priority of preventing inappropriate admissions and facilitating appropriate length of stay in hospital. We now within these teams have community matrons that will be the key link for this work and all these will have completed appropriate training for COPD management by Dec 2008. This includes ensuring that all very high dependency users with COPD having a personal management plan.	julie.mitchell@eastdevon-pct.nhs.uk
847	Doncaster Primary Care Trust	We have a research projection (Randomised Control Team) of COPD patients in the community who had previous hospital admission going on in Doncaster. The research addresses the effectiveness of Tele-health (Genesis Monitors) in reducing hospital re-admission and improving quality of life. Sample size 160 (Intervention = 80. Control = 80) followed for 12 months.	victor.joseph@doncasterpct.nhs.uk
849	Dudley Primary Care Trust	The care pathway developed will be web based. It is a comprehensive document and I am willing to share. The document is available from Dudley PCT.	joanne.hamilton@dudley.nhs.uk
851	East and North Hertfordshire Primary Care Trust	Recently commissioned a respiratory nurse specialist to complete audit of patients that have been assessed for oxygen in the acute trust to see if timely reviews would support better use of oxygen.	rachel.joyce@herts-pcts.nhs.uk
853	East Riding of Yorkshire Primary Care Trust	In Hull and East Riding we have finished comprehensive clinical guidelines for COPD. We are using these guidelines to inform the development of an integrated care pathway and commissioning plan.	joanne.lurcock@erypct.nhs.uk
860	Gloucestershire Primary Care Trust	1. Practice Based Commissioning has developed a new PCT multi-disciplinary team working in two areas of the county. Funds invested by the PBC groups aim to prevent hospital admission using a home assessment service which runs weekdays form 8.30 - 5pm; these saving are re-invested in the PR programmes however both arms of the team's work aim to reduce non-elective hospital admissions, reduce length of stay, reduce GP consultations and improved the overall Quality of Life of patients. Early reports suggest this is a very positive service. 2. An oxygen assessment centre in one area of the county's more rural locations is due to commence shortly. The service will be using a near-patients testing blood gas analyser; this will be initiated by the same team that is providing PR and COPD hospital avoidance (see previous response) and will lead on to further developments in community-based oxygen centres. 3. Tele-health is to be introduced in May 2008 for those patients suffering with COPD. The project is funded for two years and the aim is to extend the service across the county over that time (it is hoped that this project will also act as a pre-cursor to Telehealth solutions in other chronic diseases). The project will include the installation of home monitoring equipment which will enable the following data to be collated: - daily oximetry - spirometry - patient sputum reporting - coping questionnaires. This information will be transmitted via a hand held monitor that then passes the (daily) information to a hub where a clinician is alerted to any changes in basic monitoring that imply a worsening of their condition. This will then provide the opportunity for early intervention should that be deemed to be appropriate.	kathy.cambell@glos.nhs.uk
863	Gwynedd Local Health Board	District Nurse discharge support is provided throughout North West Wales Health Community. There are Case	frances.millar@gwyneddlhb.wales.nhs.uk

		Managers in the community developing skills in COPD management. The newly developed Integrated Care Pathway that is being launched in June 2008 includes the Map of Medicine. Work is currently being undertaken with the National Innovation Leadership Healthcare Agency looking at Design for Competence. Baseline competences will be identified by the workforce on the management of COPD in order to inform the training needs analysis.	
864	Halton and St Helens Primary Care Trust	Merseyside and Cheshire have produced management guidelines for end of life for respiratory patients. Document available from Halton and St Helens PCT.	sheila.mchale@hsthpct.nhs.uk
865	Hammersmith and Fulham Primary Care Trust	Clinical Nurse Manager Respiratory Services - joint post with Imperial College Healthcare NHS Trust- managing respiratory nursing across primary and secondary care.	rachel.haffenden@hf-pct.nhs.uk
866	Hampshire Primary Care Trust	We have developed a COPD high level pathway which is used to commission services in both primary and secondary care. This pathway has also been adopted by South Central SHA.	gill.harrison@ports.nhs.uk
867	Haringey Teaching Primary Care Trust	The service provider and spirometry service to GPs (addressed variable practice and interpretation of results) run in various surgeries and health centres. Link between the smoking cessation service and respiratory team to pick up lung damage earlier (link to spirometry) & to educate people as part of the Pulmonary Rehabilitation sessions. Piloting Tele-health education & monitoring of COPD patients using Docobo healthhubs in patient homes - link to secure internet access for clinical staff and alerts if readings outside set patient parameters (or questions answered in positive). (Earlier studies find they help to manage patient / carer anxiety.)	delia.thomas@haringey.nhs.uk
868	Harrow Primary Care Trust	Pilot scheme of emergency drug packages supported by hospital community intermediate care team.	sue.whiting@harrowpct.nhs.uk
871	Heart of Birmingham Primary Care Trust	Respiratory Services within the PCT are delivered through a multidisciplinary team approach including a General Practitioner with a Special Interest in respiratory disease (GPwSI), Respiratory Nurses, Respiratory Physiotherapist, Occupational Therapist, Health Care Support Worker and Community Link worker. There is also a Junior Physiotherapist rotational post sourced from the community respiratory team; this enhances the skills of this professional group within the respiratory disease area. Palliative Care - Representation on PCT End of Life Steering Group and within Service Specification development to ensure life limiting illnesses such as COPD are included. Educational component of service delivery - this supports the training and development needs of a range of Health Care Professionals within the PCT delivering care to COPD patients. This includes GPs, Practice Nurses, District Nurses, Community Matrons and is delivered through interactive training sessions. Within a general practice setting clinical support sessions are delivered and a resource pack has been developed to support the delivery of COPD care. Regular Integrated Respiratory meetings which includes membership from both PCT and main acute trust provider. This includes the PCT multidisciplinary team aforementioned, Respiratory Physicians, Respiratory Nurse (acute based), pharmacists, physiotherapist (acute based). These meetings address the organisation of respiratory care delivered and have addressed areas such as discharge planning, discharge information and palliative care.	karen.jukes@hobtpct.nhs.uk raja.ramachandram@hobtpct.nhs.uk
873	Heywood, Middleton & Rochdale Primary	The local delivery plan is based on outcomes generated from undertaking a workforce based project - using a tool entitled Brooks and Bosman (2002). The outcome was the	karen.clancy@hmrpct.nhs.uk

	Care Trust	identification of services that should be provided and the skill mix required to offer the service.	
875	Hounslow Primary Care Trust	Home Oxygen Therapy: Quality of information from Air Products not robust enough. GPs not all Read coding patients on oxygen and voluntary audit did not deliver information needed. PCT aware needs an assessment centre; plan for business case for Pulmonary Rehabilitation to include LTOT assessments.	karen.pearce@hounslowpct.nhs.uk
879	Islington Primary Care Trust	Islington PCT has developed a dedicated team of 4 staff to support the needs of COPD patients in the community. The team consists of Lead Specialist Nurse, Specialist Physiotherapist for Pulmonary Rehabilitation, a Community Matron for COPD focussing on those at risk of admission and a nurse supporting the needs of patients on home oxygen. The team have strong links with secondary care and offer support to local practices in optimising the management of their COPD patients. Following the establishment of the community team we have been able to identify patients suitable for Pulmonary Rehabilitation in Primary Care Settings. In the past the only access into rehabilitation was via secondary care. As a result Pulmonary Rehabilitation in Islington is now becoming an earlier part of the care for COPD patient's health status and reducing the burden of the disease and hopefully helping to slow down deterioration, by maintaining the patients at their best possible physical and functional level.	paula.mattin@islingtonpct.nhs.uk
883	Knowsley Primary Care Trust	The PCT went out to tender for COPD services in the community last year. The contract was awarded to a local acute trust: St Helens & Knowsley NHS Trust. The service commenced in November 2007 and was implemented in stages. The Service provides: Spirometry from local LIFT buildings and practices throughout the PCT. Pulmonary Rehabilitation which was provided from local leisure centres. For severe COPD Pulmonary Rehabilitation is in secondary care. The main components of Rehabilitation are: Optimal Medical Treatment, Physical training, Disease education and self management techniques, Nutritional support, Psychological and social support, smoking cessation, modification of life style/ environment, dietetic assessment/ advice, A weekly nebuliser clinic is run within primary care. The clinic is for optimisation of medication prior to commencing nebuliser therapy. Patients attend every two weeks for a maximum of 10 weeks. Oxygen assessment is undertaken at each visit. There is a second element to the service and this is a 24 hour 7 days a week Rapid Response Service. In the event of an exacerbation, patients can self refer to the service or be referred by a health care professional or carer. Calls for the rapid response are via a free phone number to a rapid response nurse who then undertakes a telephone triage. The telephone triage will identify which is the most appropriate location for physical assessment: 1. Telephone advice on self management and follow up via telephone contacts. 2. Assessment in the home within 2 hours - this is nurse led with a follow up the next day for a maximum period of 48 hours. 3. Assessment in the one of the community centres within 2 hours. 4. Assessment in the Acute Trust's Respiratory Acute Assessment Unit - available 24 hours a day. 5. Admitted directly to A&E via an emergency ambulance if more extensive medical intervention is required. If a patient is seen in the home environment for the 48 hour period their care is handed over to the relevant service: Community Matrons, District Nurses or GP. The Rapid Response Service also provides Early Supported Discharge following an inpatient admission. The service is aiming to	alison.vandessel@knowsley.nhs.uk

		keep regular telephone contact and support to those patients withy moderate or severe COPD. During periods of predicted poor weather telephone contact will be made more frequently to those patients with severe COPD to ensure the house is warm and to avoid going out until the weather improves if possible. The service is looking at assisting patients in self managing their care: encourage to contact the Rapid Response Team early in an acute episode and to give each patient a self management pack with antibiotics and steroids. The pack will include advice on early recognition of symptom changes and suggested actions for when an exacerbation occurs.	
885	Leeds Primary Care Trust	Healthcare professionals from across the healthcare economy contributed to the development of the Leeds COPD guidelines which were launched in 2005. The (then) 5 PCTs in Leeds signed up to the funding of a community respiratory specialist team to support the implementation of the guidelines in primary care. Since the teams came into place, there has been >30% reduction in emergency admission with 1 degree diagnosis of COPD and >40% reduction in COPD emergency bed day utilisation.	alison.sarmiento@leedspct.nhs.uk
887	Leicestershire County and Rutland Primary Care Trust	Work is underway to develop "Off the shelf" PBC schemes to deliver COPD services.	andy.williamson@lcrpct.nhs.uk
888	Lewisham Primary Care Trust	COPD Clinical Panel is reviewing its Terms of Reference and is in the process of developing a strategy to implement the forthcoming COPD NSF.	katrina.mccormick@lewishampct.nhs.uk
890	Liverpool Primary Care Trust	We have developed learning outcomes for primary care staff in relation to COPD education. Our pathway will be going on 'Map of Medicine' soon for all GPs to use. I have developed 'Health Outcomes' for practices to work through and we are currently rolling this out across the north of the city. All GPs have access to clinical physiology led spirometry with an average waiting time of 2 weeks.	steve.callaghan@liverpoolpct.nhs.uk
892	Manchester Primary Care Trust	In Manchester we are currently upgrading our community COPD service. We constantly work with secondary care trying to develop a seamless service. Recent projects done to improve our service: making of DVD on COPD - educational tool for patients are health professionals. Available in 7 languages. Now available for anyone to download and copy at www.manchesterpct.nhs.uk/health/chronic_disease . Also on the Race for Health website www.raceforhealth.org/newsdetail.php?id=175	lynn.helliwell@manchester.nhs.uk
894	Merthyr Tydfil Local Health Board	Developing a community oxygen review service. Business case is in the development, task and finish group started work. Breathe easy group established in Merthyr Tydfil with very good attendance.	jane.williams@merthyrtydfillhb.wales.nhs.uk
895	Mid Essex Primary Care Trust	Weekly MDT meeting with secondary care respiratory consultant to discuss and develop management plans for patients with complex needs. Rolling programme of Pulmonary Rehabilitation across PCT. End of Life issues, preferred place of care and living wills discussed during PR programme. Palliative care Consultant attends this session when time allows. Close links with Breathe Easy group. Member of the team attends Breathe Easy group meeting and provides talks on issues relating to COPD e.g. pulmonary rehab, use of oxygen, travel. Integrated oxygen assessment service with dedicated assessment team. Oxygen assessment team use capillary blood gases to titrate oxygen requirements. Close working relationship with heart failure service will hold joint clinics as appropriate.	tracey.cullum@midessexpct.nhs.uk imelda.doherty@midessexpct.nhs.uk

896	Middlesbrough Primary Care Trust & Redcar and Cleveland Primary Care Trust	Community Pulmonary Rehabilitation. Scoring system for COPD patients in primary care re severity. COPD outreach (hosted by the acute - commissioned by PCT). COPD nurse specialist.	helen.scott@middlesbroughpct.nhs.uk
897	Milton Keynes Primary Care Trust	1. Early discharge Pilot study; 2. Hand Held Patient Records; 3. Telecare support to prevent/reduce admissions; 4. End of Life Strategy including patient with COPD and access to Hospice beds.	lynn.kent@mkpct.nhs.uk
898	Monmouthshire Local Health Board	A respiratory Link Nurse was been developed across Monmouthshire which includes Chronic Condition Nurses, District Nurses and a Practice Nurse from each practice. This group is to be affiliated with a National Organisation. Monmouthshire also has an educational facilitator that meets with all nursing homes on a regular basis therefore can share information to this client group. Respiratory care for COPD/ housebound patients is improving following the integrated look with District Nurses and Chronic Condition Nurses. Last days of life care pathway widely used throughout.	louise.eynon@monmouthshirelhb.wales.nhs.uk
902	NHS Ayrshire & Arran	Community Pulmonary Rehabilitation. Early supported discharge from clinical decisions unit (in development). Local enhanced service - practices asked to identify COPD patients at highest risk of hospital admission (SPARRA tool) and provide proactive planned care including self-management plans, case management, review after admissions as well as case messaging to hospital and out of hours services. Support for community and practice nurses to achieve COPD diploma, attempting to have geographical cover to support EDS and PR. Co-creating Health self management initiative for patient and clinicians funded by Health Foundation (3 year project including service redesign).	hans.hartung@aaaht.scot.nhs.uk
908	NHS Greater Glasgow & Clyde	South Glasgow - Specialist multidisciplinary clinic for severe COPD patients, providing a holistic approach to the management of patient and optimisation of treatment team includes, Respiratory consultant, palliative care consultant, clinical nurse specialist, Physiotherapist with input from smoking cessation, dietician etc. North East Glasgow - Nurse led clinic for severe/ complex COPD patient to help optimise treatment/ management of patient in the community.	linda.mccarron@northglasgow.scot.nhs.uk
910	NHS Lanarkshire	The Respiratory Managed Clinical Network has worked hard over the past year to forge partnerships across all sectors of the NHS board area with local authority partners & voluntary organisations. As a result the network has developed a comprehensive business case to pilot. A COPD whole system service over the next two years and has now successfully obtained funding to implement the new service.	maureen.carroll@lanarkshire.scot.nhs.uk
911	NHS Lothian	Lothian has 4 Community Health Partnerships which use Community Respiratory Teams and Rapid Response Teams to deliver a range of anticipatory care and rapid intervention services to patients with COPD in their area. In East Lothian CHP, a supported self management course for people with COPD is being delivered by a local voluntary organisation. East Lothian CHP is also trialling the Met Office "Healthy Outlook COPD Forecast Alert Service' to inform patients of adverse weather and to advise them on action to maintain health and hopefully avoid exacerbations. West Lothian Community Health and Care Partnerships is leading on a Scottish 'Telehealth' project which is using IT and communications technology to monitor patients with COPD and to mobilise early support. A 3 day spirometry	paul.x.currie@nhslothian.scot.nhs.uk

		course for Practice Nurses and GPs has been developed in partnership with higher education; this is being supported by distribution of standardised Spirometers to all Lothian GP practices. A new Respiratory Managed Clinical Network will focus actions on COPD, working in partnership with clinicians, CHPs, Voluntary Sector, patients and the pharmaceutical sector can develop services.	
918	North East Lincolnshire Care Trust Plus	North East Lincolnshire Care Trust Plus has the first pulmonary Rehabilitation unit to form Pulmonary Rehabilitation 'buddies'. These are past participants from the unit. From this, we have won the NICE shared Learning Award and the British Thoracic Society's Silver Jubilee award for innovations in patient involvement in service design and delivery. This information can be found on the NICE Shared Learning Website. The future - we would like to enhance the admission avoidance and palliative care service areas of our practice.	simone.shepheard@nelctp.nhs.uk pam.hancock@nelcpct.nhs.uk jeremy.baskett@nelctp.nhs.uk
920	North Lincolnshire Primary Care Trust	In October 2007, North Lincolnshire PCT established a primary care respiratory clinic run by GPwSI in COPD. The clinic runs twice a week and is available 44 weeks a year. The service sees patients with COPD whose condition has been difficult to control and will eventually also be seeing patients with a wide range of respiratory conditions that would normally have been referred to secondary care for an opinion. The service aims to improve diagnosis of patients with respiratory conditions by offering a specialist service and improving education and core knowledge which will be disseminated at all levels. The service provides advice and support to local GPs either through direct or non direct contact with regards to their patients with respiratory conditions. The GPwSI post also involves close communication with secondary care in developing respiratory services in the community e.g. pulmonary rehabilitation.	denise.smith@nlpct.nhs.uk
924	North Tees Primary Care Trust and Hartlepool Primary Care Trust	Ambulance pathway across Hartlepool. Development of multi disciplinary COPD pathway across the patients' full journey. COPD service across North of the Tees and future development. Soon to be developed by the LDP, step-up, step-down beds for COPD patients, with a 10 bed unit available in the community.	carl.parker@nhs.net
926	Northamptonshire Teaching Primary Care Trust	There is an active patient group run by patients to support patients called "Kettering Airways" who meet in the community hall. Their aim is to meet and support social networks for patients; the group is supported by the Kettering General Hospital Physiotherapist and nurse specialist in an open access forum. The group can be accessed by anyone with any COPD or related problem. It is advertised locally.	toni.hewitt@northants.nhs.uk
928	Nottingham City Primary Care Trust	The PCT's COPD team and pulmonary rehabilitation programme were developed 18 months ago. Early signs have been very positive in terms of the quality of service provided to patients and in terms of admission avoidance. The PCT has been working with Nottinghamshire County Teaching PCT and Consultants KPMG on a project to look at the current COPD pathway, and how it could be commissioned differently - to identify more COPD sufferers, and to provide better care with less reliance on hospital services, providing care closer to where people live.	andy.roylance@nottinghamcity-pct.nhs.uk
929	Nottinghamshire County Teaching Primary Care Trust	The COPD services based at Ashfield, Mansfield and Newark in Nottinghamshire County PCT have recently been awarded a silver award from the British Thoracic Society for delivering high quality services with local access for patients. The service has also been filmed as part of the Darzi report as an exemplar of good practice. The Nottinghamshire wide COPD strategic network brings	lindsay.boxall@nottspct.nhs.uk

		together patients, clinicians, commissioners, planners, voluntary and statutory agencies from across all the three PCTs in Nottinghamshire and is proving a vital factor in developing a standardised care pathway for patients across the whole county. A ground breaking innovative project is being taken forward as a joint initiative between the SHA and County and City PCTs with external consultants KPMG, to support the future commissioning of the COPD pathway in line with the World Class Commissioning Competencies, by costing and analysing the current and future care pathways, identifying shifts in activity and any potential barriers to implementation and developing solutions for any challenges to implementation e.g. unbundling of tariff and the potential movement of activity from secondary care providers to primary care providers	
931	Oxfordshire Primary Care Trust	A review of oxygen prescribing is currently underway, comparing prescription to actual patient usage. A review of 100 patients so far has shown that only 5 patients [out of 100] are using oxygen as it was ordered on the original HOOF. Most patients use many less hours of ambulatory oxygen than prescribed. When HOOF adjusted to reflect actual usage, a reduction in annual oxygen spend of £80K has been identified.	joanne.riley@orh.nhs.uk
932	Pembrokeshire Local Health Board	The LHB is currently working with colleagues from the Trust and NLIAH to develop care pathways and early diagnosis processes in relation to COPD. Pulmonary Rehabilitation is high on the agenda and discussions are underway with the relevant colleagues.	sonia.briggs@pembrokeshirelhb.wales.nhs.uk
933	Peterborough Primary Care Trust	Respiratory team proactively identify patients in need of palliative care by liaising with GPs, using the Pulmonary Care Gold standard framework. Identified patients are placed on a palliative care register. Team attend palliative care meetings, liaise with Macmillan Nurses and refer for respite to a local hospice. Team issue self management plans to COPD patients and issue rescue medications in the home enabling patients to initiate treatment for exacerbations early. Respiratory nurses are then contacted for follow up and this in turn avoids hospital admissions. All patients have a named nurse and contact details and out of hours information on how to access services. Team support Community Matrons working with LTC in the community with aspects of care for COPD. Team support and train Practice Nurses in developing skills in COPD management. Run local mobile clinics for patients with more complex problems. Patients feel more supported and less isolated and this helps them feel more in control of their condition. Currently looking at Telehealth to see if any applications could be used for Long Term Conditions including COPD.	hedda.lilley@peterboroughpct.nhs.uk
934	Plymouth Teaching Primary Care Trust	As well as running a community PR programme we are also running a home-based PR programme for patients who are housebound or on LTOT. Anticipatory care is provided giving patients who are prone to multi-admissions. Find use of temp gages very useful in the home along with met office info packs. Have a care pathway for palliative care but are also developing initiative by working closer with palliative care specialists. We also run a monthly 'nurse-led' COPD clinic for more mobile patients who still require specialist support and monitoring.	margaret.barnett@plymouth.nhs.uk
935	Portsmouth City Teaching Primary Care Trust	Weekly maintenance programme post pulmonary rehabilitation. Close working arrangements with Community Matrons. We are setting up a service user group to compliment the clinical Chronic Disease Management Group.	lucy.mitchell@ports.nhs.uk
936	Powys Teaching Local Health Board	In response to the community pulmonary rehabilitation programme, we have no formal arrangements. However	julie.havardevans@powyslhb.wales.nhs.uk

		our respiratory Nurse Specialist in the south of the country provides home rehabilitation for a very small number of patients.	
938	Rhondda Cynon Taff Teaching Local Health Board	The LHB piloted the Met office health forecasting service this year. We are currently in the process of evaluating the pilot to assess whether this should be rolled out across the area.	rebecca.edwards@rhonddacynontafflhb.wales.nhs.uk
939	Richmond & Twickenham Primary Care Trust	Our community respiratory team has been set up to provide effective management of patients with COPD within the PCT. We optimise and review patients during stable periods, provide patient education and support, pulmonary rehabilitation, clinics within the PCT and early intervention for patients with exacerbation. This has been effective in improving patients quality of life and reducing admissions for our PCT.	julie.read@rtpct.nhs.uk
940	Rotherham Primary Care Trust	Our PCO in collaboration with the Coalfields Regeneration Trust has funded a primary care rehabilitation centre for patients with COPD 'Breathing Space'. It will become an inpatient as well as outpatient facility in October 2008, with 20 beds, fully 24 hour staffed with nursing and allied health professional staff to provide an admission avoidance scheme.	gail.south@rotherhampct.nhs.uk
941	Salford Primary Care Trust	Joint appointments between PCT and local acute hospital of a) Consultant Respiratory physician and b) Nurse Consultant in 07 / 08/ Four community clinics have been established in April 08 led by a) and b) above providing access to specialists within community settings.	anna.thomson@salford.nhs.uk nawar.bakerly@srft.nhs.uk
942	Sandwell Primary Care Trust	We are currently in the process of service re-design. We presently offer home visit for assessment and treatment of those with respiratory problems as well as an oxygen assessment clinic, supported by the Acute trust's consultants, 1 session per week. We are aspiring to develop a mobile spirometry service, satellite oxygen assessment clinics, and 7 day working. We have developed outcome measurements but due to a new system coming into play we have delayed recording this electronically.	kelly.redden-rowley@nhs.net
943	Sefton Primary Care Trust	Team have recently completed a 2 year research project called EXHALE looking at case management of severe COPD patients. Emerging findings are: Hospital admissions not reduced, Less '999' calls more planned admissions, Gap between 'Hospital at home' and discharge filled, Increase in walking distance and reduction in depression with cohort. Paper accepted for presentation at American Thoracic Society meeting, Toronto May 2008.	jackie.rooney@seftonpct.nhs.uk
945	Shropshire County Primary Care Trust	The PCT respiratory service has excellent patient and public involvement: strong links to the local breathing club and holds 2 monthly patient forums to discuss issues relating to the COPD service. Matters arising from the little forum are fed back to service providers and commissioners. The service has a very holistic approach to care and focuses on maintaining people in their own homes and preventing avoidable admissions.	helen.swindlehurst@shropshirepct.nhs.uk
946	Solihull Primary Care Trust	We are about to involve the Smoking Cessation team in helping to identify those clients who may be at risk of developing COPD. This is currently in the 'early planning stage', but we hope to use a screening tool as devised by Prof Price in order that high risk clients can be referred to their surgery for spirometry assessment.	sandy.walmsley@solihull-ct.nhs.uk
948	South Birmingham Primary Care Trust	The PCT has undertaken a significant and robust evaluation of the Local Enhanced Service for COPD. Clinical templates have been developed. In addition the PCT has brought together its partner agencies to devise a Guidance and	helen.southwell@sbpct.nhs.uk

		information pack based on NICE. This was distributed to every clinician within the PCT. The PCT are currently undertaking an on line audit of its use and effectiveness in managing patients with COPD. The results of which will be reported in June and assist with the commissioning decisions.	
949	South East Essex Primary Care Trust	1. Currently working towards developing an integrated Case Management and Domiciliary Service across health and social care service for palliative - to include all Long Term Conditions as well as Malignant conditions.	carolyn.hanna@see-pct.nhs.uk
953	South West Essex Primary Care Trust	We are currently introducing widespread spirometry into primary care to support the screening and diagnosis of COPD. This is being driven by the commissioning network and fully supported by secondary care.	emily.hughes@swessexpct.nhs.uk
954	Southampton City Primary Care Trust	We are commissioning an intermediate COPD care team to work in primary care to (illegible word) admitting	graham.watkinson@scpct.nhs.uk
960	Stoke on Trent Primary Care Trust	A community spirometry service run by community respiratory physiologist. COPD self management programme.	sharon.maguire@stokepct.nhs.uk
961	Suffolk Primary Care Trust	Currently mid way through the tender process for COPD services, based on a specification developed by the local COPD network. Piloting Telemedicine as part of our Health Reform Demonstration Site programme which will include COPD patients. County wide Integrated Care Pathway developed and launched. Local GP developed an 'Airway Code' leaflet for COPD patients which is based around traffic light and aims to give patients the confidence to take actions to avoid hospital admissions. Staff education programme.	julie.hattrell@suffolkpct.nhs.uk sandy.barron@suffolk.nhs.uk
963	Surrey Primary Care Trust	1. We are planning a Surrey wide respiratory steering group with members from across primary care and the acute trust. We have the interest, engagement and ear of our PCT chairman. 2. We already have small groups from across the trust in place to work on harmonising the services where possible to the highest standards within the PCT i.e. using the best of each locality to inform and help the other areas e.g. a) we are working on unifying documentation, such as assessments forms b) We are working out ways to collect the same data from all the 4 teams within the PCT to collate Surrey Wide data.	julia.bott@surreypct.nhs.uk
966	Swindon Primary Care Trust	Telehealth: Swindon PCT have implemented a Telehealth pilot scheme, grant funded for two years via the Government's assistive technology grant. As well as supporting self-management at home in line with the local long term conditions strategy and the Government's White Paper "Your Health, Your Care, Your Say", Telehealth is one of the key indicators for the Local Area Agreement. The project further integrates community services, with improved information flows between community matrons, emergency care practitioners and the Primary Care Centre. It focuses on patients with COPD, supporting up to 56 people through the lifespan of the project. The basic equipment "pack" can record heart rate, BP, weight and oxygen saturation. Additional add-on functions are skin temperature; prothrombin time; peak flow; ECG; and blood glucose. The equipment can be set up to ask 10x subjective questions most relevant to the user such as "are your ankles more swollen than usual?"; "do you need more medication?"; etc. The equipment has a wide range of languages and questions are both spoken and can be read on a monitor screen. This Telehealth project was also crowned as one of the "best in the South West" at the regional Health and Social Care Awards in the category of	tracey.obrien@swindon-pct.nhs.uk

		"Innovative Health and Social Care Technology". The Community Matron Management Plan: This is a plan completed in partnership with the patient, their medical practitioner and the Community Matron. It details what assessments need to be completed to diagnose an exacerbation of a patient's COPD and/or an infection. This leads to a clear plan detailing the treatment to be started and when review will occur. It is also explicit to any staff caring for the patient what their normal oxygen saturations are and what emergency oxygen therapy should be given. These plans have been invaluable for communication especially to the out-of-hours GPs, thereby enabling the patient often to be managed at home safely. In tandem with this plan is a Patient Management Plan completed in partnership with the patient and is based on a traffic light system with Green representing the individual's usual COPD status to Red being a COPD emergency. This latter plan promotes self-management and helps with health promotion. Each patient has the community matron's telephone number and the out-of-hours number and they receive continued support and review by the Community Matron.	
968	Telford and Wrekin Primary Care Trust	Bronchiectasis Project – a document is available. Respiratory Nurse consultant working within primary care	julie.bone@nhs.net
969	Torbay Primary Care Trust	Automated COPD health focusing: Project with Met office and GP surgeries. Cold weather is associated with an increase in admissions. Our research has evolved into using weather forecasting models to provide a trigger for anticipatory care with the aim of preventing exacerbations. The scheme aims to provide innovative long term conditions management. FREE TO BREATHE - our local hospice runs a number of day services for people with breathlessness - not just for palliative care patients.	diana.vegh@nhs.net
972	Trafford Primary Care Trust	Currently commissioning for a team of providers to work on developing a service spec over a 9 month period. This will then allow us to tender for pathways of care developed by a specialist team.	gina.lawrence@trafford.nhs.uk
973	Vale of Glamorgan Local Health Board	Our service model has been developed as part of our health care strategy with our local trust. Within our LHB we have started implementing the model locally by the appointment of a GPwSI and COPD specialist nurse along with the implementation of a fortnightly COPD GPWSI clinic in our community hospital.	christine.absi@valeofglamorganlhb.wales.nhs.uk
975	Wakefield District Primary Care Trust	We are launching patient and carer warnings for hot/ cold weather and poor air quality in association with our local authority from July 2009. We are working with our local Prisons to develop services for COPD. We are investigating the use of screening spirometry to identify symptomatic undiagnosed people with COPD through pharmacies, health trainers and stop smoking services. We have a pharmacy campaign planned for November aimed at people requesting cough medicines, to raise awareness of COPD.	lisa.chandler@wdpct.nhs.uk
979	Warrington Primary Care Trust	LTOT report - October 07-January 08 written by Carol White (Respiratory Nurse). Document available form Warrington PCT.	carol.white@nch.nhs.uk
981	West Essex Primary Care Trust	We have developed local treatment guidelines, patient held records. Primary care clinics reducing OPD attendance. Admission avoidance scheme, validated by PCT. Reduction in OPD attendances.	ram.gulrajani@westessexpct.nhs.uk ann.nugent@westessexpct.nhs.uk
982	West Hertfordshire Primary Care	There is a good multidisciplinary team including nurses, physiotherapists, dieticians who support patients in the community with COPD and have good links with the	rachel.joyce@herts-pcts.nhs.uk

	Trust	voluntary sector (Breathe Easy Groups).	
985	Western Cheshire Primary Care Trust	Western Cheshire PCT is currently engaged with the met office and optimum patient care. The met office automated forecasting project which allows anticipatory care to be delivered when the patient is most vulnerable but before their condition deteriorates. The optimum patient care COPD audit tool provides focused patient profiles to facilitate efficient review and help optimise treatment to meet needs of individual COPD patients.	joy.harrison@wcheshirepct.nhs.uk
986	Western Health and Social Services Board	Skills for Self Help Programme - run in association with Stanford University. A range of stakeholders (including the community and voluntary sector) put forward candidates for training- COPD Distance Learning Diploma (Education for Health). 65% of GP practices have either a practice nurse or a GP trained through this programme- Ongoing spirometry training for general practitioners and practice nurses. The Board has funded Spirometers and pulse ox meters for practices- Liaison with voluntary groups (for example Asthma UK and Chest & Heart & Stroke) to develop disease management pathways. Arrangements have also been developed to signpost patients to a range of support groups.- An early discharge programme based on "admission avoidance". This project was recently short listed for the finals of the Regional Innovative Health Care Awards.	eugene.gallagher@whssb.n-i.nhs.uk
987	Westminster Primary Care Trust	Together with the local respiratory teams, across Kensington Chelsea & Westminster we have developed an internal based COPD patient record (Prowellness) that will have accessibility to GP and Hospital Data (automatic download). This will provide real-time data on patients as a read only file for emergency personnel and health care professionals / GPs in community. Members of the COPD team will be able to keep real time notes on the record including pages for pulmonary rehab / nurse review / hospital at home / LTOT. We (the Joint Steering group) have been early implementers for a COPD pathway using map of medicine. We (the Joint Steering Group) have funding to implement different modes of spirometry screening in primary care. We (the Joint Steering Group) have mapped our palliative care service as part of the end of life scheme and are now developing a pathway and referral criteria. Please don't hesitate to contact us if further information is required.	caroline.durack@westminster-pct.nhs.uk
990	Wolverhampton City Primary Care Trust	We use telehealth to support patients with COPD to detect early exacerbation.	mari.gray@wolvespct.nhs.uk
991	Worcestershire Primary Care Trust	During the 07/08 winter we also commissioned the Healthy Outlook Service from the Met Office and offered the service to all Practice based Commissioning Practices. 38 practices took part with over 2000 COPD patients registering to use the service. Using science developed by the Met Office, a forecast relating to temperature and infectious disease levels in the air is made and patients contacted when they may be at additional risk of exacerbation. Patients are asked a couple of simple questions and asked to contact their practice if they have any problems. Practices are also alerted to patients who may benefit from being contacted and offered anticipatory care. We are currently evaluating the service, involving patients, practice staff and examining the impact on emergency admissions. We hope to have completed this piece of work by the end of June.	nisha.sankey@worcspct.nhs.uk
992	Wrexham Local Health Board	We have an excellent pilot in progress utilising the District nurse teams and respiratory facilitator to ensure assessments are undertaken on all housebound COPD patients. This also links in with the development of care	kath.cooper@wrexhamlhb.wales.nhs.uk

	home, residential home and nursing homes COPD leads that link in with the DN teams or respiratory facilitator. A telecare pilot is also underway with housebound and vulnerable patients with COPD.

Appendix E: The National COPD Audit 2008 – Professional roles of those completing the survey

Role of person completing the PCO survey	Frequency
Acting Assistant Director of Commissioning	1
Acting Senior Commissioning Manager	1
Assistant Commissioning Manager	1
Assistant Development Manager Chronic Diseases	1
Assistant Director Adult Nursing Services	1
Assistant Director of Nursing	1
Assistant Director of Public Health	1
Assistant Director Primary Care	1
Associate Director Community Engagement	1
Associate Director Medicine Man & LTC	1
Associate Director of Commissioning	1
Associate Director Public Health Policy	1
Audit and Clinical Effectiveness Lead	1
Care Pathway Redesign Manager & Respiratory Physician Imperial NHS Trust	1
Chairman Primary Care Committee	1
Change Manager	1
CHD & Respiratory Network Manager	1
Chronic Conditions Respiratory Nurse	1
Chronic Disease Management Coordinator	1
Chronic Disease Management Nurse	1
Clinical Auditor	1
Clinical Developer Manager – LTC	1
Clinical Effectiveness & Research Development Manager	2
Clinical Effectiveness Facilitator	1
Clinical Governance and Audit Facilitator	1
Clinical Governance Facilitator / COPD Clinical Coordinator / Assistant Director Health & Social Care Commissioning	1
Clinical Governance Lead	1
Clinical Nurse Manager Respiratory Services, PEC Member, Board Member	1
Clinical Nurse Specialist Respiratory	1
Clinical Services Manager - Primary Care Development	1
Commissioner	2
Commissioner for Community Services	1
Commissioner for LTC	1
Commissioning Development Manager	1
Commissioning Manager	2
Commissioning Manager Long Term Conditions	1
Consultant in PH / Assistant DPH, Chair of Respiratory Working Group	1
Consultant in Public Health	5
Consultant Physiotherapist	1
Consultant Respiratory Nurse	1
Consultant Respiratory Physician	1
COPD Nurse Specialist - Team Lead	1
COPD Service Development Co-ordinator	1
COPD Specialist Nurse	2
Director of Chronic Disease Systems	1
Director of Community and Rehabilitation Services	1
GP / Acute Medicine Team Lead GP (Balfour Hospital)	1
GP. PEC Chair	1
Head of Adult, LTC and Integrated Care Commissioning	1
Head of Commissioning	1
Head of Commissioning and Modernisation	1
Head of Commissioning for Long Term Conditions	1
Head of Innovation and Improvement	1
Head of Long Term Conditions Strategic Development	1
Head of modernisation / community service commissioning	1
Head of Nursing (Service Development)	1
Head of Primary Care & FPS	1
Head of Rehabilitation Services	1
Home Oxygen Therapy and Pulmonary Rehabilitation Nurse Specialist	1
Interim AD Operational Services	1
Joint Commissioner Long Term Conditions	1

Consultant in Public Health Medicine. Lead for adult respiratory services.	1
Lead COPD Nurse Specialist	1
Lead for Chronic Conditions	2
Lead Nurse COPD	1
Lead Nurse Respiratory	1
Lead Nurse Respiratory Services	1
Lead Respiratory Nurse	1
Lead Respiratory Nurse / Lead Respiratory GP	1
Lead, Community Matrons	1
Long Term Condition Coordinator	1
Long Term Conditions Manager	1
Medical Directorate Manager	1
Modernisation & Service Improvement Manager	1
Modernisation Manger	1
Nurse Consultant Long term Conditions	1
Ops Manager – LTC	1
Pathway Redesign Manager	1
Practice Based Commissioning Manager	4
Practice Based Commissioning Project Manager	1
Practice Development Manager	1
Primary Care Respiratory Facilitator	1
Professional Lead for Community Matrons	1
Programme Lead - Clinical Development	1
Programme Manager – Commissioning	1
Programme Manager - Practice Based Communications	1
Programme Manager	1
Programme Manager, Health Reform Demonstration System	1
Project Lead on ongoing conditions	1
Project Manager	1
Project Manager / Service Improvement Specialist	1
Project Manager Primary Care	1
Project Support Officer	1
Redesign Manager	1
Respiratory Care Team Lead	1
Respiratory Clinical Nurse Specialist (Community)	1
Respiratory Commissioning Lead	1
Respiratory Lead/Commissioner	1
Respiratory Nurse Consultant	2
Respiratory Nurse Specialist	5
Respiratory Physiotherapist, Head of Service - Community Respiratory Service	1
Respiratory Programme Manager	1
Respiratory Services Development Manager	1
Respiratory Specialist Nurse	3
Respiratory Specialist Nurse Primary Care Commissioning	1
Respiratory Specialist Physiotherapist and Strategic Lead for COPD Team	1
Respiratory Specialist Practitioner	1
Senior Nurse Manager	1
Senior Nurse Manager Primary Care	1
Senior Public Health Manager COPD	1
Service Development and Commissioning Manager	1
Service Development Lead	1
Service Development Manager	1
Service Improvement Manager	1
Service Manager - Adult & Older People	1
Service Manager Adult Specialist Community Nursing	1
Service Manager Long Term Conditions & PCT Practice Nursing	1
Service Redesign Manager	2
Strategic Programme Manager	1
Strategic Service Development Manager	1
Strategy and Policy Lead	1
Total	141

Appendix F: The National COPD Audit 2008 - glossary of terms and acronyms

Abbreviation	Term / Acronym
NSF for COPD	National Service Framework, now known as the National Strategy, for Chronic Obstructive Pulmonary Disease
SPARRA	Scottish Patients at Risk of Readmission and Admission
NICE	National Institute for Health and Clinical Excellence
KPMG	Klynveld Peat Marwick Goerdeler - provider of professional services including audit, tax, and risk advisory
HOOF	Home Oxygen Order Form
NLIAH	National Leadership and Innovation Agency for Healthcare
LTOT	Long-term Oxygen Therapy
ECG	Electrocardiogram
OPD	Outpatients Department
LIFT	Local Investment Finance Trust
CHP	Community Health Partnership
ARAS	Acute Respiratory Assessment Service
DART	Darlington Respiratory Team
SHA	Strategic Health Authority
MDT	Multidisciplinary Team
HaH	Hospital at Home
PBC	Practice Based Commissioning
GPwSI	General Practitioner with Special Interest
HAD Scores	Hospital Anxiety and Depression Scores
CDR Q Scores	Chronic Disease Respiratory Questionnaire
PR	Pulmonary Rehabilitation
KSF	Knowledge and Skills Framework
Camden REACH	Camden REACH [Re-enablement for Adults in the Community and at Home] is a home visiting service for people in Camden [physiotherapy, occupational therapy, speech therapy] offering assessment, advice and treatment to people who are unable to go to a hospital or health centre, or who have problems related to their home environment.
LDP	Local Delivery Plan
LTC	Long Term Conditions
ATS	American Thoracic Society