Project:	Joint Strategic Needs Assessment		
Profile Title:	Chronic Obstructive Pulmonary Disease		
Author/Priority Lead:	Gillian Gibson		
Date of Submission:	[insert date of submission here]		
Document Reference n$^{o:}$	[insert reference n^{o} here]	**Version n$^{o:}$**	0.4

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Version	Comments	Author	Date Issued	Status
0.1	First draft to be shared with commissioners	Gillian Gibson	28.09.11	Draft
0.2	Second draft updated for WA's comments, public engagement overview and EIA	Gillian Gibson	27.11.2011	Draft
0.3	Third draft updated updated commissioning recommendations linked to current PCT priority workstreams	Ailsa Nokes	30.11.2011	Draft
0.4	Third draft updated to incorporate information from engagement event	Gillian Gibson	27.04.2012	Draft

Template

This first page is intended to be a short Exec Summary of the Chapter and should be no more than 1-2 sides

Introduction

Chronic obstructive pulmonary disease or COPD is a progressive disease which covers a range of conditions, including bronchitis and emphysema. Its symptoms include cough and breathlessness and in time it can become increasingly severe, having a major impact on mobility and quality of life as it impacts on people's ability to undertake routine activities. In the final stages it can result in heart failure and respiratory failure. Because of its disabling effects, it impacts not only on the person with the disease but also on those who provide informal care to that person.

COPD is a very significant disease within Sunderland with 8,750 patients having a recorded diagnosis, although diagnosis is considered to be significantly under recorded. The prevalence of recorded COPD is 3.1% which is significantly worse in Sunderland than the England average of 1.7% which ranks NHS Sunderland CCG as 209 out of 211 CCGs in England.

Premature deaths from respiratory disease in Sunderland are significantly higher than the national average. In 2011 there were 118 deaths in Under 75s as a result of respiratory disease. NHS Sunderland CCG has the highest Under 75 mortality rate from respiratory disease in the North East.

The biggest risk factor for the development and progression of COPD is smoking. Tobacco has been identified as the greatest hazard for health in Sunderland and so it is not surprising that a disease which is so closely linked to smoking should be so prevalent in this City. In terms of prevention, then, there continues to be a need to tackle the use of tobacco. Until we see significant reductions in smoking COPD will continue to lead to poorer life expectancy and quality of life within Sunderland.

Interventions to reduce the levels of smoking are not included in this chapter as the importance of tackling this issue is so fundamental to improving health in Sunderland that it is being considered as a priority in its own right. This should not minimize the importance of reducing levels of smoking as a hugely significant element of tackling COPD alongside a number of other conditions.

Key issues and gaps

In 2011, the recorded prevalence of COPD in Sunderland was 3.1%. However, COPD is a disease that is significantly undetected. Estimates suggest that only 71% of people with COPD in Sunderland appear on a register. Being on a register is the first step towards receiving systematic care and so the under-recording of people with COPD is a major concern.

Once people are on a register, there is variation in the management of patients. This means that for some people with COPD outcomes are not as good as they would be if there was a consistent approach to management of this condition across the City.

A significant proportion of people with COPD receive support from informal carers. This care needs to be recognised and supported.

There are clear inequalities in the prevalence of COPD across the City. Admissions to hospital suggest that the areas where prevalence is highest are Southwick (387), Pallion (366), St. Anne's (355), Sandhill (346), Castle (344) and Redhill (326). The numbers in brackets are the number of COPD admissions per 100,000 population and compares with a Sunderland average of 234.

Looking forward, it is anticipated that if the undetected cases of COPD are identified, prevalence will increase by 3500. This would result in an increase of 29% in the size of practice registers. In addition to the under-recording, it is also estimated that due to population changes, prevalence will increase by 570 (4.6%) by 2014/15 and a further 552 by 2019/20, an increase of 9.1% in ten years.

Recommendations for Commissioning

1. Develop population approaches to the identification of people with undiagnosed COPD, including systematic case finding and better recognition of signs and symptoms, integrating with other population based approaches where possible.
2. Improve training and education of Primary Care staff in the diagnosis and delivery of care for COPD patients.
3. Reduce variation and improve the systematic evidence-based management and review of patients with COPD in primary care to reduce avoidable hospital admissions.
4. Develop personalised care plans with patients with COPD, including self care information and an exacerbation management plan, and consider establishing a key worker role to coordinate care for this at highest risk of hospital admission.
5. Improve quality of care from diagnosis to end of life.
6. Develop the pulmonary rehabilitation services and ensure that patients are referred at the appropriate points in their management, including access to prehab, intermediate and refresh options, reablement support and self management.
7. Improve access to psychological support and opportunities for motivational support, including the use of telehealth to support self management and remote monitoring of an individuals condition.
8. Review the provision of long-term oxygen therapy and commission a home oxygen assessment service.
9. Develop integration of secondary and community services to enable joint discharge planning and early supported discharge.
10. Provide more care for patients at home with the support of community health and social services.
11. As services are improved and developed locally, consider the differing needs of individuals as identified in the Equality Impact Assessment and the findings of the British Lung Foundation review into access to services for BME communities due to report in 2012 and implement where appropriate.

1) Who's at risk and why?

The risk of COPD increases with age and so it primarily affects people over the age of 45. It is linked to social deprivation and the most common direct cause is smoking with 86% of COPD deaths attributed to smoking. Other risk factors are occupational dust and pollution.

In Sunderland 80% of hospital admissions occur from people in the following population groups identified through the Mosaic® Public Sector Profiler: -

- Low income families living in estate based social housing (34%)
- Upwardly mobile families living in homes bought from social landlords (17%)
- Older people living in social housing with high care needs (14%)
- Close-knit, inner city and manufacturing town communities (13%).

The above groups feature for two reasons: either they make up a large proportion of the Sunderland population and so are more likely to feature in any statistic relating to Sunderland or they are at higher risk of developing the disease. There are also four groups of the population who feature more prominently in COPD admissions than would be expected given their proportion of the total population. These are listed below. The figure in brackets gives the number of admissions as a percentage of the expected number given the proportion of the total population in the group.

- Older people living in social housing with high care needs (293)
- People living in social housing with uncertain employment in deprived areas (145)
- Low income families living in estate based social housing (135)
- Upwardly mobile families living in homes bought from social landlords (104)

Both sets of groups are important as the above analysis identified the groups in the population who make up the biggest proportion of people who are likely to suffer from COPD as well as those at highest risk. Although not all of these people will develop COPD they are the groups of the population that need to be targeted for prevention and early detection, which is essential in reducing the numbers of people diagnosed.

A national survey by the Royal College of Physicians identified the following characteristics of people with COPD: -

- There has been an increase in the proportion of admissions that are female so that COPD is now a disease of equal importance in both men and women.
- The mean age of admissions has increased by one year to 73 years for men and 72 years for women.
- 90% of patients still live at home, 36% on their own.
- 39% of patients received some form of personal care at home, whether paid or unpaid.
- In 2008 there were fewer current smokers (33%) than in 2003 (41%).
- There is a very high level of co-morbidity, the association with cardiovascular disease being particularly strong.
- 51% of patients had been admitted for COPD within the preceding 24 months.

The DH commissioned the Picker Institute to undertake a review of the experience of BME communities affected by COPD. The review found a low prevalence of COPD in BME communities with very few significant differences between the experience of patients from BME backgrounds and those from the majority white population. This, however, raises some concerns that will be explored more fully in section 7.

2) The level of need in the population

COPD is a very significant disease within Sunderland with 8,750 patients having a recorded diagnosis, although diagnosis is considered to be significantly under recorded. The prevalence of recorded COPD is 3.1% which is significantly worse in Sunderland than the England average of 1.7% which ranks NHS Sunderland CCG as 209 out of 211 CCGs in England.

As with other health indicators, however, COPD is not experienced uniformly throughout the City. Between 2006/07 and 2008/09 the rate of admissions for Sunderland was 234 per 100,000 population. There were, however, six wards within Sunderland where the rate was over 300 as follows: Southwick (387), Pallion (366), St. Anne's (355), Sandhill (346), Castle (344) and Redhill (326). Conversely, there were three wards that had a rate of less than 150. These were Fulwell (120), St. Michael's (130) and Barnes (138).

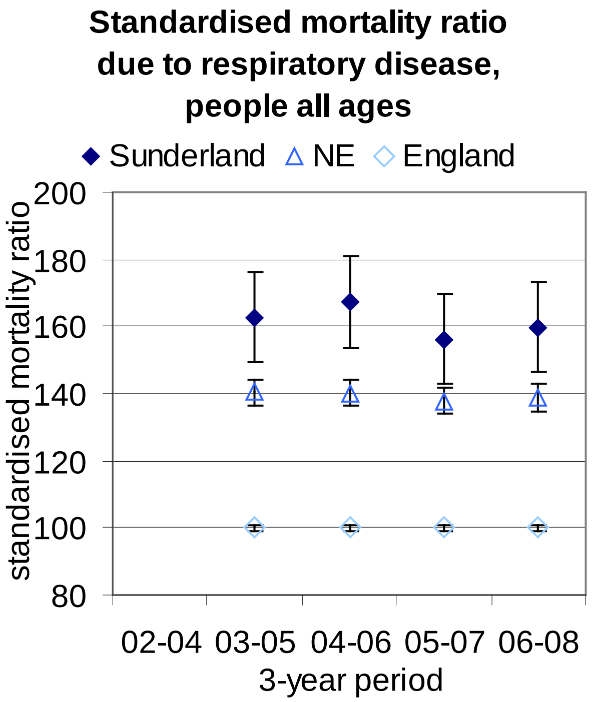
COPD is known to be under diagnosed. National surveys identify that the actual prevalence is considerably higher than that identified through GP disease registers. The real UK prevalence is currently estimated to be between 2-4% although the diagnosed prevalence is 1.7%. In 2011, the recorded prevalence of COPD in Sunderland was 3.1%.

National surveys tell us that COPD patients admitted to hospital are frequent users of primary care in the 12 months prior to their admission. Three quarters (74%) of admitted patients make contact with their general practice in the month before admission and nearly a third (31%) have 3 or more contacts in those 4 weeks.

Carers are major providers of care to people with long-term illnesses and disabilities. In Sunderland. 11% of the population are carers with 3% of the population providing at least 50 hours per week of care (census 2001). The cost of replacing this care is estimated at £706.9 million p.a. (Circle at University of Leeds/Carers UK). Stressed and ill carers are unable to maintain their caring responsibilities and the people they care for end up in residential/nursing care, with expensive care packages or as inappropriate hospital admissions, as well as losing the care from the people who are often closest to them.

Premature deaths from respiratory disease in Sunderland are significantly higher than the national average. In 2011 there were 118 deaths in Under 75s as a result of respiratory disease. NHS Sunderland CCG has the highest Under 75 mortality rate from respiratory disease in the North East.

As can be seen from the graph below, death rates in Sunderland are significantly higher than for the North East and England.



3) Current services in relation to need

There is a long and consistent history of strong clinical leadership and local action to improve care for COPD in Sunderland.

Action to date has mainly focussed on developing good quality structured care including self care. The approach has been based on local needs analysis with an emphasis on development and evaluation, supported by structured education and training and the use of monitoring and outcome measures. Another key approach has been the involvement of external consultants such as GSK who, through the 2 year Joint Care Initiative, have been able to support training, data analysis and facilitate practice audits and action plans. This local work has shown consistent improvements in measures of patient care as well as reductions in unplanned admissions to hospital with COPD. There has also been a rise in observed prevalence of COPD reflecting improved local awareness of the condition.

Key elements of the work on structured care includes:

- Actions to improve the skills and knowledge of primary care staff -using training audits, spirometry audits and a survey of patient experience
- Application of the GSK audit tool 'POINTS ' which has been used across all practices in the previous Practice Based Commissioning consortia of Wearside and SCN and 2 out of 8 practices in SunWest. The tool provides a

means of identifying the needs of specific patients compared with NICE guidance. It is specific in signposting GPs where they should focus their efforts to have the greatest impact.

- Development of a desk top treatment guide based on NICE and North of Tyne guidelines
- An information pack for newly diagnosed patients
- Validation of COPD registers

There has also been a focus on end of life care through partnership work with the local hospice to provide training and education to local clinicians enabling appropriate identification of COPD patients for palliative care. Subsequently there have been observed increases in the proportion of COPD patients on palliative care registers.

The community provider service has developed the Lung Improvement Project led by community matron, Marie Herring. Dr Clague, a respiratory physician at City Hospitals Sunderland is on the project group. The project has not yet been formally evaluated.

More recently a Home Oxygen Service – Assessment and Review (HOS-AR) has been commissioned to assess new patients referred for provision of oxygen and carry out reviews in a structured manner for patients already on oxygen therapy.

A Kaizen event in July 2012 identified the need for major changes to the existing community pulmonary rehabilitation service including the development of a multi disciplinary team approach to assessment and provision, joint working with the local authority to improve choice of activities and capacity and to improve access for patients by delivering the service in a range of leisure centre venues across Sunderland. The new service is called “Breathe Well, Live Well” and even though it has only recently been launched there has been a large increase in the number of referrals received from primary and secondary care clinicians.

Sunderland CCG has established a Respiratory Network to drive the respiratory agenda forward for Sunderland. The Network includes representation from a wide range of stakeholders and it provides a forum for discussion of priorities.

There is also continued support from a range of voluntary and community organisations within the City for COPD patients and their carers who provide significant levels of care to people with long-term illness and disabilities.

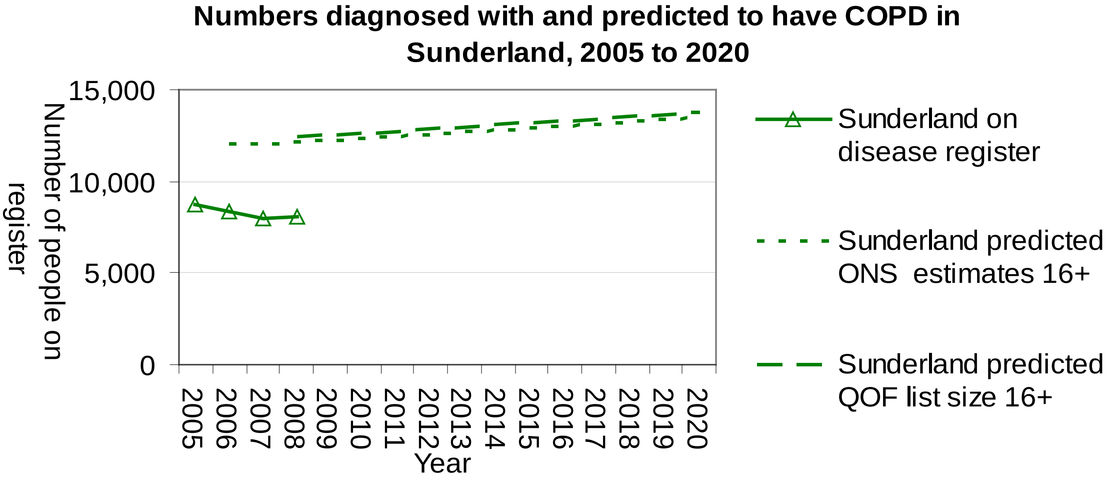
4) Projected service use and outcomes in 3-5 years and 5-10 years

As has been identified above, national survey data suggests that generally there is an under-recording of the prevalence of COPD. This has prompted the development of models which estimate true prevalence of six key long-term conditions, including COPD.

The Eastern Region Public Health Observatory has estimated the prevalence of chronic obstructive pulmonary disease (COPD) among people ages 16 and over for the populations of all English Primary Care Trusts and Local Authorities using a model developed at the Department of Primary Care and Social Medicine, Imperial College, London. The model was developed using data from the 2001 Health Survey for England.

The model takes into account age, sex, ethnicity, smoking status, rurality and deprivation score. PCT population data for 2006 by age (quinary age band), sex and ethnic group were provided by ONS. Smoking prevalence is taken from the model-based estimates of healthy lifestyle behaviours based on Health Survey for England data from 2003 to 2005, published by the Information Centre. PCTs are categorized as urban, suburban or rural based on a combination of the percentage of the population living in rural areas and the DEFRA classification as applied to PCTs by NEPHO. Deprivation scores are from the Indices of Multiple Deprivation 2004.

ONS 2006-based population projections were input into the model to create projections of the prevalence of COPD to 2020. The 2006 ethnic distribution is used for the 2006 – 2009 projections. The distribution of ethnic groups within the population is lagged by 5, 10 and 15 years for the 2010, 2015 and 2020 projections respectively. So, for example, in 2015 the ethnic distribution in the age group 40-44 is calculated using the ethnic proportions from the 30-34 age group in 2006.



As can be seen from the graph above, there is currently a large gap between the number of people on registers and the number of people in Sunderland who are estimated to have COPD. It is estimated that only 65% of people with COPD in Sunderland were included on registers in 2009/10.

It is likely, therefore, that the number of people identified with COPD will increase significantly if case-finding is undertaken. In all, this could result in an additional 3,500 people with COPD being identified. This would result in an increase of 29% in the size of practice registers. In addition to the under-recording, it is also estimated that due to population changes, prevalence will increase by 570 (4.6%) by 2014/15 and a further 552 by 2019/20, an increase of 9.1% in ten years.

5) Evidence of what works

The National Outcomes Strategy (July 2011) identified a number of features that would be required across the health and social care system to improve outcomes for people with COPD.

key features are:

- early recognition of disease to minimise late diagnosis through opportunist and systematic case finding and better recognition of signs and symptoms by healthcare professionals especially those in primary care and by the population itself
- personalised care and support for self management, with people with COPD and carers receiving disease specific education and training to become active partners in a systematic approach to care planning and management

which provides opportunity for problem based learning and a shared understanding of risks and issues

- proactive management by healthcare professionals starting with an accurate diagnosis and a disease register, monitoring and assessment of severity, co-morbid conditions and impact of disease, regular review with specialist input depending on severity of condition, and early and specialist rehabilitation and social services support to prevent disability and improve quality of life and community equipment and other support to promote independent living and activities of daily living and reablement
- effective prevention and management of acute episodes with prompt identification and treatment (where possible in the community) in a care model which facilitates admission avoidance, early supported discharge and structured hospital admission with structured admission/specialist intervention, proactive follow up post exacerbation for treatment review and optimisation
- treatment intervention using evidence based pharmacological treatments and regular review to ensure optimisation as well as community provision of specialist interventions/devices to support treatment and monitoring of signs and symptoms
- effective and equitable end of life care including palliation of symptoms, end of life care management, bereavement care and support for relatives.

The Health Inequalities National Support Team identified ten priority actions: high impact changes for tackling inequalities in COPD: -

1. Ensure there is a network in place to co-ordinate activity with
    a. Senior level leadership.
    b. A clinical lead with dedicated time
    c. A dedicated co-ordinator with dedicated time providing management support
    d. Appropriate public health specialist input
    e. Membership which includes primary, secondary, intermediate and community care and patient representatives
2. Is recording of COPD on practice registers accurate? To understand their accuracy it is essential that actual spirometric readings be recorded, along with whether they meet national and international standards (i.e. quality assurance). Address mis-diagnosis and gaps by:
    a. reviewing all patients with a diagnosis of COPD
    b. improving patient capture from records
    c. improving practice of screening high risk patients (e.g. smokers over 40 with chronic cough).
3. Have strict criteria for exemptions and exclusions from registers for QOF purposes. Audit records of patients excluded. Ensure exempted patients have a care plan - they are likely to be high risk, and should be targeted as such. Develop a specific strategy for housebound COPD patients
4. Ensure all patients with COPD are assessed and managed for all co-morbidities (common and often hidden due to lack of activity in these patients), that they are on the appropriate registers and the following issues are risk managed:

   a. Smoking (through proactive and intensive stop smoking support)
   b. Raised blood pressure
   c. Raised cholesterol
   d. Taking aspirin
   e. Low glucose tolerance
   f. Cold damp housing
   g. Annual Flu vaccination

   The aim should be to risk manage all 7 issues rather than one or two

5. Pulmonary rehabilitation and self-management development should be offered as a menu of options for delivery, reflecting severity of condition and capacity to self manage, rather than a one-size-fits-all approach. Target people with different educational needs and tailor to different relevant groups. Make sure the proportion of patients offered and matched with the appropriate option and receiving the appropriate programme within 12 months of diagnosis is high and any drop out is followed up.
6. Carry out a baseline assessment of service for COPD patients in each GP practice. Use this to appraise and accredit practices according to their competency to provide differing levels of care. Use this to develop a joint action plan between the practice and respiratory specialists for each practice and provide incentives for improvement. Intermediate/ secondary services then provide the missing elements proactively. All patients can therefore receive effective and comprehensive care.
7. Ensure there is an educational programme in place to meet any identified gaps in Primary Care delivery to raise the competency of practice staff. Use experiential learning opportunities offered by joint working with respiratory specialists and ensure this learning is accredited for portfolios
8. Develop the training programme and ensure it is used for all GP practices. It will be important to keep an active register of training taken by all practice staff. This should be used to target gaps, and design update and refresher training so as to make raising of standards more systematic. This should ensure spirometry standards, calibration and maintenance
9. Develop prescribing guidance that promotes cost effective as well as effective prescribing for COPD and its complications with prescribing guidelines coordinated across primary and secondary care. This should include ensuring management of Long Term Oxygen Therapy and ambulatory oxygen is systematic and timely. Evaluate and benchmark the cost of COPD prescribing in primary care in relation to outcomes being achieved and work with outliers to change manage improvements.
10. Introduce mechanisms to reduce hospital admissions and lengths of stay for people with acute exacerbations of COPD. Include:
    a. the commissioning of a specialist 24 hour advice service so people can understand their worsening symptoms and exacerbations and allow management of these without hospital admission if appropriate
    b. a specialist respiratory review when acute episodes have required referral to hospital

c. structured hospital admissions to ensure that length of stay and subsequent readmission are minimised

d. a supported discharge scheme

e. evaluation of effectiveness

f. post exacerbation reviews by general practice.

6) User Views

Based on the RCP survey of in-patients and focus group research with BME patients identified the following issues

- Most diagnosed patients accepted that smoking had at least contributed to their condition.
- Frustration at the generally low profile of COPD
- Most knowledge about COPD came from pulmonary rehabilitation courses and there was a call for such courses to be “better marketed”.
- People are happy with existing technology and not averse to more tele-monitoring if it would avoid admission.
- 42% of those admitted usually attended a chest clinic in addition to being managed within primary care.
- Inpatients provided numerous different suggestions for service improvement, which broadly fell into the following categories:
    - The need for care and help at home,
    - The need to access respiratory nurses,
    - The need to have a good home oxygen service,
    - The need for nebulisers to be available to patients.

The recent National Outcomes Strategy for people with COPD and asthma identified specific elements that people with COPD and their carers wanted from services:

- timely access to comprehensive quality assured assessment and diagnostic services
- information related to their condition and how it is managed to be available to all practitioners involved in their care irrespective of the setting
- access to reliable information about their condition which sets out all the options so that they can make choices which are appropriate for them
- easy access to comprehensive information about the services available to them and the outcomes achieved by these services
- to be empowered to make choices about their care where these are clinically appropriate and to be supported in decision making to the extent that they wish
- to know that they will receive the support they need whilst living with their condition and to be supported to remain in work and play an active role in

society and local communities

- to be treated as a whole person, often with a range of other conditions
- to know that everyone involved in their care has the necessary skills, training and expertise and be reassured that everyone involved in their care will work effectively together, so that their care will feel seamless even when delivered in different locations
- to be able to access specialist services without delay should they need to do so; and to be assisted where necessary to remain at home
- to know that if they are approaching the end of life their preferences for care will be discussed with them and every effort will be made to meet their needs and their preferences
- to be treated as a whole to enable them to fully undertake activities of daily living and for the care providers to act as one team.

Locally, there has been consultation with the Breathe Easy group about the self-management plan format and content, as well as discussion about the plans generally. In addition, the British Lung Foundation has been involved in a day focussed on developing local plans for COPD. Representatives from the Breathe Easy group and the British Lung Foundation were involved in the development of the "Breathe Well, Live Well" community pulmonary rehabilitation service for Sunderland and are members of the Respiratory Network. Previously in the Wearside PBC Consortium there was a survey carried out by an independent third party (Ipsos Mori) to look at patient understanding following their annual reviews.

Feedback obtained from a voluntary and community sector engagement event, highlighted the need for a focus on prevention, early intervention and healthy living, underpinned by the availability of quality information and support across a number of areas, including regular aftercare, to ensure patients receive the treatment and medication that is most appropriate to them at that time.

7) Equality Impact Assessments

The description of the level of need in the population has identified some of the inequalities within the population in relation to COPD. It is important that as services are developed these inequalities are borne in mind and equity audits are undertaken to ensure that services are responsive to local needs.

In addition, an equality impact assessment of the National Outcomes Strategy identified a number of equality issues in relation to the protected characteristics. These are summarised below.

Race

As described above, research into the prevalence of COPD in different black and minority ethnic groups found that the available information identified similar levels of known prevalence among all groups. However, given that 85% of COPD is related to smoking, data from the Health Survey for England would suggest that Bangladeshi men, men who are Irish, Pakistani or Black Carribbean would all be at greater risk as levels of smoking amongst these groups is higher than the national average. Similarly, Irish and Black Carribbean women have a higher smoking prevalence than the average for the female population. It is also likely that Bangladeshi women are likely to have been heavily exposed to second-hand smoke, even if they do not smoke themselves. In spite of this, levels of diagnosed COPD amongst these populations tend to be low as they do not present until hospitalized.

There have also been issues raised nationally about the engagement of some female patients from South Asian backgrounds with services such as pulmonary rehabilitation or taking an active part in self-management. The British Lung Foundation has set up a working group to look at access to services for BME communities and will report in early 2012. It is recommended that the findings of this report are considered in the development of services locally.

Religion or belief

Although there is no obvious impact of religion or belief on COPD, services should incorporate religion or belief alongside other cultural requirements in the assessment of individuals. This is a particularly important consideration for end of life care.

Disability

As with most services, disabled people with COPD may face barriers to physical access or communication barriers. People with mental health problems are more likely to develop COPD because they are more likely to smoke than the rest of the population, consuming 42% of all cigarettes smoked in England. Any strategies for identifying people with COPD should take account of the high risks experienced by this population, linking into mental health services as appropriate.

Age

The higher prevalence of COPD amongst older people has already been identified. Again this should be considered in relation to prevention and early identification strategies. It is worth noting that as BME communities age, COPD is also likely to become a more prevalent disease.

Sex

COPD is the primary cause of death for a higher proportion of men than women. In the UK, however, the rate of lung disease has been increasing three times faster amongst women than men. Women are also more susceptible to developing lung diseases than men. Stop smoking strategies should, therefore, prioritise the relatively high levels of smoking prevalence amongst girls and young women.

Sexual orientation

There is some evidence that smoking rates are high amongst lesbian and gay people which is significant. Although there is no obvious differentiation in care given following diagnosis based on sexual orientation, ongoing training of staff is important to ensure that negative experiences of services do not discourage people from presenting to services as symptoms develop.

Gender reassignment, marriage/civil partnership, pregnancy and maternity

There is no known impact of these characteristics on COPD.

8) Unmet needs and service gaps

- Early diagnosis: there is no population approach or systematic approach in primary care to the early diagnosis of COPD.
- Accuracy of diagnosis: there is no system for quality assurance of spirometry
- Structured care: access to smoking cessation for COPD patients is not part of the patient pathway for COPD.
- Structured care: improvements in more coordinated care and information sharing,

could lead to improved outcomes for people with COPD.

- Early supported discharge supported by community and secondary care integration.
- Variations in care: there are variations in the care received which is likely to lead to avoidable variations in outcome.
- Systematic carer identification and support. This remains a significant priority to ensure that carers are aware of the services offered, to protect carers' own health (mental and physical), to lessen the burden of care and to ensure that services are carer sensitive.

9) Recommendations for Commissioning

1. Develop population approaches to the identification of people with undiagnosed COPD, including systematic case finding and better recognition of signs and symptoms, integrating with other population based approaches where possible.
2. Improve accuracy of diagnosis of COPD by developing a system of quality assured spirometry
3. Improve training and education of Primary Care staff in the delivery of care for COPD patients.
4. Reduce variation and improve the systematic evidence-based management and review of patients with COPD in primary care to reduce avoidable hospital admissions.
5. Develop personalised care plans with patients with COPD, including self care information and an exacerbation management plan, and consider establishing a key worker role to coordinate care for this at highest risk of hospital admission.
6. Improve quality of care from diagnosis to end of life.
7. Improve access to psychological support and opportunities for motivational support, including the use of telehealth to support self management and remote monitoring of an individuals condition.
8. Develop integration of secondary and community services to enable joint discharge planning and early supported discharge.
9. Provide more care for patients at home with the support of community health and social services.
10. As services are improved and developed locally, consider the differing needs of individuals as identified in the Equality Impact Assessment and the findings of the British Lung Foundation review into access to services for BME communities due to report in 2012 and implement where appropriate.

10) Recommendations for needs assessment work

- Given the large percentage of people with COPD requiring personal care at home identified through national surveys, a needs assessment that takes account of the views and needs of carers should be undertaken.
- Local patient views should be sought on current services and future developments.

Key contacts
Gillian Gibson, Consultant in Public Health Dr Henry Choi, Planned Care Lead, SCCG Dr Rob Rutherford, Respiratory Clinical Lead, SCCG

Appendix 1

Data Annex

Ref No	Description of data	Data source	Other profiles that use this data
Pg 2 & 5	Prevalence of COPD in Sunderland and nationally: • Numbers of people • % • CCG ranking	None given	
Pg 2	Premature death / mortality rate from respiratory disease: • In Sunderland • National average	None given	
Pg 2 & 5	Rates of COPD per Ward per 100,000 population	None given	
Pg 3 & 8	Projections of COPD prevalence	None given	
Pg 4	% of COPD deaths by smoking	None given	
Pg 4	% of COPD hospital admissions by population groups (Sunderland)	None given	
Pg 4	Characteristics of people with COPD	Royal College of Physicians	
Pg 5	COPD patients admitted to hospital as frequent users of primary care	None given	
Pg 5	% of the population in Sunderland that are carers	(census 2001)	
Pg 5	% of the population providing at least 50 hours per week of care	(census 2001)	
Pg 5	Cost of replacing this care is estimated at £706.9 million p.a.	(Circle at University of Leeds/Carers UK)	
Pg 5	Premature deaths from respiratory disease: • In Sunderland • National average • North East	None given	
Pg 6	Standardised Mortality Ratio due to respiratory disease, people all ages	None given	
Pg 8	Numbers diagnosed with and predicted to have COPD in Sunderland 2005 – 2020.	Eastern Region Public Health Observatory	

Pg 8 - 9	Key features needed across the health and social care system to improve outcomes for people with COPD.	National Outcomes Strategy (July 2011)	
Pg 9 - 11	Ten priority actions / high impact changes for tackling inequalities in COPD.	The Health Inequalities National Support Team	
Pg 11	User views	Royal College of Physicians	
Pg 11 - 12	Specific elements that people with COPD and their carers wanted from services.	National Outcomes Strategy for people with COPD and Asthma	
Pg 12	Levels of smoking in the BME community	Health Survey for England	
Pg 13	Levels of smoking by people with mental health problems.	None given	
Pg 13	The rate of lung disease has been increasing three times faster amongst women than men.	None given	