HARTLEPOOL
BOROUGH COUNCIL

AUDIT AND GOVERNANCE COMMITTEE

FINAL REPORT

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

May 2014

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Report of: AUDIT AND GOVERNANCE COMMITTEE

Subject: FINAL REPORT – INVESTIGATION INTO CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

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1. PURPOSE OF REPORT

1.1 To present the findings of the Audit and Governance Committee following its investigation into Chronic Obstructive Pulmonary Disease (COPD).

2. BACKGROUND

2.1 The Audit and Governance Committee met on the 27 June 2013 to consider their Work Programme and agreed that the Committee would in 2013/14 focus on COPD as the health topic for investigation.

2.2 COPD is a chronic disabling disease which causes a gradual decline in lung function, with increasing episodes of chest infections and exacerbations as the condition progresses. It is a general term which includes chronic bronchitis and emphysema. It mainly affects people over the age of 40 and risk increases with age. Smoking is the main cause in the vast majority of cases.

2.3 COPD is incurable but treatments help to slow down the decline in the lung function therefore early diagnosis and support for effective self-management and self-care can help patients live an active life. About 835,000 people in the UK are currently diagnosed with COPD and an estimated 2.2 million people have the condition but do not know it. COPD is the fourth biggest killer in the UK, the second most common cause of emergency admissions to hospital and one of the most costly in-patient conditions treated by the NHS. In Hartlepool, there is a decreasing trend in the number of deaths from COPD but the number of people with COPD is increasing, placing additional demand on services[1].

2.4 The key issues, as identified in Hartlepool's Joint Strategic Needs Assessment (JSNA), relating to COPD are as follows:-

[1] Hartlepool Joint Strategic Needs Assessment – www.teesjsna.org.uk

(a) The estimated prevalence of COPD in Hartlepool is 4.3% but only 2.7% of the population has been diagnosed. This suggests that about 1,250 people with COPD remain undiagnosed.
(b) There is a lack of community awareness of COPD and its risk factors.
(c) There are high numbers with undiagnosed COPD that may lead to increased complications, ill health and health inequalities and inefficiency.
(d) The number of people with COPD is increasing, placing additional demand on services.
(e) There are variations in the quality of diagnosis and management of COPD among general practices.
(f) The COPD emergency admission rate in Hartlepool is higher than the England average.
(g) The capacity and capability of current services to cope with the projected increase in the number of people with COPD, from a recorded prevalence of 2.7% in 2010 to 4.4% in 2020.
(h) There is low awareness of lung health and COPD in communities that are at high risk, for example, current and ex-smokers and women.

(i) There is inequitable access to high quality spirometry in primary care and Community settings.

3. OVERALL AIM OF THE SCRUTINY INVESTIGATION

3.1 The overall aim of the Scrutiny investigation was to examine the effectiveness of the services and pathways available to people diagnosed with COPD and explore how awareness of COPD can be increased to aid early diagnosis and prevention.

4. TERMS OF REFERENCE FOR THE SCRUTINY INVESTIGATION

4.1 The Terms of Reference for the Scrutiny investigation were as outlined below:-

(a) To gain an understanding of COPD and the pathways available to people diagnosed with COPD (including the causes; signs and symptoms; prevention; and treatment);

(b) To consider the numbers of people with COPD in Hartlepool and examine the impact of unplanned emergency admissions on service provision;

(c) To identify the services available in Hartlepool for those diagnosed with COPD and ensure effective partnership working to encourage / increase early diagnosis and positive treatment outcomes;

(d) To examine the quality of diagnosis and management / treatment of COPD across GP practices and NHS services in Hartlepool;

(e) To explore how community awareness of COPD can be increased, in particular to those people / communities who are 'seldom heard, seldom seen' and to people / communities that are at high risk, for example, current and ex smokers and women;

(f) To seek the views of COPD patients and their families and carers; and groups / bodies who provide services for people diagnosed with COPD

5. MEMBERSHIP OF THE AUDIT AND GOVERNANCE COMMITTEE

5.1 The membership of the Scrutiny Forum was as detailed below:-

Councillors Ainslie, S Akers-Belcher, Brash, Fisher, Loynes, Robinson and Shields

6. METHODS OF INVESTIGATION

6.1 Members of the Audit and Governance Committee met formally from 22 August 2013 to 2 May 2014 to discuss and receive evidence relating to this investigation. A detailed record of the issues raised during these meetings is available from the Council's Democratic Services.

6.2 A brief summary of the methods of investigation are outlined below:-

(a) Setting the Scene presentation from the Public Health Team

(b) Presentation and verbal evidence received from North Tees and Hartlepool NHS Foundation Trust

(c) Presentation and verbal evidence received from the Hartlepool and Stockton-on-Tees Clinical Commissioning Group

(d) Presentation and verbal evidence received from the British Lung Foundation

(e) Presentation and verbal evidence received from Stockton and Hartlepool Stop Smoking Service

(f) Presentation, written and verbal evidence received from Tees Valley Public Health Shared Service

(g) Focus Group held on 10 December 2013

(h) Written evidence received from the COPD Exercise Group

(i) Presentation from Hartlepool Families First

(j) Report of HealthWatch Hartlepool entitled 'Listening to the Seldom Heard'

7. FINDINGS

WHAT IS COPD AND WHAT ARE THE PATHWAYS AVAILABLE TO PEOPLE DIAGNOSED WITH COPD (INCLUDING THE CAUSES; SIGNS AND SYMPTOMS; PREVENTION; AND TREATMENT)

7.1 Members at their meeting of 3 October 2013 received a setting the scene presentation from the Council's Specialty Registrar in Public Health to gain an understanding of COPD and the pathways available to people diagnosed with COPD (including the causes; signs and symptoms; prevention; and treatment).

Signs, Symptoms and Causes of COPD

7.2 Members were informed that COPD is the name for a collection of lung diseases including chronic bronchitis and emphysema.

7.3 The principal cause of COPD is smoking. At least four out of five people who develop the disease are, or have been, smokers. Exposure to certain types of dust and chemicals at work, including grains, isocyanates, cadium and coal, have been linked to the development of COPD, even in people who do not smoke. The lining of the airways becomes inflamed and permanently damaged by smoking. This damage cannot be reversed. There is a rare genetic tendency to develop COPD called alpha-1-antitrypsin deficiency which causes COPD in about 1% of cases.

7.4 Members were interested to know about the numbers of people suffering with COPD who had not smoked but had been diagnosed with the disease and the potential causes other than smoking. The Public Health Registrar confirmed that not all people diagnosed with COPD were smokers or ex-smokers, and that people could have contracted the disease through environmental factors. Although looking at the population as a whole, the vast majority of COPD is smoking related.

7.5 The symptoms of COPD usually develop over a number of years and many people are unaware that they have the condition. COPD does not usually become noticeable until after the age of 35. Some of the signs include:-

- increasing breathlessness when exercising or moving around
- a persistent cough with phlegm that never seems to go away
- frequent chest infections, particularly in winter
- wheezing
- weight loss
- tiredness and fatigue
- swollen ankles

Prevention, Diagnosis and Treatment of COPD

7.6 Being diagnosed early allows for appropriate treatment and advice and help to stop or slow the progression of COPD. In order to assess how well the lungs work a spirometry breathing test is carried out, which measures the volume of air a person can breathe out in one second. A comparison is then carried out with normally expected readings to indicate whether airways are obstructed.

7.7 The Committee was informed that early identification of COPD and reducing the numbers that presented to Accident and Emergency departments was a major target. Members acknowledged that identifying sufferers before they presented to Accident and Emergency would be extremely difficult. Twenty percent of all Accident and Emergency attendances related to COPD. Members questioned whether other venues such as the One Life Centre would be able to treat people during an exacerbation, which is a flare up of symptoms, but it was pointed out that during an exacerbation treatment by specialist respiratory team was the most appropriate response.

7.8 COPD causes about 25,000 deaths a year in the UK, progression to severe COPD can be prevented by making lifestyle changes. Stopping smoking is the single most effective way to reduce the risk of getting the condition. Early detection leads to improved outcomes and health and wellbeing.

7.9 There is no cure for COPD, but treatment can help slow the progression of the condition and reduce the symptoms. Treatments help to slow down the decline in the lung function, so early diagnosis and support for effective self management and self care can help patients live an active life. If a person smokes, the best way to prevent COPD from getting worse is for the person to seek help to stop smoking.

7.10 The main aims of therapy are to improve symptoms such as breathlessness and help prevent an exacerbation. Inhaled bronchodilators are generally the first therapies that should be offered to people with COPD. Inhaled bronchodilators and inhaled steroids are used to reduce breathlessness and the chance of an exacerbation.

Numbers of people living with COPD in Hartlepool

7.11 The following diagram illustrates those people diagnosed with COPD compared to those that are undiagnosed across the Tees Valley.

Locality	**Reported Diagnosed COPD - GP disease register aged 16+, 2010/11)**	**Estimated Undiagnosed - 'missing numbers' - with COPD (based on GP registered population aged 16+, 2010/11)**
Hartlepool	2,578	1,602

Middlesbrough	3,828	5,208
Redcar & Cleveland	3,643	2,246
Stockton	4,032	5,544
Tees Total	14,081	14,600

8. SERVICES AVAILABLE IN HARTLEPOOL FOR THOSE DIAGNOSED WITH COPD AND EFFECTIVE PARTNERSHIP WORKING TO ENCOURAGE / INCREASE EARLY DIAGNOSIS AND POSITIVE TREATMENT OUTCOMES

8.1 The Committee at their meeting of 2 May 2014 welcomed evidence from Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) and North Tees and Hartlepool NHS Foundation Trust (NTHFT) in relation to service provision. The Chair of the CCG informed Members that:-

- Acute services are provided via NTHFT
- There is a pulmonary rehabilitation service for stage 1-2 patients and stage 3 and 4 patients
- Community services are provided via NTHFT, which includes a Community Respiratory Assessment and Management Service (CRAMS)
- Oxygen assessment is provided

8.2 The Consultant Respiratory Physician from NTHFT explained the service pathways for patients with COPD. Members were informed that patients can use self referral via the Single Point of Access at the One Life Centre to the CRAMS team. In addition to this there is a nurse led clinic at Hartlepool and Peterlee once a month, and daily at the One Life Centre. Patients can also be referred by their GP to the weekly delivered service at the One Life Centre and the CRAMS Team.

8.3 There is also a pulmonary rehabilitation service available to COPD patients. This programme includes a physical exercise programme and advice on lung health and coping with breathlessness. It is a gold standard programme which has proven benefits for up to 18 months afterwards. It can be accessed via GPs or via the CRAMS service. The programme is based in hospital or in the community and locations are Seaham, Peterlee and Hartlepool. It is a rolling programme with no waiting list. A member of the public who attended the Committee reported that the programme does work and is very beneficial. Members recognised that pulmonary rehabilitation is

a service that is effective and very helpful to COPD patients. Members questioned whether there was anything that the Committee could do to help its success and suggested widely promoting the service.

8.4 Members were informed that a new pilot programme had recently been developed and was running from Hartlepool Hospice. The programme is a breathlessness support group and is being funded by the CCG. It is to help patients and carers with anxiety when patients become breathless. A member of the public who was present at the meeting when this programme was discussed, reported that the programme was very beneficial, as the biggest problem for COPD sufferers was managing breathlessness. It was questioned whether more could be done through GPs on how to manage breathlessness. Representatives from the CCG said that there are educational projects for GPs and nurses to roll out the lessons from such pilots. There is also a patient education programme delivered via the CRAMS service.

Partnership Work

8.5 The Committee heard that many partnerships are in place to aid early diagnosis and these include ongoing work with the Local Authority / the Public Health Team and the Area Team. There is a COPD screening programme carried out in GP practices, where all patients aged 35 or over who smoke are invited to attend for screening and practices have signed up to provide Healthy Lung checks. The CCG will also continue its partnership working with the voluntary and community sector.

8.6 The Council, through the GP Referral Co-ordinator run a weekly exercise programme for COPD patients. The group completed a questionnaire and the results highlighted that six out of ten people had reduced their need for hospital visits since they had been involved in the exercise programme. Examples of some of the comments from the group are as follows:-

"It gives you the motivation to continue to do the exercises and also helps to keep you mobile"

"Feel a lot better in my mobility; feel relaxed and more energetic after class. My balance has improved. Enjoy the class very much".

Access to Services

8.7 Members were informed that the CCG are looking at the ideal pathway between GP practices and community/hospital services, as everyone wants the best possible experience of health services. The Better Care Fund plans to try and move care from hospital into the community. The respiratory pathway and associated services are under review and further work is being undertaken to improve direct access to services.

8.8 HealthWatch Hartlepool and COPD patients reported that the CRAMS service had developed a very good reputation with patients. However, throughout this investigation, it become apparent to the Committee that access to the CRAMS service, since the introduction of the single point of access is extremely difficult. COPD patients and family / carers reported that access to respiratory nurses used to be direct, for example patients could contact a respiratory nurse by calling him/her direct, but now access is via the single point of access number. A message is then passed onto the respiratory nurses. Both NTHFT and the CCG were aware of these problems and the Lead Respiratory Nurse at NTHFT reported that a Task and Finish Group had been set up to investigate the problems. The Group are due to meet in June to evaluate the practices and procedures. Further work is being undertaken to improve access and response times, for example, appointment times when visiting respiratory nurses have been extended and a late clinic is due to be piloted one day a week to see if this helps improve access.

8.9 The Committee was pleased to hear that there is more support for patients attending the One Life Centre as volunteers now work within the One Life Centre to escort patients to the COPD Clinic. It was acknowledged that patients have lost a little faith with the CRAMS services, and this faith needs to be restored. That is why direct access to nurses/consultants is being reviewed and a new pathway of care being developed. The Lead Respiratory Nurse commented that the satisfaction surveys that she sent out to COPD patients highlighted that patients were not happy with access to the service. A leaflet is also being collated with key contacts and patients will be asked to evaluate it to see if it will help improve access and the information provided to patients.

8.10 Members raised concerns about access to GPs and how there are problems with people not being able to get appointments. The Chair of the CCG commented that there are new changes to GP contracts, from 1 April 2014, which means that COPD patients, over 75, have a named responsible GP, in addition to their 'family' GP. Members were informed that this is an additional service that will provide speedier access to GP services. There is also a telephone line for patients to call. The CCG want to make sure that this service enhances links with patients. In order to further help links between patients and GPs, the CCG are looking to advertise using media methods such as Sky TV and Smart TVs.

8.11 The CCG sought views on health services through a 'Call to Action' questionnaire. HealthWatch Hartlepool gathered views, using the questionnaire from under-represented groups. One of the sections in the questionnaire related to long term conditions and the top three answers in relation to what is most important to you were, services are easy to access, services are available at weekends and there are good public transport links. In relation to how services could be improved, a sample of the comments are listed below:-

- ‘people with long term conditions together with their carers need to be made aware of local support groups’
- Planned follow-up with continuity of care i.e contact with the same doctor
- A better phone service – bring back direct contact with respiratory unit
-

8.12 Members received information from Hartlepool’s Families First in relation to the Health Bus. The Health Bus offers a range of health advice and health checks. The Bus used to offer spirometry tests, however, the Committee was informed that the spirometry equipment was removed for use by the NTHFT community teams and was not returned. Members were informed by the Lead Respiratory Nurse that national best practice is saying that spirometry testing should be carried out by GPs and respiratory nurses. Therefore, it was suggested that the use of the COPD questionnaire was appropriate to use in locations, such as the Health Bus, to direct people to the GP if they were showing signs of COPD.

Challenges for Commissioners and Service Providers

8.13 Members were interested to hear about the challenges that both Commissioners and Service Providers face. The CCG, as Commissioner, highlighted that their challenges are as follows:

(a) Managing the increasing demand for services, with patients with multiple conditions which means increased reliance on care and costs;

(b) Improving the commissioned provision to allow patients to avoid admission;

(c) Ensure that the service review is robust enough to meet the future demands and does not need to be repeated in the near future; and

(d) Integration across health and social care

8.14 The challenges facing the service provider NTHFT, include the volume of patients, although the statistics were high it was better to have identified those patients than not. Another challenge was the low uptake of extremely effective interventions, for example, the pulmonary rehabilitation programme.

8.15 In order to improve service provision further, Members were informed that improvements to the enhanced care team and the single point of access would contribute to an improved service. Along with improving patient self referral into the CRAMs service.

8.16 The Chair of the CCG outlined further changes which will help improve services including closer links in health and social care to ensure that patients can be supported to avoid hospital admission and quickly discharged, when appropriate. Also, effective reduction in the numbers who

smoke, and early diagnosis will mean fewer patients to be treated and managed in the longer term.

8.17 The Chair of the CCG highlighted to the Committee that COPD hardly happens if you do not smoke and it is about encouraging people not to smoke or stop as soon as possible or if people cannot stop then to reduce the amount they smoke.

9. QUALITY OF DIAGNOSIS AND MANAGEMENT / TREATMENT OF COPD ACROSS GP PRACTICES AND NHS SERVICES IN HARTLPEOOL

9.1 Members received a presentation from NTHFT and the CCG at their meeting on 2 May 2014 which explained how quality of diagnosis and management of COPD is measured. Hartlepool has a higher proportion of people diagnosed with COPD but Hartlepool GP practices perform better than others in the CCG area, which is better than the National average. However, work still needs to continue to diagnose people with COPD. The Committee was informed that there was a new programme, which involves a team visiting GP practices to do comprehensive assessments of diagnosis and management of COPD, to see what is happening at a 'grass roots level'. Contracts with providers include quality measures and clinical quality review meetings.

9.2 In primary care there is a standardised criteria for diagnosis of COPD and there is ongoing clinical training, for example lunch and learn sessions.

9.3 Members were informed that NTHFT provide a rolling education programme for primary care staff, which includes COPD courses for practice nurses (there is a demand for this type of training) and COPD study days. There are new guidelines on providing COPD care and NTHFT are looking towards a gold standard management of COPD.

9.4 The review of COPD pathways currently being conducted is expected to result in, improved access; reduction in emergency admissions; and services closer to home with patients being seen in either an acute or community setting.

10. IMPACT OF UNPLANNED EMERGENCY ADMISSIONS ON SERVICE PROVISION

10.1 Members received evidence in relation to the impact of unplanned admissions on service provision. Every exacerbation that a COPD patient has reduces lung function. Representatives from NTHFT informed Members that unplanned admissions have a significant impact on COPD patients and also on NHS services. The rate of admission is 144.9 per 1000 COPD patients. Approximately six patients per week have a length of stay of one day of less, which is a cost of £160,000. The total number of beds days in 2012/2013 was 6517 with the cost of hospital interventions being £298,164 per 1000 COPD patients.

10.2 NTHFT informed Members that NTHFT was improving the enhanced care team. This service aims to reduce hospital admissions and shorten the length of stay. The service will be consultant led and will include a nurse delivered 'hospital at home' for patients with COPD. It will be a fully comprehensive service, including respiratory consultant input for every patient. Rather than a patient coming into hospital, the patient would be visited by a specialist nurse, which would be able to provide packs, antibiotics, nebuliser etc and a follow up would be provided for five days. This will be backed up by rapid access to a GP, if needed.

10.3 Members discussed the use of rescue packs, which are packs that are kept at home with the patient that can help control an exacerbation and help prevent deterioration, which in turn avoids hospital admission. Members queried whether these packs were still available and it was confirmed by the Chair of the CCG that rescue packs were still available, however, the process for distributing them to people seems to have changed. The Committee recognised that these packs really help people with COPD and should be made readily available.

11. RAISING AWARENESS OF COPD AND BENEFITS OF EARLY DETECTION

11.1 The Committee focussed on the benefits of early detection of COPD and also how awareness can be raised of COPD at their meeting on 20 February 2014. Members received evidence from the British Lung Foundation, the Smoking Cessation Service and the Tees Valley Public Health Shared Service.

Evidence from the British Lung Foundation

11.2 The Committee welcomed evidence from Bev Wears, the Service Development Manager at the British Lung Foundation, who provided a very informative presentation outlining awareness of COPD and early detection of COPD.

11.3 Members were informed that respiratory disease is the third commonest cause of death but was not prioritised for treatment services. Members were astounded that mortality rates in the UK were twice the European average and lung cancer survival rates were also significantly lower than those in the USA.

11.4 The British Lung Foundation is the only UK charity for all lung conditions and the charity support people affected by lung disease, so that no one has to face it alone. The charity also promotes greater understanding of lung disease and the charity campaign for change in the nations' lung health. In addition to this the charity also funds vital research so that new treatments and cures can help save lives.

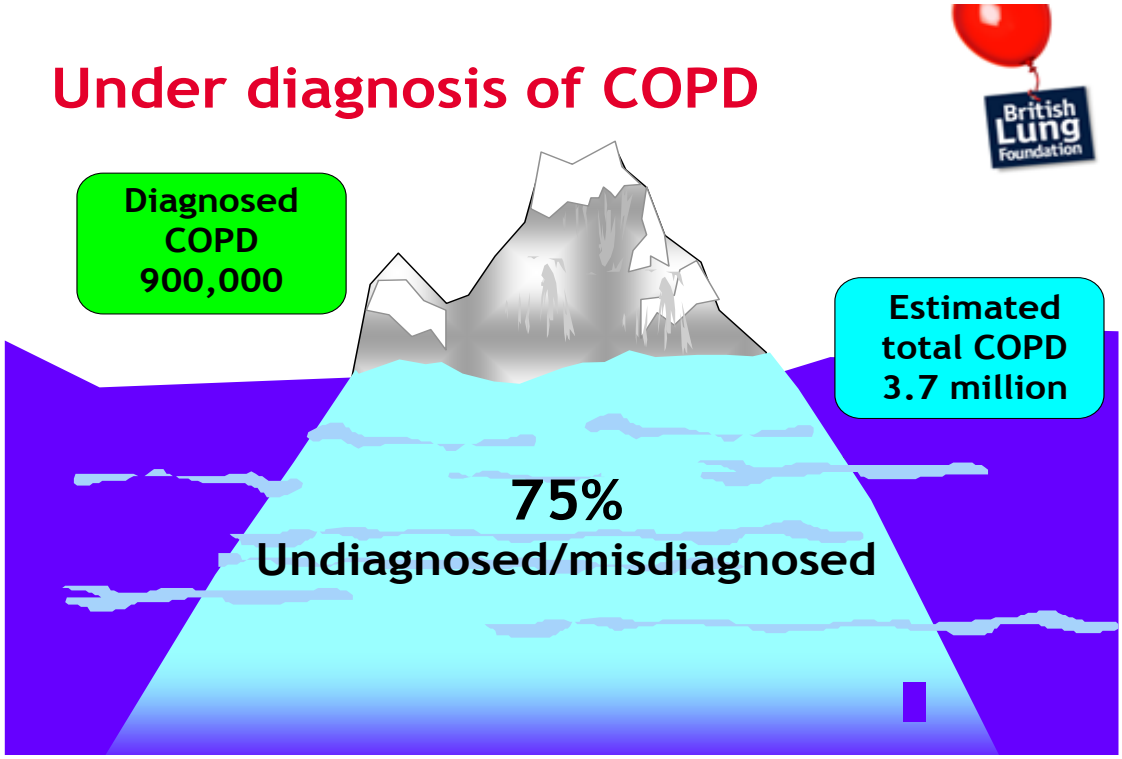
11.5 The Foundation in their Invisible Lives report mapped areas most at risk of future COPD hospital admission and found COPD hotspot areas across UK and the Foundation predict these communities are most likely to contain the 'missing millions'. The following identifies the top ten areas within the North East who have the highest proportion of people at risk of COPD:-

NORTH EAST - Top ten PCTs with highest proportion of people at risk of COPD

• South Tyneside	62% higher than UK average
• Gateshead	54%
• Sunderland Teaching	51%
• **Hartlepool**	**42%**
• County Durham	37%
• Middlesbrough	35%
• Newcastle	34%
• Redcar and Cleveland	28%
• North Tyneside	28%
• Darlington	11%

www.blf.org.uk

11.6 It was reiterated to the Committee that the number of people under diagnosed with COPD was extremely high and an area for concern. The diagram below illustrates the 'missing millions'.



11.7 In Hartlepool the estimated prevalence of COPD is 3.41 (% attributed populated) and the England average is 2.93%. The recorded prevalence in Hartlepool is 2.42 (% GP practice lists) against an England average of 1.69. The prevalence of undiagnosed COPD is 28.5 (% estimated with COPD).

11.8 The Committee was informed of a recent targeted awareness campaign at North Tyneside. The British Lung Foundation, CCG and North Tyneside Council worked together to deliver the awareness campaign. The campaign involved outbound calling to 5,000 'at risk' households, 6 public awareness events were held and promotion was carried out.

11.9 The Committee questioned if a targeted campaign had been undertaken in Hartlepool and they were informed that one had not happened in Hartlepool. However, the British Lung Foundation indicated they would be happy to run such a campaign subject to funding. It was highlighted that there was a systemic approach to screening for people over 35 who were or had been smokers. However, Members did raise concerns at the levels of screening undertaken by different GP surgeries as not all appeared to be proactive on COPD.

11.10 On 13 February 2014, results of a 20 year study led by researchers at Plymouth University Peninsula Schools of Medicine and Dentistry were published and found that:-

- doctors are missing chances to diagnose COPD earlier in up to 85% of cases

- 5 years before diagnosis, 85% of patients had visited their GP or hospital at least once with lower respiratory symptoms
- Opportunities were missed in 58% in 6-10 years before diagnosis and 42% in 11-15 years before diagnosis

11.11 The Committee questioned whether there is any good practice around the region that could be utilised in Hartlepool to try and help diagnose people with COPD. Overall, there is a large amount of good work being promoted around the region and within the community. However, there was variation in the work, with some excellent examples and some requiring improvement.

11.12 In relation to the resourcing services, the British Lung Foundation representative indicated that there was no uniform service delivery, therefore some areas were better resourced than others. Members thought that working with GP surgeries did limit the target group to those who visited the GP, however, wider campaigns had been carried out in the community, for example at supermarkets.

11.13 One of the key messages is around earlier diagnosis and lifestyle changes in order to increase early diagnosis of COPD. These lifestyle changes include stopping smoking and regular exercise. Other factors that need to be considered post diagnosis include good quality information at the time of diagnosis, self management options, which include written plans; educational programmes to reduce hospital admissions, improve quality of life, improve exercise endurance and reduce depression. Also, post rehabilitation long term exercise with a trained instructor prolongs functional and emotional benefits. Of benefit are also integrated patient support groups, for example Breathe Easy Groups.

11.14 The Committee was informed about how to help manage COPD and the British Lung Foundation has developed pathways of good practice based on Nice Quality Standards. There is also a range of information produced which includes British Lung Foundation free publications, helpline and online web community, penpals and Breathe Easy Groups, living well with COPD DVD, exercise handbook and information packs available at diagnosis.

11.15 Self management plans are available which include a range of information to help manage the condition and help and contacts. A patient record book is available which contains information that will be very useful to those who treat patients.

Evidence from the Smoking Cessation Service

11.16 Representatives from the Stockton and Hartlepool Stop Smoking Service attended the meeting of the Audit and Governance Committee on 20 February 2014 to provide information on active case finding of lung ill health.

11.17 The Committee was informed that the Stop Smoking Service aimed to help people stop smoking and not only did they identify people through the GP

practices but also did so within the wider community, who may not realise they were showing symptoms of COPD.

11.18 The service informed Members that they had developed a Lung Health Questionnaire with five basic questions that could lead to an individual being referred to their GP for a spirometry test. The roll out of this questionnaire to local pharmacies was also being explored. Members thought that the use of the questionnaire was very beneficial as it was a means of directing people with potential symptoms of COPD into their GP practice for screening. The Committee agreed that this questionnaire should be promoted and distributed in as many places as possible. It was noted by Members that the British Lung Foundation used a similar set of questions in its publicity and it was suggested that a consistent approach may help spread the message.

11.19 Members were supportive of advertising campaigns but were concerned that the messages are being delivered but are not having an effect, as some people with COPD are still smoking. It was suggested that educational campaigns in schools may help distribute the message.

11.20 Members highlighted that one of the areas that needed to be addressed was young people who smoked. Advertising campaigns, such as 'every breath you take' and 'stobtober' have played a major role in highlighting the dangers of smoking and helping people understand how early diagnosis of COPD can make a significant difference. One of strong messages that featured in the 'stoptober' campaign was the amount of money people could save if they quit smoking, for some people this could equate to £250 per month. The Committee was of the view that as well as highlighting the chronic debilitating effects of smoking, maybe by highlighting the financial saving this would have the most effect.

11.21 The Stop Smoking Service concluded that it is about balancing prevention and treatment approaches, detecting COPD early, using the stop smoking service as a gateway and reducing NHS costs and improving quality of life.

<u>Evidence from the Tees Valley Public Health Shared Service</u>

11.22 Dr Ononeze, Public Health Registrar attended the Audit and Governance Committee on 20 February 2014 to provide details on the Tees COPD Screening programme. There is a Tees COPD Screening Programme called 'the missing thousands', which is about systematic early identification of patients with undiagnosed long term conditions, which is key to improving health and reducing health inequalities. It is important to reduce variations in the management of patients with long term conditions and also important in reducing emergency hospital admissions. All Hartlepool GP practices have signed up to the campaign, which started in January 2013. The funding for this programme is non-re-occuring. It is important to find people who have COPD because it is key to improving health, reducing health inequalities and reducing hospital admissions

11.23 The Committee was interested to know the numbers of people screened and diagnosed, the diagram below illustrates.

Number screened and subsequently diagnosed with COPD: Jan - Dec 2013

TEES VALLEY PUBLIC HEALTH SHARED SERVICE

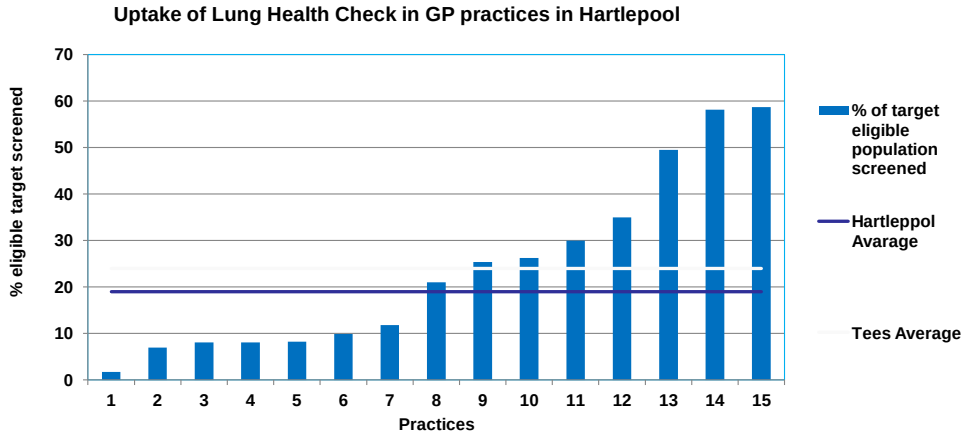
	Annual target of eligible population	Eligible number screened	Eligible number screened from Quintile 1 area (most deprived)	Number diagnosed following screening	Number diagnosed following screening from Quintile 1 (most deprived)
Hartlepool	2,140	410 (19%)	296 (72%)	89 (22%)	65 (21%)
Middlesbrough	3,336	774 (23%)	602 (78%)	147 (19%)	73 (12%)
Redcar & Cleveland	2,768	526 (19%)	385 (73%)	61 (12%)	37 (10%)
Stockton-on-Tees	3,710	1189 (32%)	731 (61%)	96 (8%)	80 (14%)
Tees Total	11,954	2,899 (24%)	2,014 (70%)	393 (14%)	255 (13%)

Darlington Borough Council · Stockton-on-Tees Borough Council · Middlesbrough moving forward · Hartlepool Borough Council · Redcar & Cleveland Borough Council

11.24 Members raised concerns about the variations of people diagnosed with COPD across the GP practices in Hartlepool and questioned why screening should differ significantly from one surgery to the next. Although, some areas will have higher levels of COPD, (as around 13% of those diagnosed from the current screening programme were from deprived communities) some GP practices may be more proactive in determining the illness than others. Members were of the opinion that it would be valuable for the community to know the number of screenings taking place at the various GP surgeries in Hartlepool. This would then assist people in comparing their surgery to others to determine whether to move to another surgery that was more proactive in determining illness. Dr Ononeze commented that those figures may be published in the future. The below diagram illustrates the uptake of Lung Health Checks in GP practices in Hartlepool

TEES VALLEY PUBLIC HEALTH SHARED SERVICE

Percentage of eligible target population screened by GP practices: Jan - Dec 2013



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11.25 The Committee considered the cost of emergency admissions for those people with no previous COPD diagnosis and were provided with the below information:

Case for screening (2): emergency COPD admissions* in those with no previous COPD diagnosis

	2010/11		2011/12	
Activity	**Hartlepool**	**Stockton**	**Hartlepool**	**Stockton**
Total number of patients admitted as emergency for COPD	467	717	443	689
No. of patients with no previous COPD	158	243	114	212
% of patients with no previous COPD	33.8%	33.9%	25.7%	30.8%
Cost of patient's admissions with no previous COPD	£ 309,144	£ 464,984	£ 239,976	£ 386,355

•Data relate to all Finished Consultant Episodes where the primary or secondary diagnosis was coded with a COPD ICD10 code (J40-J449). Excludes TEWV patients (provider = RX3) and MRCCS patients, NHS Tees Information Services, 2012

11.26 Dr Ononeze concluded her presentation by informing the Committee of the future plans, which are to embed the programme in general practices, undertake public health campaigns to raise awareness of lung health checks and explore how to implement lung health checks in appropriate community venues in order to improve availability and increase access.

12. VIEWS OF COPD PATIENTS AND THEIR FAMILIES AND CARERS AND GROUPS / BODIES WHO PROVIDE SERVICES FOR PEOPLE DIAGNOSED WITH COPD

12.1 The Committee recognises that COPD can affect daily life in many ways and by keeping healthy, being as active as possible, learning breathing techniques, and taking medication as prescribed can help to reduce the symptoms of COPD. The Committee held a focus group for COPD patients and their families and carers on 10 December 2013 to explore patient pathways and experiences.

12.2 The following summarises the key issues that were raised during the focus group session:-

1) The majority of people who attended the focus group were aware of COPD as they had the condition or they were aware of someone who had the condition. One woman had symptoms and had attended to find out more about the condition;

2) Change in access to services has resulted in patients / families finding it difficult to contact respiratory nurses. Access to respiratory nurses

used to be direct, for example patients could contact a respiratory nurse by calling him/her direct, and now access is via the 'single point of contact' number, who then passes on the message to the nurses. However, with COPD, it is more often than not, that an immediate response is required;

3) The system appears to be broken, the system has been changed and now it appears not to work and there was frustration and anger expressed;

4) It appears that the change in the system has resulted in a loss of expertise as people have been grouped together and now people cannot access the experts;

5) Patients are advised by the GP how best to manage their condition and if part of that management is direct access to a respiratory nurse then this should be available;

6) People who attended the focus group were finding it difficult to get appointments with their GP and often appointments were only available late afternoon or patients were having to wait for the GP to call them, which is hours later. Also, people would like appointments with their family doctor. Often people see locums who do not know them or their condition which means time is wasted on explanations, which affects the continuity of care.

7) Seems to be a great variation of how health professionals diagnose people who have COPD. People have been diagnosed with a different condition at first and then years later diagnosed with COPD. There needs to be a consistent approach to diagnosis. COPD needs clinical evaluation as there are a spectrum of conditions that fall within the term COPD;

8) People were of the view that there is a lack of information on COPD and said those people that are newly diagnosed would struggle to find information as information is not available;

9) The cost of emergency admissions needs to be compared with the cost of providing additional respiratory nurses. The changes to the services may have been as a result of cost saving, however, saving money in one place will more than likely result in additional cost in another, for example, an increase in emergency admissions;

10) People have produced their own exercises to manage their conditions, which includes cardboard breathing tubes;

11) GP practices should do two things:- 1) provide timely and appropriate access to care and 2) provide continuity of care. People with COPD are flagged on GP systems and care is tailored to the patient; and

12) GPs refer to the Community Respiratory Assessment and Management Service (CRAMS). All people at the focus group thought that the CRAMS service was an excellent service, which needs to be increased as it is under resourced.

12.3 A person who could not attend the Focus Group spoke to the Scrutiny Support Officer and said that she received a good service from her own GP and did not have trouble accessing nurses.

13. CONCLUSIONS

13.1 The Audit and Governance Committee concluded that:-

(a) Early diagnosis leads to improved outcomes and improved health and wellbeing:

(b) That stopping smoking is the most effective way to reduce the risk of COPD and targeting young people could help to reduce the numbers of young people smoking;

(c) Exercise programmes, such as pulmonary rehabilitation are an extremely effective intervention and need to be widely prompted to encourage people to attend;

(d) Work needs to continue to try and diagnosis the 'missing thousands'. The Committee was supportive of the 'missing thousands campaign';

(e) The service provision that is provided to COPD patients and their families is very good, however, patients are finding it difficult to access services and it is hoped that the review of the COPD pathways, including a review of the single point of access, will result in better direct access to services and to GP appointments;

(f) That COPD rescue packs are very beneficial to COPD patients and should be widely available to people with COPD;

(g) Overall, there is a large amount of good work being promoted around COPD, however, there is variation in the work, with some excellent examples and some requiring improvement;

(h) The level of screening undertaken by different GP surgeries varies and it appears that not all surgeries are proactive on COPD screening;

(i) There are a variety of questionnaires used to direct people who may have COPD to their GP for screening. The Committee agreed that the questionnaires were very beneficial but would be helpful if a consistent approach across organisations could be developed, with the use of a single questionnaire.

14. RECOMMENDATIONS

14.1 The Audit and Governance Committee has taken evidence from a wide variety of sources to assist in the formulation of a balanced range of recommendations. The Forum's key recommendations to the Health and Wellbeing Board are as outlined below:-

(a) That the Health and Wellbeing Board develop a strategic approach to COPD to ensure that inequality is not worsened by:-

(j) monitoring the review of the single point of access to establish whether the changes have had a positive impact on COPD patients and their families

(ii) ensuring that any changes to service provision are appropriately evaluated to provide assurance that these changes are effective from an evidence and cost perspective

(b) That the Health and Wellbeing Board explores ways to promote COPD support programmes, such as the pulmonary rehabilitation programme, to encourage people to attend;

(c) That the Health and Wellbeing Board, through an integrated and co-ordinated approach, work in partnership with relevant organisations and groups to promote a consistent message on COPD through the use of a single questionnaire;

(d) That the Health and Wellbeing Board raises community awareness of COPD by placing the COPD questionnaire in community and health venues across Hartlepool to find those people with undiagnosed COPD;

(e) That the Health and Wellbeing Board explores the development of a targeted COPD awareness campaign for young people to raise awareness of the long term implications of smoking;

(f) That the Health and Wellbeing Board explores whether the number of COPD screenings taking place at various GP surgeries across Hartlepool can be publicised, as it would be valuable for the community to be aware of the variations in practices in order to aid patient choice and help to alleviate variations across GP surgeries.

COUNCILLOR KEITH FISHER
CHAIR OF THE AUDIT AND GOVERNANCE COMMITTEE

ACKNOWLEDGEMENTS

The Forum is grateful to all those who have presented evidence during the course of our investigation. We would like to place on record our appreciation, in particular of the willingness and co-operation we have received from the below named:-

Hartlepool Borough Council:

Councillor Carl Richardson – Chair of the Health and Wellbeing Board

Louise Wallace – Director of Public Health

Andy Graham – Public Health Registrar

Lorraine Harrison – GP Referral Co-ordinator

External Representatives:

Hartlepool residents

Healthwatch Hartlepool

Hartlepool's Breathe Easy Group

Bev Wears – Service Development Manager, British Lung Foundation

Pat Marshall – Stop Smoking Service Manager, Stockton and Hartlepool Stop Smoking Service

Dr Victoria Ononeze – Public Health Specialist, Tees Valley Public Health Shared Service

Dr Monaghan - Consultant, NTHFT

Dr Elmer - NTHFT

Sandra Stych – Nurse Co-ordinator Lung Health, NTHFT

Dorothy Wood – Lead Respiratory Nurse, NTHFT

Sally Thompson, Assistant Director for Anaesthetics and Emergency Care, NTHFT

Dr Posmyk – Chair, Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Deborah Ward - Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Paul Thompson – Hartlepool Families First

Evidence provided to the Committee

The following evidence was presented to the Audit and Governance Committee throughout the course of the investigation into COPD:-

Date of Meeting	**Evidence Received**
22 August 2013	Scoping Report – *Scrutiny Support Officer*
3 October 2013	Setting the Scene Presentation – *Speciality Registrar in Public Health.*
10 December 2013	Focus Group with COPD patients
20 February 2014	Presentation and verbal evidence from:- - Smoking Cessation Service - Tees Valley Public Health Shared Service - British Lung Foundation
2 May 2014	Presentation and verbal evidence from:- - North Tees and Hartlepool NHS Foundation Trust - Hartlepool and Stockton on Tees Clinical Commissioning Group - Hartlepool Families First Feedback from the COPD Exercise Group