The East of England Respiratory Network is one of ten regional groups funded by the Department of Health to oversee the development of respiratory services throughout the region. Our aim is to improve the quality and effectiveness of care delivered to respiratory patients through our commitment to the DH Chronic Obstructive Pulmonary Disease (COPD) and Asthma Outcomes Strategy. Supported by our fourteen Local Respiratory Networks, the East of England Respiratory Team brings together those involved in the delivery and receipt of this care, to work in a co-ordinated way across geographical, organisational and professional boundaries.
## Contents

**Forward from:**  
Professor Tony Davison, Co-Respiratory Lead EoE & Honorary Consultant Physician  
Lianne Jongepier, Co-Respiratory Lead, EoE & Respiratory Services Manager, North East Essex

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Forward from the Clinical Leads

On behalf of the East of England Respiratory Team, we are delighted to present the East of England Respiratory Team Annual Report 2011-12. The report outlines the team’s activity during the year and provides a plan of action to continue the delivery of our goals.

Building on our previous years work, the Outcomes Framework for COPD & Asthma has been the driver for our work this year, together with the other supporting documents that have been published: NICE Commissioning guidelines for people with COPD, NICE Quality standards for COPD, a COPD competency Framework for managing & developing a skilled workforce and a Good Practice Guide for Home Oxygen Assessment Services.

The focus of our work has been to translate policy to real change at the front line, which improves patient care. In the East of England this has been achieved through enthusiastic and committed local respiratory networks. We thank all the countless patient representatives and health care professionals who have helped this vision become a reality.

The continual changing NHS landscape and financial constraints, presents us with further challenges during 2012/12 to ensure our networks remain an integral part of the health landscape and enable the delivery of our national and local priorities. The plans to achieve this are outlined in this report and we believe that respiratory care will continue to improve in the East of England into the future.

Professor Tony Davison
Co-Respiratory Lead EoE &
Honorary Consultant Physician
Southend University Hospital

Lianne Jongepier
Co-Respiratory Lead EoE &
Respiratory Services Manager
North East Essex
Who we are

The East of England (EoE) Regional Respiratory Board oversees the development of respiratory services throughout our region and within each PCT, in particular with regards to the implementation of the COPD Strategy. It is co-led by a respiratory honorary consultant, Professor Tony Davison and a physiotherapist, Lianne Jongepier, with support from Liz Paddison, Network Programme Manager, Sophie Moss, Project Manager, seconded one day a week from GlaxoSmithKline and Elaine Ellis, administrative support. The Board reports to Dr Steve Laitner and Dr James Quinn, Associate Medical Directors, who are accountable to the Department of Health Respiratory Team. Board members were selected to ensure a broad spectrum of interests, knowledge and skills across the region and include:

- Service Development Manager, Long Term Conditions Board EOE SHA – Heather Ballard
- National Improvement Lead, Lung Improvement Programme NHS Improvement – Ore Okosi
- Pharmacy Lead – Carol Roberts
- A Director of Social Services (or deputy) co-opted as necessary
- Representatives from each local network including:
  - Respiratory Consultant
  - Respiratory Nurse
  - PCT Home Oxygen Service Lead
  - Commissioner of Respiratory Service
  - General Practitioner
  - Pharmacist
  - Patient representative/s – BLF/Asthma UK
  - EoE Pharmaceutical Alliance Representative

The Board may co-opt other subject national experts as maybe required from time to time to advise on specific aspects of the strategy, such as EoE Ambulance Service.

To enable delivery of the Strategy and current national and local directives, the Board is supported by 14 Local Respiratory Networks. Memberships of these networks are also multidisciplinary: with representation from professionals, commissioners and patients across the care pathway. In line with the EoE Regional Commissioning Framework 2012/13, patients are put in the centre of decision making in preparation for an outcomes approach to service delivery. They ensure mechanisms are in place to involve users in their planning and review and have the active engagement of all MDT leads from the relevant constituent organisations in the network. Their activities include, service planning, service improvement and design, service quality monitoring and evaluation. The range of outcomes over the past year from the local networks has delivered on many aspects of the Strategy and to ensure continued delivery, our work streams and work plans fall under the 5 national priorities and 1 local priority as described in this report.

The East of England Thoracic Society (EATS) is a very well established and long standing organisation. It has been agreed that from March 2013 the EoE Respiratory Programme Board will be renamed the EoE Clinical Respiratory Network. It will have representation from all local networks with the same multidisciplinary and community expertise as currently. Its membership will also include a Clinical Commissioning Group lead (CCG), research and academic representative, training representatives, chair of pulmonary rehabilitation, regional oxygen groups and patient groups. It will meet twice a year on the same day and place as EATS. The British Thoracic Society (BTS) will provide web support and support from the Academic Health Science Network (AHSN) will also be sought.
Development of our Local Networks

Our Achievements

The benefits that networks bring to services are well recognised. Nationally, networks are regarded as crucial to the development and support for commissioning services and are the way forward to engage stakeholders in the delivery of national strategies. Networks can ensure the provision of quality care and services. Recognising this, the Department of Health is finalising the model to ensure networks are included into the new commissioning arena.

The consultation document for the national strategy on COPD also identified that introducing Networks was the way forward to introduce their strategy across England [link](http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_127970) Following our last year’s regional network mapping events, fourteen local respiratory networks were established in the East of England, and have subsequently shown they have:-

- Brought together clinical and commissioning expertise from across the pathway to improve outcomes for patients
- Been a forum to share multi professional advice, influence and learning, maximising knowledge and delivering better outcomes
- Worked in a collaborative and co-ordinated way to best meet local needs and priorities.
- Been unrestrained by professional and organisational boundaries and ensuring equitable provision of quality clinically effective services
- Focussed on problem solving, considering total resources.
- Improved communication and co-ordination
- Made patients contact with the health care sector easier, with standardised care.
- Have driven change

Continued Development and Support

We acknowledge that our local networks are at differing stages of maturity and we have strived to support both the establishment and development of these in a number of ways:

- Invite to join our NHS Network – EoE Respiratory Programme where we provide helpful resources and news
- The respiratory leads and programme manager provide personal support if required, together with attendance at network meetings
- Development of ‘Top Tips’ documents for ‘Setting up and Sustaining a Local Respiratory Network’ (Appendix 1) and ‘Organising a Local Respiratory Network Meeting’ (Appendix 2)
- Development of example Network Action Log Template (Appendix 3) and Local Terms of Reference (Appendix 4)
- Development of an EoE Respiratory Bulletin ‘Open Airways’ (Appendix 5), sent to all members, which provides updates, news and developments across the region
- Recognising that patient users representatives are essential network members, in collaboration with British Lung Foundation and Asthma UK, establishment of a working group to provide additional support and resources for this group
- Development of a tool to measure the effectiveness of a network ‘Local Respiratory Services and Network Update’ (Appendix 6). We recognise that there needs to be a number of ways this should be assessed as it is dependent on the maturity and development of the networks, so this tool assesses the level of integration through network activities and outcomes. Analysis of the responses will support continued development of the networks to ensure they are all operational, effective and sustainable by April 2013 and additionally supports the sharing of good practices across the region.
Successes

Building a cooperative network of inter-organisational relationships collectively provides services more effectively and efficiently than a system based on fragmented funding and services. This has been facilitated by local respiratory networks in each PCT with involvement of all provider organisations, commissioners and patients. Some network outputs are shown here and further successes are demonstrated in the section 'Integrated care and QIPP'

Cambridge
- Investment in new clinical leads for integrated services across Cambridge & Huntington
- Integration of PHP into PR, Community services & GP Practices
- Adoption of SystmOne in hospital & community teams

Peterborough
- Integrated COPD service with a single point of access
- Integrated care pathways with smoking cessation
- TB Service
- Lung Cancer Service

Bedfordshire
- With help from network, able to commission a countywide, integrated COPD service
- Finalising local COPD guidelines covering Primary, Community & Secondary Care
- Working on improving the use of Emergency Oxygen, particularly between Ambulance Trust & Secondary Care

Luton
- Acute respiratory assessment for admission avoidance
- Early supported discharge
- In-reach service
- End of life care
- Community Integrated Clinics
- Telehealth
- Community Pulmonary Rehabilitation

West Hertfordshire
- Joint clinical governance meetings
- Development of a network of stop smoking champions
- Collaborative working with local hospices, including joint home visits and MDT meetings
- Joint breathlessness clinic

East & North Hertfordshire
- Joint COPD pathway
- Joint COPD clinical guidelines
- Integrated smoking cessation service
- Appointment of a respiratory specialist nurse working in the community
- Appointment of oxygen specialist nurse in working in the community

Norfolk
- Commissioned Pulmonary rehabilitation service
- Integrated smoking cessation service
- Agreed district wide asthma self management /action plan
- Increased Practice nurse involvement

Great Yarmouth & Waveney
- Appointment of 2 specialist nurses in the community
- Common prescribing pathway
- Pathway development
- Commissioned pulmonary rehabilitation
- Commissioned HOS-AR service

Suffolk
- Integrated COPD service
- Jointly agreed clinical guidelines for COPD
- Jointly agreed asthma Care pathway
- Jointly agreed clinical guidelines for asthma
- Integrated smoking cessation service
- Integrated Pulmonary Rehabilitation service

Mid Essex
- Development of an Ambulance Admission Avoidance Scheme
- Joint working with pharmacies on spirometry project
- Joint COPD clinical guidelines
- Integrated smoking cessation service
Regional Special Interest Networks

To improve regional standards of care, reduce unwanted variation and enable sharing of best practice the EoE Respiratory Team set up 2 regional Special Interest networks. These clinical networks initially formed after a mapping exercise, identifying both Pulmonary Rehabilitation & HOS-AR services throughout the region. Regional surveys which established local service provision & local champions for both clinical areas were conducted.

Pulmonary Rehabilitation:
A first successful meeting was held with representation of 12 out of 14 localities. The agenda centred on the regional data collected from the survey. The group decided all would continue collecting data to monitor service provision and align services to Impress Clinical Guidelines. The group agreed data collected should be standardised and a subgroup will action this. A further meeting date in set for July.

HOS-AR:
Two surveys, one year apart, have been completed and enabled the respiratory team to monitor regional progress. There are new HOS-AR services in all areas. The group links in with the regional HOS transition/contract board, led by Carol Roberts.

The EoE Respiratory Team has also funded a regional respiratory End of Life course, facilitated by ARNS (Association of Respiratory Nurse Specialists). The course was attended by representatives from all 14 localities.

Next Steps 2012-13

<table>
<thead>
<tr>
<th>PRIORITY</th>
<th>Continued Development of our local Networks</th>
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</table>
| ACTIONS  | 1. To be allied to East of England Clinical Respiratory Network (Steering Group) aligned with EATS and discuss support from AHSN  
2. Engagement of CCGs in local networks  
3. Networks and local health care providers to review respiratory outcomes for key indicators and develop work plans to improve outcomes  
4. Work with BLF to enhance patient input to networks |
| OUTCOMES | Sustainability of networks |
A Core Data Set

East of England and the National Initiative INHALE

Recognising that robust data is key to service improvement, the project INHALE (Interactive Health Atlas for the Lungs in England) was successfully launched at the winter BTS meeting 2011. A web site was set up, and comments about the site have been recorded (www.inhale.nhs.uk). A National steering group has now been formed and EoE co-lead, Professor Tony Davison, has been asked to chair it.

The EoE Respiratory Team agrees that data showing variation can drive change, and for this to be achieved there needs to be collaboration between the data gurus and clinicians. Developing a core data set has therefore been a work steam for two years. The team decided that robust National Data was required rather than weak parochial local data. The latter is often only available on a one off basis, and suffers in that many do not trust it. This type of data is not therefore a vehicle for change.

Much early collaborative work was done with EoE Observatory and the Pharmaceutical Industry through the East of England Pharmaceutical Alliance. Dr Robert Winter, previously EoE Medical Director and subsequently Co-National Respiratory Director has also been part of the group. The work subsequently has been with Quality Intelligence East, the Quality Observatory in the EoE, who have led the project while the Respiratory Team have provided the clinical input. The aim has been to try to produce one core data set for the whole of England. Quality Intelligence East developed data sets from approximately 70 indicators.

Regional Data Initiatives

In the EoE we have ranked 4 indicators which will be widely circulated to clinicians and commissioners in a data pack and will include overall ranking, an individual ranking of the 4 key indicators, and a trend analysis for 3 key indicators (Appendix 7). The leads will meet and discuss with representatives, Chief Executives and Commissioners, in those areas with low rankings, suggesting actions that they can take for improvement (Appendix 8)

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Rank summary for key indicators: East of England (Inhale, May 2012)
In the next year we will identify those GP practices with the best Observed to Expected Ratios for COPD and try to identify the good practice that produced this and then distribute this to CCGs. Excellent Pulmonary Rehabilitation data has been collected in the EoE, however, discussion in the Pulmonary Rehabilitation Special Interest Network established that uniform definitions weren’t being used e.g. for a completer. This group has now set up a work stream to agree uniform definitions so that PR can be directly compared between Districts in the future.

Data has also been collected from all HOS-AR Services, this enables clinicians to compare the services that are being offered. There has also been a HIEC study of door to mask time for NIV in Essex, which showed considerable variation. These results will also be discussed with hospitals at visits.

**Next Steps 2012-13**

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<tr>
<th>PRIORITY</th>
<th>A Core Regional Data Pack</th>
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<tr>
<td>ACTIONS</td>
<td>1. Produce local data packs</td>
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<td>2. Circulate to networks, clinicians and commissioners</td>
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<td></td>
<td>3. Leads to meet with CEO and Commissioners</td>
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<td></td>
<td>4. Networks to consider and source local data requirements</td>
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<td></td>
<td>5. Data to be included in network agendas and work plans</td>
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<tr>
<td>OUTCOMES</td>
<td>Evidence of data used in formulating local work plans</td>
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**Medicine usage, optimisation and prescribing**

We know there is significant variation in evidence-based prescribing and medicines management of people with COPD, with some receiving inadequate or inappropriate treatment. We need to ensure that people with COPD receive evidence-based treatment in a structured medicines management approach. The NHS Companion Document to the Outcomes Strategy for COPD and Asthma, recommend the provision and optimisation of pharmacological treatment within Domain 2 ‘Enhancing the quality of Life for people with Long Term Conditions’

To support this recommendation we are focussing on Long Term Oxygen Treatment (LTOT) and will be endorsing key prescribing messages from PRESQIPP, specifically their work on inhaled medication and oral prednisolone.

**Long Term Oxygen Treatment (LTOT)**

It is known that there is vast over expenditure if patients are prescribed oxygen inappropriately and they are not properly assessed. Recommendations we will make through our networks are:-

- All patients prescribed long term oxygen should have their diagnosis confirmed and management reviewed by a respiratory consultant.
- All respiratory patients prescribed oxygen should be seen by the HOS-AR service.

**Switching From Seretide R 250 Evohaler to Seretide R 500 Accuhaler**

From the PRESQIPP work we know that:-

1. Seretide R evohaler (2 puffs bd) costs £59.48 for 30 days compared £40.92 for the equivalent dose of Seretide R 500 accuhaler (1 puff bd)
2. If all the patients taking Seretide R evohaler 250 were taking Seretide R 500 the saving would be £5.7 million
3. Seretide 250 evohaler is not licensed for use in COPD.

Full information on this subject and switching is available on their website, and from this we will be recommending through our networks:-

- All clinically stable patients on Seretide R 250 evohaler should have a clinical review and a trial of Seretide R 500 accuhaler if they can use the accuhaler device
- As studies show significant numbers of people using inhalers do not do so correctly. This limits their effectiveness, and to substantially improve symptoms and outcomes and reduce costs further, inhaler technique needs to be improved. We will also recommend regular teaching and checking of technique is carried out by health professionals

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<td>ACTIONS</td>
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<tr>
<td>1. Patients prescribed LTOT have diagnosis confirmed and management reviewed by a consultant</td>
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<td>2. Patients prescribed oxygen are seen by HOS-AR service</td>
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<tr>
<td>3. Joint communications bulletin produced with Pharmacy Lead with advice on</td>
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<tr>
<td>a) clinically stable patients on Seretide R 250 evohaler should have a clinical review and a trial of Seretide R 500 accuhaler if they can use the accuhaler device</td>
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<tr>
<td>b) Patients to receive regular teaching and checking on inhaler technique</td>
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<tr>
<td>c) Enteric-coated prednisolone</td>
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<tr>
<td>OUTCOMES</td>
<td>Improved symptoms and outcomes Cost saving</td>
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Integrated care and QIPP

The challenge to achieve quality, improvement, prevention and productivity (QIPP) is a key driver of activity in the region. The COPD Strategy and gap analysis undertaken by the networks of its 24 recommendations, has proven an excellent basis for improvements across the whole pathways, therefore having the potential to align with the QIPP agenda. EoE has demonstrated that integrated care can and does deliver on QIPP, and continues to promote and support the development of integrated services. Benefits we have seen are

- Barriers to improved care which exist at the boundary of organisations can be broken down.
- Duplication and waste is reduced.
- Continuity of care is improved.
- There are opportunity for new models of care
- Members of different organisations regard themselves as part of the same service.
- Communications between members of the service improves.
- Knowledge of this communication reduces patients anxiety.
- Training and educational deficiencies can be addressed.
- Audit can occur across boundaries.
- Job satisfaction increased, encourages innovative ideas, everything is possible.
- Financial savings
What we have achieved

• Integrated Services
  Integrated services have been commissioned in many localities, including South East Essex, Luton, Bedfordshire, North East Essex, Mid Essex, Suffolk and Peterborough. Some of these localities provide completely integrated pathways and others have worked in a collaborative way to provide services between primary, secondary and community care, with decisions made in a shared way. Outcomes from services being integrated include; agreeing patient pathways across organisations, self management plans, improving continuity of care, reducing duplication, improving communications, developing common IT systems, multidisciplinary meetings, universal availability of pulmonary rehabilitation and HOS(AR), introduction of early discharge and prevention of admission services, education initiatives, community COPD clinics, respiratory consultants involved in community care and education, availability of outcome data through INHALE. Outcome data from one region South East Essex shows a reduction of 19% in COPD admissions and 24% in COPD bed days, and £650,000 saving per annum after the introduction of an integrated service. (DH Atlas Variation)

• HOS(AR) - 100% coverage in EoE and Regional Interest Group set up
  The respiratory team has worked closely with local HOS-AR (Home Oxygen Assessment & Review) Services and the regional HOS Transition Board (lead by Carol Roberts) to influence & improve the commissioning and provision of HOS-AR services throughout the region. A HOS-AR network has been set-up to facilitate this aiming to drive up standards of care and enable sharing of good practice. A survey enabled us to compare provision of services over time, showing us that regionally, we now have 100% of localities providing HOS-AR services, compared to last year

• Discharge Bundle in Operation in 7 Hospitals
• COPD Discharge Bundle is a simple (usually 5-items) check-list for ward staff when preparing patients for discharge after admission for AECOPD (Acute Exacerbation of COPD). The list encompasses evidence-based items and when implemented correctly addresses the wide variation in care provided by acute trusts, highlighted by the 2008 National COPD Audit (reference 1). There has been a national enthusiasm to support trust with the implementation of these bundles aiming to drive up clinical care and improve the experience of people with COPD. In our region, Great Yarmouth led the way and introduced this as a CQUIN. The EoE Respiratory Team collaborated with HIEC’s (Health Innovation & Education Cluster) and obtained a regional start-up fund to help 5 localities with its implementation. The team also worked with the HIC (High Impact Changes) team at the SHA to produce a regional Good Practice Bulletin, aiming to influence further uptake and influence a region-wide CQUIN). All 5 localities have adapted their bundle to ensure local relevance and are currently collecting data to demonstrate its benefits. The EOE Respiratory Team will continue to promote this work, aiming to double regional uptake by 2013

• Pulmonary Rehabilitation
  Pulmonary Rehabilitation (PR) is acknowledged to be an evidence-based, high value element of care for patients with COPD. It reduces morbidity, mortality and hospital attendances in people with COPD disabled by their disease (IMPRESS, 2011). As a region we recognised that that PR should receive commissioning priority given its proven clinical and cost effectiveness and relative value compared to many of our other interventions for COPD, and it is now available in all localities. We expect that availability will also increase with the adoption of discharge bundles

• **Self Management Plans**

It is recognised that self management of mild exacerbations will reduce health care dependency and costs. The Regional Board agreed that all networks should introduce exacerbation plans in 2011/12 (NICE Quality Standards) and all have done so.

### Next Steps 2012-13

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<thead>
<tr>
<th>PRIORITY</th>
<th>Integrated Care and QIPP</th>
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| ACTIONS        | 1. Increase uptake of discharge bundles across the region  
  2. All COPD admissions to be seen by respiratory team  
  3. Work with CCGs to support their QIPP respiratory deliverables  
  4. Continue to promote integration though the networks |
| OUTCOMES       | To increase integrated working and service development |

### Late Diagnosis

**The need to improve diagnosis in Primary Care**

The national strategy for COPD identifies that there are an estimated 2 million people with COPD who remain undiagnosed and there are also a significant numbers of misdiagnosis. Late diagnosis is known to result in poorer outcomes. There is good evidence to suggest that identifying those with known risk factors or early lung function changes will enable a proactive approach to be taken to monitor these changes and provide early management and appropriate treatment for this group.

Throughout our region there has been varying approaches to identify the ‘missing millions’ including:

- Public screening events, such as the Health Bus and ‘Know it, check it, treat it’ campaigns and spirometry days, to raise awareness of COPD and lung health in general
- Commissioning of additional spirometry courses
- Spirometry Schemes where equipment and training is offered to GP practices to improve diagnosis and management

Though we acknowledge there have been examples of proactive activity to enable earlier diagnosis, we recognise that this is often piecemeal and we will have to work towards making our approaches systematic. Our region will be tasked with reducing the gap between recorded and expected prevalence for COPD and will draw on areas of good practice to ensure we deliver on this through improved diagnosis within primary care.

### Next Steps 2012-13

<table>
<thead>
<tr>
<th>PRIORITY</th>
<th>Late Diagnosis. The need to improve diagnosis in Primary Care</th>
</tr>
</thead>
</table>
| ACTIONS        | 1. Determine from Quality Intelligence East practices with high observed to expected rates  
  2. Establish practices with good rates and investigate their actions, especially if systematic record searches have been successful  
  3. Circulate the areas of best practice to CCGs throughout the region |
| OUTCOMES       | Reduction of the gap between recorded and expected prevalence for COPD |
Education and Workforce

High quality care and support is a major consideration of the national strategy. Education is acknowledged as integral to high quality care, so as a region we agreed a locally determined priority to improve the quality, effectiveness and efficiency of care through an educated workforce. Most people with changes to their lung function will visit general practice for diagnosis and management. Once diagnosed with COPD or asthma, it is the practice nurses who carry out the majority of clinical reviews, so we agreed to focus on this particular professional group by undertaking a training needs analysis for Primary Care Nurses. The Training Needs Analysis is a collaborative project undertaken by the East of England Pharmaceutical Alliance (EPA) with The East of England Respiratory Team.

Implementing a training needs analysis is the first step towards improving the quality of respiratory education available across the region by enabling future interventions to be put in place to address weaknesses and gaps. This will ultimately improve skills and capabilities and therefore the quality and effectiveness of care delivered to the respiratory patients.

Highlights of the interim analysis are

- Very high response rate, 60% of all practices across the region completed the survey
- 62% of nurses have the asthma diploma
- 36% have the COPD diploma
- The most common forms of education are self directed learning and pharmaceutical supported education
- Approximately 20% of nurses are not very confident in dealing with many aspects of asthma or COPD care

Further analysis is to be undertaken, specifically focusing on specific correlations

Next Steps 2012-13

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<tr>
<th>PRIORITY</th>
<th>Education and Workforce</th>
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| ACTIONS        | 1. Share results with GPs, Practice Nurses, Clinical Commissioning Groups and local networks  
2. Develop and deliver a needs based respiratory education programme  
3. Consideration as to how EPA can support respiratory education in the future |
| OUTCOMES       | Improved care  
Improved patient satisfaction  
Reduction in unnecessary admissions  
Potential increase in case finding (less late diagnosis)  
Provision of continued education opportunities |
TOP TIPS
Setting up and Sustaining an EoE Local Respiratory Network

**What are Networks?**
- Networks bring together clinical and commissioning expertise from across the pathway to improve outcomes for patients.
- Networks are a forum to share multi professional advice, influence and learning, to maximise knowledge and deliver better outcomes.
- They work in a collaborative and co-ordinated way to best meet local needs and priorities.
- They are unrestrained by professional and organisational boundaries and ensure equitable provision of quality clinically effective services.

**What do they do?**
- Focus on problem solving, considering total resources.
- Improve communication and co-ordination.
- Ensure patients contact with the health care sector is easier, with standardised care.
- Drive change.

**How to start and sustain?**
- Be clear about its purpose, accountability, decision making and leadership—Terms of Reference. Example TOR available - [ToR Local Respiratory Network.doc](mailto:ToR Local Respiratory Network.doc)
- Spend time engaging your stakeholders from the start.
- Requires MDT membership – Primary Care, Acute Trust, Community, Pharmacy, Mental Health, Public Health, Ambulance Trust. **Essential** to link with CCG and **must** include Commissioner and Patient/Public.
- Ensure you have the support and commitment of your key decision makers.
- Essential to identify your committed clinical leader.
- Requires a member to sit on the EoE Clinical Respiratory Network.
- Requires administrative support - Top Tips for meetings and action plan available - [20120502 Top Tips - Setting up a Network Meeting.docx](mailto:20120502 Top Tips - Setting up a Network Meeting.docx)
- Data drives improvements. Use local and national data - [www.inhale.nhs.uk](http://www.inhale.nhs.uk).
- Develop and monitor a work/action plan to include Regional Board priorities.
- Deliver on work plan = a sustainable network 😊

Contact [l.paddison@nhs.net](mailto:l.paddison@nhs.net) for more information.
Organising a Local EoE Network Meeting

Setting up the Meeting

- Agree who is responsible for setting up/organising the meetings
- Have an up to date membership list and contact details
- Agree which day and time is best for members
- Decide on and book up venue
- Set-up meetings at least 4-6 weeks in advance. Ideally book for the year
- Ask for acceptances or apologies

Preparation

- Always have an agenda agreed by the chair– use your work plans/action log to shape this – click here for an example action log template.
- Work plans/actions logs are essential for outcomes. Identify small working parties to tackle practice-based issues. Mapping or pathway exercises are a good way to start
- Gain stakeholder input into the agenda to ensure it meets the group’s needs and there is ‘buy-in’
- Identify who leads on each agenda item
- Each agenda item will need an output – what do you need to achieve?
- Circulate the agenda approx. 1 week before the meeting – this will service as a reminder, and give people time to do any pre-work/reading

At the Meeting

- Identify a scribe to take notes and capture any actions from the meeting (who, what, when)
- Review any actions from previous meeting. Using an action log helps. Which actions are still open and what is the progress? Does the responsible person remain the same? Does the target date need reassigning? What are the blocks, and how can these be resolved? Can the EoE Clinical Respiratory Network help?

Follow up

- Type up and agree minutes/action log with chair/co-chair
- Circulate minutes/action log

Contact l.paddison@nhs.net for more information
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<thead>
<tr>
<th>No</th>
<th>Topic</th>
<th>Date Entered</th>
<th>Action by</th>
<th>Progress</th>
<th>Date Completed</th>
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<td>1</td>
<td>Introductions &amp; Apologies</td>
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<td>Attendees:</td>
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<td>Action Log from last meeting</td>
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<td>3</td>
<td>Feedback from EOE</td>
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<td>Workstream A</td>
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<td>Workstream B</td>
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<td>AOB</td>
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<td>Date of Next Meeting</td>
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LOCAL EoE RESPIRATORY NETWORK

Membership

Networks are multidisciplinary: with representation from professionals, commissioners and patients across the care pathway; ensure mechanisms in place to involve users in their planning and review; and have the active engagement of all MDT leads from the relevant constituent organisations in the network. The representation on the Network should be such that the Regional Board agree to authorise it as a source of the Network’s clinical opinion on matters relating to respiratory care

Service Planning

Networks should ensure that service planning:

- Is in line with national guidance/standards (including reconfiguration where necessary)
- Covers the whole care pathway.
- Promotes high quality care and reduces inequalities in service delivery.
- Takes account of the views of patients and carers.
- Takes account of opportunities for service and workforce redesign.
- Establishes common guidelines, including clear referral guidelines.

Networks should

- Recommend priorities for service development to the network board.
- Ensure decisions become integrated into constituent organisational structures and processes.

Service Improvement/Redesign

- All Networks should commit to service improvements.
- Process mapping and capacity and demand analyses should become part of the norm
- Develop/approve/use high quality local information for patient, for use across the network.

Service Quality Monitoring and Evaluation

- Agree on priorities for local common data collection in line with national priorities, but go beyond this where possible.
- Review the quality and completeness of data, recommending corrective action where necessary.
- Produce audit data and participate in open review.
- Ensure services are evaluated by patients and carers.
Terms of Reference Local Respiratory Network

- Monitor progress on meeting national respiratory measures and ensure action plans agreed following peer review are implemented.

Workforce Development

Networks should:

- Consider the overall workforce requirements of the group
- Consider the education and training needs of teams, and where appropriate, of individuals

Research and Development

- Networks should agree a common approach to research and development, working with the Network Board, participating in nationally recognised studies whenever possible.

Annual Work Plan and Report

Networks should:

- Draw the above together in an annual work plan in the context of a prioritised clinical governance development plan, for approval by the network board.
- Ensure this is fed into commissioning, with agreements specifying standards, service developments and improvement, data collection, audit, research, education and training.
- Provide an annual report of activity to feed health economy clinical governance reporting processes.
East of England Respiratory News Bulletin

Launch of new East of England Respiratory News Bulletin!

Welcome to the first edition of the East of England Respiratory News Bulletin. Every other month we will update you with the exciting respiratory news and developments from across the region. In our first newsletter we would like to highlight the COPD discharge bundle being implemented across the region, celebrate the launch of the INHALE data set, and update you on the training needs analysis due to take place across the region.

We hope you enjoy the read—please let us know what you think! sophie.moss@nhs.net

New National Respiratory Data Hub

The Interactive Health Atlas for Lung conditions in England (INHALE), launched recently, presents powerful, actionable data on respiratory disease of value to both clinicians and commissioners.

INHALE can drive ahead change by informing commissioning and planning decisions that will tackle disease and improve the health of local communities. A wide range of indicators have been chosen, focusing on three main themes: prevention and burden of disease; early identification and good-quality early diagnosis; and High-quality care and support.

Further updates to the INHALE data set are planned, and this is set to continue to be a pivotal resource for those involved in respiratory service provision and improvement.

INHALE can be accessed through the BTS website or at www.inhale.nhs.uk. Please take the time to visit the hub and start exploring!

Did you know?

NICE Quality Standard 7: People who have had an exacerbation of COPD are provided with individualised written advice on early recognition of future exacerbations, management strategies, and a named contact.

This is an area of focus for the Respiratory Team. To see examples of local COPD action and exacerbation plans, visit our website here.

Inside this issue:

- COPD Discharge Bundle—what’s it all about? 2
- Regional Training Needs Analysis 3
- New online Asthma Test 3
- Upcoming Resp. Events 3
- Did you know? 3

The new Outcomes Strategy for COPD and Asthma includes a number of evidence based recommendations. A COPD Discharge Bundle incorporates these important recommendations, aiming to improve patient safety and quality of care by acute trusts.

Discharge bundles are already in use in four London acute trusts, and follow up studies have shown clear improvements in the process of care and a reduction in the 30 day readmission rate where the care bundle was used compared to where it was not. A 39% reduction in 14 and 28 day readmission rates was found after using a discharge bundle on the respiratory ward at the West Middlesex Hospital.

Discharge bundles can also improve other areas of COPD management including smoking cessation and referral rates to pulmonary rehabilitation. The following 5 areas should form part of an effective bundle:

1. Smoking cessation referral;
2. Pulmonary rehabilitation recommendation and referral;
3. Self-management plans and disease education;
4. Inhaler technique check and correct device implemented;
5. Appropriate follow-up with either GP, community teams or hospital respiratory clinic.

The bundle is a major step-up in care, but will only have a meaningful impact if it is implemented across a trust, requiring clinical leadership and management intervention. This may be best done through proposing it as a local CQUIN, providing the right incentive to prioritise this. Locally, Great Yarmouth have adopted this approach and are leading the way. Regionally, the East of England Respiratory Team have promoted the use of this bundle and have worked with various organisations to get this implemented locally, for example Southend and Colchester. The Respiratory Team have received some funding from HIEC (Health Innovation & Education Cluster) to support local implementation in the 5 Essex localities and have received the support from the HIC (High Impact Changes Team) at the SHA.

Regional Training Needs Analysis

The East of England Pharmaceutical Alliance and the East of England Respiratory Team will be completing a regional Respiratory Training Needs Analysis over February/March.

The objective of the survey is to understand how current respiratory training is delivered across the region, and to identify any existing gaps. The results of this training needs analysis will then be used to inform the design of a future Joint Working project between the two parties with the aim of improving the quality and effectiveness of care delivered to respiratory patients across the region.

AstraZeneca have been selected to provide the Training Needs Analysis due to their previous experience in this area. The training needs analysis will be deployed across the region using the Survey Monkey online tool. All practice managers will receive an email containing a link to the survey week commencing 27th February and will be asked to forward on to the respiratory leads in their practice. The closing date for the survey is 9th March (2 weeks).

What are the benefits of this survey? This survey will allow gaps in the current delivery of respiratory training across the region to be identified, allowing us to develop a bespoke training plan for the region. Additionally, all respondents will receive their own individual report for future personal development planning.

How can you help us? It is essential that the response rate to this survey is maximized, and therefore you can help by raising awareness in general practice of the training needs analysis, and ensuring that the survey reaches the right people within practices.

Look out for future communications. If you have any further questions, please contact Sarah Watts, project manager for the Training Needs Analysis:
sarah.watts@nhs.net
Tel: 07977 725456

New online Asthma Test

Asthma UK have launched a new online asthma test called Triple A: Avoid Asthma Attacks. The test aims to reduce the number of deaths through asthma attacks, which claim the lives of three people in the UK a day.

Anthony Davison says “This is a good exercise for Asthma Nurses and other healthcare professionals to go through because it highlight the risk factors for asthma death. Interestingly, much of the research was done in EoE some years ago”.

What next? We recommend taking the test yourself, and using with local patients and families to highlight the individual’s risk of an asthma attack and to provide advice on how to avoid attacks, and what to do in the event of an attack.

Did you know?

The Respiratory Team is working with Respiratory Networks to maximise the benefit of patient representatives across the region and share-best practice. All Networks should have at least one, preferably two, patient representatives (Asthma / COPD).

Clinicians across the region have been unanimous that patient representatives make a big difference on networks. For example, in Bedford and Luton, a patient representative was pivotal in commissioning the new service.

Additionally, the BLF and AUK are working in this area to support patient representatives in their roles.

For more information, or to share an example of where a patient rep has made a difference, please Tony Davison.

Dates for the Diary

Upcoming Respiratory Events

- Regional Pulmonary Rehabilitation Clinical Group, 2—4pm, 29th February, Victoria House, Capital Park, Fulbourn, CB21 5XB.
- East Anglian Thoracic Society, 17th April, Colchester Hospital. Nurses and Allied Healthcare Professionals—AM. Please contact Lianne Jongepier for further details.
- COPD8 Conference, 20th—22nd June 2012, Birmingham ICC.

Don't forget to visit the East of England Respiratory Team Website for local news and examples of best practice: 
1. Your Network Details

Who organises/leads your network meetings?

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<thead>
<tr>
<th>GP</th>
<th>PCT Commissioner</th>
<th>Acute Trust</th>
<th>Community</th>
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Jointly organised/led [ ] Comments

Which groups are represented on your network?

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<tr>
<th>GP’s</th>
<th>PCT Commissioner</th>
<th>Acute Trust</th>
<th>Community</th>
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</table>

Social Care [ ] Ambulance Trust [ ] Public Health [ ] Patient/Public [ ]

Other (please give details)

Do you have plans for involving CCG’s in your network?

YES [ ] NO [ ]

How often does your network meet?

1-3 months [ ] 3-6 months [ ] 6-12 month [ ]

Has your network undertaken a whole pathway review? E.g. Gap Analysis, Stakeholder Event

YES [ ] NO [ ]

On a scale of 1 to 10 how would you rate the extent of collaborative working in your area?

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<td>HIGH</td>
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On a scale of 1 to 10 how would you rate the effectiveness of your network in improving integration/coordination of services?

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<td>HIGH</td>
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Please give details of the areas that have been your major successes in terms of integration

1. 
2. 
3.

Do you link in with any other networks?

YES
Please give details
NO

Are there any major difficulties within your network?

YES
Please give details
NO

2. Pathways and protocols

Is there a current care pathway for COPD, from diagnosis to end of life, jointly agreed between primary, secondary and community care?

YES
NO
IN PREPARATION
REQUIRES REVIEW

Is there a separate pathway for COPD within Secondary Care, Primary Care or Community Care? (Y/N or ? in each box)

Secondary Care
Primary Care
Community Care

Is there a current care pathway for Asthma, from diagnosis to end of life, jointly agreed between primary, secondary and community care?

YES
NO
IN PREPARATION
REQUIRES REVIEW

Is there a separate pathway for Asthma within Secondary Care, Primary Care or Community Care? (Y/N or ? in each box)

Secondary Care
Primary Care
Community Care
Are there local joint primary, secondary and community care clinical guidelines for COPD?

YES ☐ NO ☐ IN PREPARATION ☐ UNSURE ☐

Are there separate clinical guidelines for COPD within Secondary Care, Primary Care or Community Care?(y/n or ? in each box)

Secondary Care ☐ Primary Care ☐ Community Care ☐

Are there local joint primary, secondary and community care clinical guidelines for Asthma?

YES ☐ NO ☐ IN PREPARATION ☐ UNSURE ☐

Are there separate clinical guidelines for Asthma within Secondary Care, Primary Care or Community Care?(y/n or ? in each box)

Secondary Care ☐ Primary Care ☐ Community Care ☐

Is there sharing of respiratory patients records between primary, secondary and community care?

YES ☐ PAPER FORMAT ☐ YES ELECTRONIC FORMAT ☐ NO ☐ IN PREPARATION ☐

Is there proactive activity to address and reduce the gap between recorded and expected prevalence for COPD in your area? (Finding the ’Missing Millions’)

YES ☐ NO ☐ IN PREPARATION ☐ UNSURE ☐

3. Smoking Cessation Support

Which of the following have easy access to Smoking Cessation Support Services? (y/n or ? in each box)

Secondary Care ☐ Primary Care ☐ Community Care ☐ Social Care ☐

Are these services integrated?

YES ☐ NO ☐

4. Pulmonary Rehabilitation

Is this a Hospital or Community Service? (y/n or ? in each box)

Hospital ☐ Community ☐

Are these services integrated?

YES ☐ NO ☐
<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO BUT PLANNED</th>
<th>NO PLANS</th>
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<tbody>
<tr>
<td>Can Primary Care access any of the PR services?</td>
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<td>Is there direct access to PR post discharge?</td>
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<tr>
<td>Waiting list</td>
<td>1 – 2 wks</td>
<td>2 – 4 wks</td>
<td>4 – 8 wks</td>
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<tr>
<td>Is there a COPD Discharge Bundle in place?</td>
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<td>Is there an Early Discharge Scheme in place?</td>
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<td>Is there an Admission Avoidance Scheme in place?</td>
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<td>Is there an agreed district wide COPD Self Management/Action Plan?</td>
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<td>How has this been achieved?</td>
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<td>What are the issues and details of any progress you have made towards this?</td>
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<tr>
<td>Is there a COPD Discharge Bundle in place?</td>
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<td>Is this given to patients by Secondary Care, Primary Care or Community Care?</td>
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<td>Are there separate plans in Secondary Care, Primary Care or Community Care?</td>
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</table>
Is there an agreed district wide Asthma Self Management/Action Plan?

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<th>YES</th>
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Is this given to patients by Secondary Care, Primary Care or Community Care?

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<th>Primary Care</th>
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Are there separate plans in Secondary Care, Primary Care or Community Care?

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<th>Primary Care</th>
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7. End Of Life Care

Is there an Integrated End of Life Care plan jointly agreed for COPD patients?

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<th>YES</th>
<th>NO</th>
<th>PLANNED</th>
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Is there an End of Life Care Plan within Secondary Care, Primary Care or Community Care?

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<th>Primary Care</th>
<th>Community Care</th>
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Is there a multi-disciplinary meeting across secondary, primary and community care for patients with severe COPD?

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Please use this section to provide any additional comments you may have on this section


8. Inhaled and Oral Therapies

Is there an agreed district wide (across Primary & Secondary Care) drug policy for COPD?

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<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>BEING INTRODUCED</th>
<th>NOT SURE</th>
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Is there a drug policy for COPD in primary care?

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<th>YES</th>
<th>NO</th>
<th>BEING INTRODUCED</th>
<th>NOT SURE</th>
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Is there a drug policy for COPD in secondary care?

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<th>YES</th>
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<th>BEING INTRODUCED</th>
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Is there an agreed district wide drug policy (across Primary & Secondary Care) for Asthma?

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<th>YES</th>
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<th>BEING INTRODUCED</th>
<th>NOT SURE</th>
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<td>Question</td>
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<td>Is there an agreed district wide drug policy for Asthma in primary care?</td>
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<td>Is there an agreed district wide drug policy for Asthma in secondary care?</td>
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9. Education

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<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>BEING PLANNED</th>
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<tbody>
<tr>
<td>Is there a multi-disciplinary respiratory education programme available in Secondary Care?</td>
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<tr>
<td>Is there a multi-disciplinary respiratory education programme available in Primary and Community Care?</td>
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10. Service Targets

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<th>What are there agreed service targets in your area for?</th>
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<tbody>
<tr>
<td>COPD Emergency Bed Days</td>
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<tr>
<td>COPD Re-admission</td>
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<tr>
<td>COPD Population mortality</td>
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<tr>
<td>Gap between observed and expected prevalence for COPD</td>
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<tr>
<td>COPD New Outpatient Appointments</td>
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<tr>
<td>COPD Follow Up Outpatient Appointments</td>
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</tbody>
</table>

11. Audit

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>BEING INTRODUCED</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you undertaken any of the following national audit projects?</td>
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<tr>
<td>BTS Asthma Audit</td>
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<tr>
<td>ERS COPD Audit</td>
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<tr>
<td>BTS Emergency Oxygen Audit</td>
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</tbody>
</table>

Thank you on behalf of the EoE Respiratory Network for completing this update

Please return by **WEDNESDAY 2ND MAY 2012**

by email: l.paddison@nhs.net

or post to:
Liz Paddison, EoE Respiratory Network Programme Manager
NHS Midlands and East – East of England Office,
2-4 Victoria House,
Capital Park,
Fulbourn,
Cambridge,
CB21 5XB
Summary indicators data pack for COPD – East of England - Contents

- This pack contains information about 4 key measures relating to COPD outcomes for EoE.
- The information is drawn from INHALE (www.inhale.nhs.uk) which pools data on respiratory disease from a range of sources.
- There are 3 presentations:
  - A summary showing ranking of each PCT, and a measure of improvement (next slide)
  - A slide showing the distribution of each indicator
  - Slides showing funnel plots for these indicators
- NOTE: due to merger of E&N Herts and West Herts into Herts some data is only available for Herts – where historical data is not available for Herts we have recombined E&N and W Herts

Improvement

- Based on trend data for the 4 variables we:
  - Assessed if there was a statistically significant trend over time using simple linear regression (so that the confidence interval of the trend excluded 0)
  - Looked at the direction of the trend if one existed
  - Assigned a simple score
    - +1 for improvement (ie significant trend in the right direction)
    - 0 for deterioration
    - 0 for no change
  - We summed these (unweighted) to give an overall score

Ranking

- 4 key indicators ranked within the EoE in this example (1 is “best”)
- Ranks summed to give overall score
- Scores re-ranked

Rank summary improvement scores: East of England

Rank summary for key indicators: East of England
Distribution of emergency beddays for COPD admissions 2010/11 (per 1,000): East of England

Funnel plot: readmission rates East of England

Distribution of emergency readmissions within 28 days for COPD admissions 2009/10 (%): East of England

Funnel plot: mortality rates East of England

Distribution of ratio observed: expected COPD prevalence 2010/11: East of England

Funnel plot: bedday rates East of England
**Key Processes and Actions to Improve Outcomes in COPD**

All commissioners and clinicians should aim to improve these four outcomes. This paper highlights processes which will help achieve this. Some processes will improve one outcome, others will improve more than one outcome. If they are not in place then actions should be taken to introduce them. If they are in place then audits should be done to ensure they are being complied with, and actions taken if they are not.

Importantly mortality is improving in some areas but not all. What can be done in your area to further reduce mortality? Most of the processes below will help but particularly number two.

<table>
<thead>
<tr>
<th>Process</th>
<th>NICE Quality Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Smoking cessation should be provided across the whole patient pathway. It should be offered to smokers at all COPD reviews, in obstetrics, in mental health, in hospital admissions etc.</td>
<td>5</td>
</tr>
<tr>
<td>2. Systematic methods should be in place for identifying previously undiagnosed cases of COPD in Primary Care, i.e. improving the Observed to Expected Ratio for COPD. Examples include performing spirometry on smokers on inhalers, or smokers who are SOB.</td>
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<tr>
<td>3. Spirometry should be quality assured.</td>
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<td>4. People meeting the criteria for pulmonary rehabilitation should be receiving it.</td>
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</tr>
<tr>
<td>5. Pulse oximetry should be measured at all reviews of COPD in primary /community/hospital care to identify hypoxia. Hypoxic patients should then be assessed in a HOS-AR service.</td>
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<tr>
<td>6. All COPD admissions should be cared for by the Respiratory Team.</td>
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<td>7. There should be daily respiratory consultant ward rounds on the Acute Medical Ward.</td>
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<tr>
<td>8. Patients with COPD should be prescribed oxygen to a target saturation of 88-92%. BTS emergency Oxygen Guideline.</td>
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<tr>
<td>9. All hypoxic COPD admissions should be reviewed by a respiratory nurse specialist within 1 hour of arrival at hospital in the normal working week. NIV should be started promptly if indicated (within one hour of hypercapnic acidosis being identified).</td>
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</tr>
<tr>
<td>10. A discharge bundle should be used for all COPD discharges from all wards.</td>
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<tr>
<td>11. There should be an early supported discharge service.</td>
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